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EXECUTIVE SUMMARY

This report provides a detailed formative evaluation of 15 adult/transitional age youth (TAY) mental health crisis programs funded by the Investment in Mental Health Wellness Act of 2013 (SB-82) in 2018 and implemented in 14 California counties and one city. This formative evaluation was conducted to understand the implementation of mental health crisis services funded by SB-82 and to obtain generalizable lessons learned that will inform future crisis intervention program development in California. This section includes a summary of the background information on the grant funds distributed and methods used; program structures and contextual factors; services delivered and populations served; impact of services from the perspective of community partners; barriers and facilitators to effective program delivery; the important role of community partnerships; and key lessons learned and recommendations.

Background

The Investment in Mental Health Wellness Act of 2013 provided grant funds to improve access to and delivery of crisis triage services across California. These services focused on increasing capacity in crisis prevention, intervention, stabilization, mobile crisis support, and connection with post-crisis mental health services. The goals were to meet the needs of individuals in crisis in the least restrictive manner and to reduce the costs of avoidable emergency department use, law enforcement involvement, and inpatient hospitalizations.

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During the second round of grant funding, from 2018 through November 2021, over $33 million was distributed to 15 grant recipients to fund programs directed to adult/TAY clients. The start-up and operating time varied based on resources available, administrative needs, and the existing structure of each program. Funds were used to build new programs or add services to existing ones.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) required participating grant recipients to participate in an evaluation of their programs. The University of California, Davis (UC Davis), was selected to lead the formative evaluation for the 15 SB-82

grant–funded adult/TAY programs throughout California. The intent of this formative evaluation was to assess ongoing project activities, with a focus on the evaluation of program implementation and progress towards the project aims.[1] The report will inform a subsequent summative evaluation, led by the MHSOAC, which will focus on assessing the degree to which the fully matured programs have met their stated goals.

The UC Davis team utilized a mixed methods (qualitative and quantitative) approach for evaluation of the 15 adult/TAY programs funded by SB-82. The analysis was conducted from multiple data sources, including the original program grant proposals and the revised program descriptions that followed budget reductions; interviews with program providers, clients, and collaborating law enforcement officers; two surveys administered to grant recipients including detailed questions about each program funded by SB-82; review of memoranda of understanding (MOUs) that grant recipients secured with community partners; and county census data.

Results

Program Structures and Contextual Factors

The diversity of California counties' infrastructure and geography contributed to the heterogeneity in the composition of programs and services provided across grant recipients. The 15 adult/TAY programs funded by SB-82 were located across diverse regions of California including the North State, Bay Area, Sacramento, Central Valley, and Los Angeles. Population size across the counties served varied widely, from 45,670 (Calaveras County) to 10.2 million (Los Angeles County). Over half of the grant recipients reported implementing programs in nonrural communities. The resources (e.g., number of psychiatric beds) and needs were largely unique to each region, reflected in the variability of the program models seen across grant recipients.

Key Contextual Factors

Key contextual factors that could impact the implementation and outcomes of programs funded by SB-82 were identified through engagement with the Community Advisory Board and individual programs. These factors included:

- Local transportation infrastructure,
- Population size and density,
- Staff retention and burnout,
- Total number of direct service providers in crisis care,
- Local 5150 policy,
- Characteristics of engagement with law enforcement and other agencies,
- Continuity of care, and
- Availability of additional resources to supplement programs.

Across the 15 adult/TAY grant recipients, eight operated their programs with SB-82 funding for 2 to 3 years, five operated for 3 to 4 years, and two programs operated for more than 4 years. **Program activities broadly fit into four categories of service delivery: 1) prevention, 2) crisis access and lifeline, 3) mobile crisis assessment and triage, and 4) post-crisis follow-up.** Most programs (12 of 15) provided services across several service domains, particularly post-crisis follow-up and mobile crisis assessment and triage. Notably, most services were an expansion of existing services or new services integrated within another program.

Across programs there were **substantial differences in structure**, including hours of operation, program locations, services offered (e.g., case management, education, outreach), and other components of care delivery. However, programs were largely **similar in the types of interventions** deployed during client encounters, including psychoeducation, peer support, and de-escalation.

During the evaluation period (2018-2021), all grant recipients were impacted by the **COVID-19 pandemic**. Stresses attributable to COVID-19 have been associated with various negative behavioral health outcomes, including increases in substance use, elevated suicidal ideation, and higher prevalence of mental health disorders.[2] **An important pandemic-related change was the substantial expansion of remote telehealth services.** Five grant recipients reported utilizing telehealth for at least 40% of client appointments, and two reported utilizing telehealth in more than 80% of client appointments.

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Community engagement was integral to this evaluation to ensure a health equity lens was used in the assessment of the programs. The evaluation team engaged with the community on three levels: oversight, research, and public engagement. The evaluation team met regularly with a Community Advisory Board (CAB) and utilized input from key members with personal experience of mental health crises or providing services. Their input informed the design, delivery, and reporting of findings. The evaluation team focused on purposeful sampling of urban/rural and racially diverse settings for qualitative interviews of clients, providers, and law

enforcement personnel involved in the programs. The team also collected quantitative data focused on training that supports culturally responsive practices, language availability and translation services, and inclusivity in treatment access. Additionally, a team member participated in a ride-along to observe a county crisis care program. This provided a rich context for understanding the complexity of delivering services. Lastly, the team conducted webinars during various stages of the evaluation to solicit feedback to improve evaluation development and aid the interpretation of the findings.

Services Delivered and Populations Served

Based on aggregated data collected via surveys, 14 of 15 of the adult/TAY programs receiving SB-82 grants reported providing **81,643 services** cumulatively during **23,485 encounters with 17,408 individual clients** from the start of the programs through December 21, 2021.[*] Total encounters, which may include the same client more than once, were calculated as the sum of quarterly data and increased from 2018 to 2021.

Clients included a range of ages: children (0-15), TAY (16-25), adults (26-59), and older adults (60+). More than half of encounters across programs involved adult clients aged 26 to 59, and overall encounters were split almost evenly between clients who identified as male and clients who identified as female. Programs served a diverse population of clients, which largely reflected the demographics of the counties in which they were located. However, individuals identifying as Asian were underrepresented in the total client encounters provided by some programs, when compared to their county population. Based on data reported from 14 programs, 44% of total client encounters involved individuals who identified as White, 22% Other, 16% Black, 11% Unknown, 4% Asian, 2% American Native, 1% Hawaiian Native/Pacific Islander, and 1% Multiple Races.

More than half of total services provided by the programs from 2018 to 2021 were case management/brokerage or outreach/engagement services. The most common referral source was hospitals, and programs most often referred to outpatient clinics or services. This finding is notable, given a key goal of SB-82 was to support the development of services that can divert people away from hospitals and the justice system to less restrictive forms of care.

[*] Survey data were reported by individual grantees who utilized sources available to them to report the data requested in the surveys. Survey data was not independently validated.

Impact of Services from the Perspective of Community Partners

Based on personal experiences of delivering or receiving care, providers, law enforcement partners, and clients interviewed reported that they believed **services funded by SB-82 had a positive impact on many key outcomes** detailed in the original call for proposals. These included:

- Reducing the number of psychiatric hospitalizations and involuntary holds,
- Reducing referrals to psychiatric hospitals from the emergency department,
- Reducing emergency department involvement in mental health crisis care,
- Reducing law enforcement involvement in crisis care,
- Increasing the rate of linkage to behavioral health services following an experience of crisis, and
- Improving client experiences of utilizing crisis services.

In addition, interviewees suggested other areas where the services may be making positive impacts, such as supporting those currently unhoused, facilitating longer-term recovery, and reducing suicide.

Provider, client, and law enforcement partner interviewees attributed these positive outcomes to the **low barrier, rapid engagement model** of many programs funded by SB-82, which meant they could intervene during the crisis early, effectively triage, and divert clients to the most appropriate care setting given the needs of the individuals. The additional training mental health providers have in mental health crisis situations relative to law enforcement personnel was considered a critical factor in more effective de-escalation and conducting more complete assessments, which enable the opportunity for less restrictive care outcomes. Positive outcomes were also related to the ability of the programs and providers to develop **positive therapeutic relationships** with individuals who had previously been highly ambivalent or actively resisted behavioral health services. These relationships were considered a critical factor in improving client satisfaction and facilitating engagement into longer-term care.

Barriers to Effective Program Delivery

Barriers to effective crisis care delivery were identified at the **client-level**, the **service-level**, and the **wider community** or **system-level**.

Client-level barriers included low motivation to engage in services during crisis prevention and post-crisis follow-up. Factors that were considered to impact motivation included prior negative treatment experiences, low levels of insight, more severe psychotic symptoms, younger age,

and ongoing substance use. To address these barriers, the importance of rapport and relationship building, consistent follow-through on promises, and the utilization of motivation interviewing were seen as helpful.

Other client-level barriers included homelessness, particularly amongst those that don't have phones or change them frequently, and in situations where the crisis team only has a limited case history of the client.

Regarding **service-level barriers**, the most consistent issue identified concerned the recruitment and retention of licensed providers. Multiple factors were identified, which included:

- The high liability of crisis work, particularly in counties where providers have the power to rescind medical holds;
- Perceived inadequate compensation and under-classification of the role;
- Extended work hours that often included evenings and weekends;
- Increased staff caseloads related to staffing shortages; and
- The highly stressful nature of crisis work, leading to burnout.

Source: Shutterstock.com

Proposed solutions to barriers included higher base pay, collaboration between providers to mitigate staff burnout, and identifying providers who excel within a highly stressful, community-based position.

Other service-level barriers included insufficient program capacity; excessive paperwork and bureaucracy; and the lack of crisis provider availability during moments of crisis, either due to geographic distance or the opening hours of the programs.

Community or **system-level barriers** included the lack of wider service availability, particularly housing services; county-level policies such as mandated law enforcement co-response to crisis events; the difficulty of liaising with services outside the county system; inappropriate referrals; and unique challenges of delivering care in rural or small communities.

Facilitators to Effective Program Delivery

Program providers identified several key facilitators to effective program implementation and care delivery.

Addressing basic needs (e.g., food, clothes, housing) was considered a simple and highly effective method to de-escalate situations and develop rapport with those in crisis. Therefore, carrying food and water during mobile interventions was a suggested outreach strategy to meet clients' needs.

To increase engagement, strategies included **delivering services within the community (e.g., schools, transitional housing programs, drop-in centers)** and **warm hand-offs** to follow-up care. When working with **TAY clients**, engagement was reported to be increased when programs had an active social media presence, used non-stigmatizing language, and used texting rather than phone calls.

Optimal crisis program structure included providing services 24/7 as a substantial proportion of crisis incidents occurred either late in the evening or during weekends. Additionally, 10 of 14 SB-82 grant recipients reported that working with **certified peer specialists** helped to normalize and destigmatize mental illness and decreased power differentials. Peer specialists helped clients to navigate community resources and authentically relate to clients, which led to increased client trust, engagement, and follow-up.

Provider Skills

Effective **provider skills** included:
- Empathy
- Use of destigmatizing language
- Timely follow-up
- Awareness of the power differential between the client and an individual who has the power to place an involuntary psychiatric hold
- Delivering services with a client-oriented and client-directed focus

Additional provider skills necessary for crisis care included:
- Effective de-escalation skills (e.g., neutral tone, respect for personal space)
- Risk assessment skills
- Use of motivational interviewing

Other facilitators identified included respect and collaboration among the care team, extensive support and supervision for clinicians, laptops with necessary paperwork available within the community, uniforms, mobile phones that have signal in rural areas, vehicles that could navigate the terrain in rural areas, standardized assessments to identify client referral needs and structure the risk assessment, incorporating physical health providers, bilingual program providers, and increased staff training.

Community Partnerships

A key facilitator to effective crisis care included the development of strong collaborations with community partners such as local law enforcement, emergency departments, other county behavioral health teams, and other community agencies. These collaborations were reported to be **critical to the delivery of safe and effective care, to ensure crisis services were able to meet the need in the community and to connect clients post-crisis through linkage with longer-term care.** Building these collaborations can present challenges, such as balancing competing priorities between mental health providers and law enforcement co-responding to the same client, rules and regulatory barriers, patient confidentiality, and mental health stigma. **Outreach, respect for and knowledge of a collaborating provider's role, trust, defined expectations, and clear communication** were reported as important variables to foster effective working relationships in the high-stress environments of crisis care.

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Key Lessons Learned and Recommendations

Key Lessons Learned Overview
• **Over $33 million** was invested in 15 adult/TAY mental health crisis programs in the second round of SB-82 funding.
• **81,643 services were provided to 17,408 clients** from 2018 to 2021.†
• **The programs served a diverse population** of clients, which largely reflected the demographics of the counties in which they were located.
• **A one-size-fits-all crisis care model will not meet the needs of individual counties** due to unique challenges and opportunities present within each county.
• **Program sustainability is a recurring challenge.** Initial program planning and design should include identifying mechanisms to sustain crisis programs beyond the grant funding period.

† Data is based on 14 programs. City of Berkeley was not included due to the unique nature of being a telephone hotline only.

Crisis Care Delivery

- **Deliver crisis care through a transparent, empathetic, and person-centered approach.** The most valuable skill reported for a crisis provider was the ability to establish rapport and trust with individuals and their families. Providers and law enforcement participants emphasized the importance of showing empathy and humanity, the use of destigmatizing language, awareness of the power differential between the client and an individual that has the power to place an involuntary hold, rapid follow-up on the established plan, and delivery of services with a person-centered focus.

Source: Shutterstock.com

- **Care across the crisis continuum should be delivered *in* the community.** "Meeting the people where they are" as a low-barrier alternative to clinic or facility-based services was considered necessary to successfully identify those in need and to support ongoing engagement in care.
- **Offer linguistically and culturally appropriate services.** Making appropriate materials and translation services readily available is critical during a crisis response.
- **Utilize social media, non-stigmatizing language, and texting rather than calling when supporting TAY clients.** Program providers reported that these strategies were important to connect with TAY clients and increase engagement.
- **Provide post-crisis follow-up support and coordinate with community-based services.** Provider and law enforcement participants indicated that support following a crisis was essential to facilitate client engagement in longer-term care, which in turn can promote recovery and reduce the risk of future crises. Additionally, a greater proportion of clients were successfully linked to longer-term care if crisis service providers utilized warm handoffs with community-based service partners and actively supported them in attending their first session.

Program Structure

- **Extend mobile crisis availability outside of standard office hours.** Only three programs (20%) provided services 24/7. Funding and recruiting providers to deliver services at night

and on weekends can be challenging, but both law enforcement and provider interviewees reported that this is when a disproportionate amount of crisis events occur. The lack of availability of crisis triage services during these periods may limit the ability of programs to meet crisis needs in their communities, and lead to increased involvement of law enforcement and emergency departments.

- **Incorporate peer specialists into crisis care programs.** In the qualitative interviews, peer specialists were considered critical to improving engagement in care through normalizing and destigmatizing mental illness, decreasing power differentials between clients and providers, and fostering trust in services.

Source: Shutterstock.com

- **When conducting mobile crisis work, provide for basic needs (e.g., food and water).** Multiple providers suggested that having water and food on hand during crisis assessments can be a highly effective tool to de-escalate a challenging situation and facilitate client engagement in the process.
- **Use technology to create efficiencies.** Providers reported it was helpful to deliver services via telehealth in routine situations when rapport has already been established. Programs also described optimizing electronic health record systems to easily capture needed data and streamline information sharing.

Crisis Program Staffing

- **Utilize a higher base pay and/or a higher classification title to improve recruitment and retention of mental health clinicians.** Recruitment and retention of mental health clinicians were reported as the *largest barriers* to program success. Increased salary and/or a higher classification title is important to offset both the increase in liability crisis workers face and the need for extended working hours.
- **Address provider burnout.** Senior staff cited burnout as a high area of concern, and a factor in the challenge around staff retention. To reduce staff burnout, support clinician retention, and improve clinician competency, program providers identified the following strategies: offer trainings to enrich professional development, collaborate between providers, increase supervision, set boundaries around work, and support self-care.

- **Increase training and support for providers.** Amongst program staff interviewed, areas of training need identified most frequently included the management of substance use disorders (SUDs), harm reduction approaches, additional risk assessment training, safety planning, and motivational interviewing.
- **Offer full benefits for peer specialists.** Programs faced challenges with retaining peer specialists due to peers wanting to advance their careers, seek full-time employment, and/or receive benefits. Offering full benefits to peer positions may decrease turnover.

Partnership with Law Enforcement and Community Organizations

- **Foster effective collaborations with community partners.** Trustworthy, respectful collaborations with community partners were identified as critical to ensure programs received referrals, enabled access to spaces that may be unsafe without law enforcement support, optimized care delivery, and facilitated linkage to longer-term recovery-oriented services. Law enforcement officers interviewed reported a *culture shift* in their department when they collaborated with mental health workers on crisis calls, resulting in considering alternative solutions and greater knowledge of how to support both clients and themselves.
- **Identify scenarios where law enforcement would not be necessary before responding (e.g., clients who were frequent utilizers and were known to present a low risk)**. While the co-response model was important for safety in potentially dangerous situations, the ability to provide services without the mandated presence of law enforcement was often preferred by clients and was supported by provider staff. This could allow for a more efficient use of law enforcement resources and potentially decrease barriers to crisis care.

Sustainability

- **Identify long-term sustainability plans prior to funding.** Various strategies were considered to sustain programs, including utilizing Medi-Cal billing, future Mental Health Services Act (MHSA) funding, general funds, reducing staff, reducing services, redistributing existing funding sources, and consolidating programs funded by SB-82 into other programs. Despite the variety of strategies, there were challenges with sustaining programs after the grant funding ended. Anticipating common challenges outlined in this report, building infrastructure that supports program facilitators, and identifying sustainable funding streams from the outset may decrease the likelihood of the difficult cycle of establishing and closing programs often experienced with cyclic grant funding and improve the overall mental health program landscape in California.

Conclusions

These formative evaluation findings indicate the beneficial impacts of the mental health crisis programs funded by SB-82 and document the provision of services to many clients across the state in the face of numerous challenges. Overall, these programs have been highly successful at delivering a range of crisis services during the unprecedented backdrop of the COVID-19 pandemic. Proposed facilitators to effective crisis care have the potential to inform how crisis services should be delivered across the state and beyond. Finally, while the beneficial impacts of the programs appear promising, exploring program outcomes on hospitalization, incarceration, and other quantitative metrics as part of the SB-82 summative evaluation will be critical to assessing the overall impact of these services.

BACKGROUND

Status of Mental Health Crisis Services in California

A mental health crisis is defined as "any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community."[1] Examples of crisis situations include but are not limited to thoughts of suicide, aggressive or erratic behavior, losing touch with reality, rapid mood swings, or an inability to perform basic daily tasks.[1] The goal of crisis service programs is to provide timely assessment and immediate support, referrals, and access to the least restrictive settings that support stabilization. From 2008 to 2019, the rate of serious mental illness diagnosed in California increased by more than 50 percent.[1] The pandemic further exacerbated mental health concerns, with a reported prevalence of anxiety and depressive symptoms tripling between April and June 2020 compared to the previous year,[2] adding more mental health crises and putting greater demands on the mental health system.

To meet the range of demands presented by mental health crises, several service models have been developed. These include hotlines, community crisis centers, and mobile crisis programs. Services may be located in hospitals, emergency departments (EDs), schools, emergency placement shelters, foster homes, community clinics, jails, juvenile justice settings, homeless shelters, crisis intervention and wellness centers, law enforcement settings, nursing homes, and veterans service offices. Counties across the state have created a variety of systems of care in their given area; however, these systems are often not well integrated, and individual elements often struggle to work cohesively within the larger behavioral health care system, which is widely experienced as underfunded and understaffed.[1]

Source: Shutterstock.com

Investment in Mental Health Wellness Act of 2013 (Senate Bill 82/833)

Expanding mental health crisis services has been a priority of California lawmakers for many years, yet implementing new models of care has proven challenging. People in mental health crises may encounter law enforcement, and often present to emergency departments or psychiatric crisis units. About one in four individuals with mental disorders have a history of arrest, and for 1 in ten, police have been involved in clients needing mental health care.[3] In California from 2009 to 2013, the estimated statewide ED visit rate for people with primary mental health diagnoses was 23.73/1,000 population, with over six-fold variation in adjusted rates between counties.[4]

To address these concerns and the growing need for additional mental health services in California, the Investment in Mental Health Wellness Act of 2013 (SB-82) was approved to provide grants to improve access to and delivery of effective mental health outpatient and crisis stabilization services. The act was expanded in 2016 by SB-833 to apply to children. The SB-82/833 grants, known as triage grants, had three initiatives: adults and transitional age youth (adult/TAY), children and adolescents (children/youth), and collaboration between county behavioral health agencies and schools to promote child wellness (school-county collaboration). The triage grants were intended to provide crisis intervention, crisis stabilization, mobile crisis support, intensive case management, and linkage to services across care sectors. These grant-funded programs aimed to stabilize individuals in their community settings to avoid unnecessary ED visits, hospitalizations, and recidivism in the criminal justice system.

> *Definition of Program Funded by SB-82*
>
> "**Program**" in this report is used to refer to the new or expanded services provided by an individual grant recipient as funded by the SB-82 adult/TAY grant.

The first round of triage grant funding supported evaluation of mental health crisis programs from 2014 to 2017. Grant recipients conducted a local evaluation of their program to understand how their program fit into the larger statewide system. The second round of triage grant funding was released in 2018, with the goal to "help crisis responders connect those having a mental health episode with wellness, resiliency, and recovery-oriented programs that offer the least restrictive settings appropriate for their needs."[5] Twenty counties/entities across the state received grants to fund 30 mental health crisis intervention programs, 15 of which provided services to adults and TAY (see **Figure 1**).

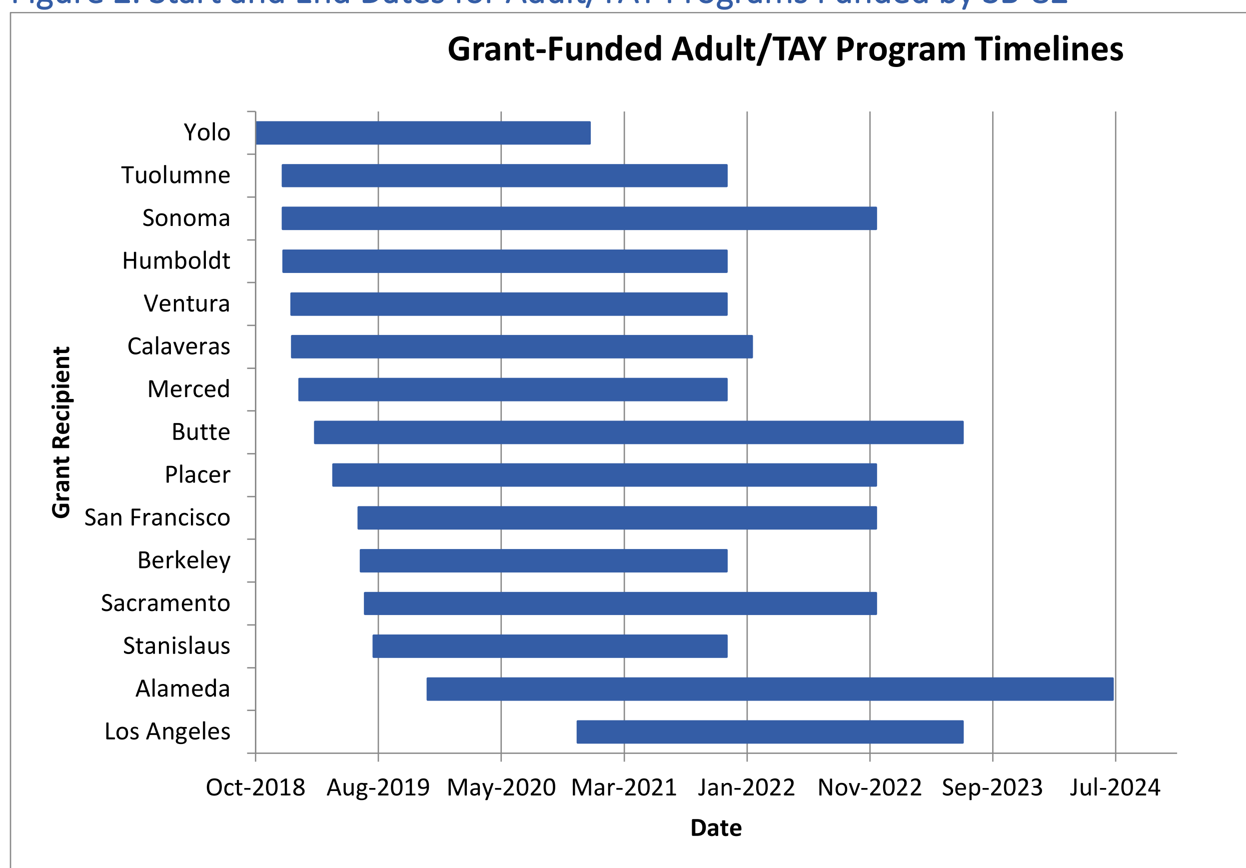
Figure 1. Map of Adult/TAY Programs Funded by SB-82

Counties Funded by SB-82
City of Berkeley Funded by SB-82

To understand the challenges and successes of these grant-funded programs during the second round of triage grant funding, formal evaluations were conducted. The University of California, Davis (UC Davis), was selected to conduct a formative evaluation on the 15 adult/TAY programs funded by SB-82, while the University of California, Los Angeles (UCLA), was selected to evaluate child and school-county collaboration programs funded by SB-82/833. The findings from these formative evaluations will inform a summative evaluation of impact and outcomes across all programs, being conducted by the Mental Health Services Oversight and Accountability Commission (MHSOAC). All teams have worked collaboratively to cross-inform evaluations with the shared goal of providing a statewide story of mental health crisis care in California.

This report details findings from the formative evaluation of the 15 adult/TAY programs funded by SB-82. As explained in detail in the section ***How Programs are Integrated within Other Established Clinical Services***, most SB-82 grant recipients reported using funds to either expand an existing mental health program or add new services to an existing program. However, some grant recipients reported using funds to establish standalone/independent programs. See **Program Descriptions** for individual summaries describing how funds were used by each grant recipient. **Figure 2** shows the start and end dates for each of the programs, as reported by the grant recipients. **Table 1** details the amount of funding each program received.

Figure 2. Start and End Dates for Adult/TAY Programs Funded by SB-82



Note: The original grant end date was November 2021. All programs were offered a 1-year, no cost extension.

Table 1. Grant Funding Awarded by County

Grant Recipient	Funding Awarded
Yolo	$207,909
Calaveras	$212,071
Tuolumne	$461,371
Butte	$514,743
Berkeley City	$614,835
Humboldt	$690,935
Merced	$718,034
Placer	$799,922
Stanislaus	$893,321
Sonoma	$1,194,098
San Francisco	$1,660,527
Ventura	$1,754,733
Sacramento	$2,837,195
Alameda	$3,759,492
Los Angeles	$17,558,367
Total	$33,877,551

Of note, the national crisis hotline — 988 Suicide and Crisis Lifeline — was implemented on July 16, 2022. The data captured in this evaluation covers the period from 2018 through December 2021, and therefore does not reflect how the implementation of the crisis hotline lifeline has impacted crisis services.

METHODS

A mixed-methods design was used for the formative evaluation of 15 adult/TAY programs funded by SB-82. The methods utilized are summarized below and detailed in **Appendix 4**.

Project Aims and Objectives

The focus of this formative evaluation was to understand the complexity of program implementation including underlying layers of context, adaptations, and responses to change.[6]

The first steps to develop the evaluation framework consisted of a literature review and engaging key community members to understand various lived experiences of those providing and receiving mental health services.

Program Evaluation Definitions

The **formative evaluations** were defined as "a rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts."[7]

The **summative evaluation** was defined as a "systematic process of collecting data on the impacts, outputs, products, or outcomes…providing information on the degree of success, effectiveness, or goal achievement of an implementation program."[7]

Literature Review

To understand the effectiveness of crisis interventions on outcomes (e.g., hospitalizations, incarceration) the team conducted a literature search from 1998 to 2018 and identified 17 studies, including systematic reviews, randomized controlled trials, observational studies with concurrent control groups, and a health technology assessment. Findings were categorized using a conceptual framework reflecting the continuum of crisis care (see **Appendix 1** including: pre-crisis (preventive) interventions, first contact interventions (e.g., co-responder interventions), acute crisis services, and post crisis linkage and follow-up interventions.

Results indicated few high-quality studies on the effectiveness of crisis interventions, a point highlighted in six of seven systematic reviews and notable in the lack of tangible findings detailed in **Appendix 2**. An updated search of the literature, including 32 studies from 1999 to 2021, confirmed the lack of high-quality evidence. Although the current literature falls short in providing clear guidance on effective crisis intervention strategies, this process highlighted an important opportunity for the current evaluation to target gaps in knowledge of program development across the crisis continuum.

Community Advisory Board

The team focused efforts on understanding the lived experiences of those delivering services, receiving services, and managing mental health crises through engagement with a Community Advisory Board (CAB). The CAB included members with expertise, experiences, and knowledge of county mental health triage crisis services including members from counties where programs funded by SB-82 existed and who had professional, personal, and/or lived experiences with mental health crisis triage services. Committee members included a client, a patient navigator, a family advocate, a UC Davis law enforcement representative, a public-school representative, two emergency medicine physicians, a mental health administrator, and a representative from the National Alliance on Mental Illness (NAMI). Committee members' expertise and experiences with crisis services provided opportunities for the evaluation team to learn about challenges and successes to explore as part of the evaluation. The evaluation team hosted CAB meetings during each year of data collection on the following dates: December 3, 2019; November 30, 2020; and October 13, 2021. A final meeting to solicit CAB feedback on evaluation findings was held on August 28, 2023.

Source: Shutterstock.com

Key Formative Evaluation Domains

A logic model was developed based on project aims, specified by the MHSOAC from the outset of the project, which helped to guide the evaluation. See **Appendix 3** for details of the model. To address the different components of the logic model, the evaluation team developed key formative evaluation domains presented in the box to the right. See the **Results** section for further discussion of each domain.

Key Formative Evaluation Domains

- Program Structures and Contextual Factors
- Services Delivered and Populations Served
- Impact of Services from the Perspective of Community Partners
- Barriers to Effective Program Delivery
- Facilitators to Effective Program Delivery
- Community Partnership

Qualitative Data Collection Procedures

Semi-structured qualitative interviews were conducted to explore provider, client, and collaborating law enforcement partner experiences of delivering and receiving care, as well as the barriers and facilitators of successful implementation. The process for implementing the qualitative component of the evaluation was completed across three steps:

1. Development of the interview guides,
2. Recruitment and completion of the interviews, and
3. Data analysis.

All interviews were audio recorded, and recordings were transcribed, cleaned, and coded prior to analysis.

Provider Interviews

Two rounds of provider interviews were completed. The goal of the first round of provider interviews was to obtain a baseline understanding of each of the program structures from each of the program leads. The goal of the second round of provider interviews was to gain a deeper understanding of program structures, challenges, and successes with program management, frontline licensed clinicians, case managers, and peer specialists.

Client Interviews

Program staff helped to identify clients to be interviewed. Topics included how clients accessed services, who they encountered as part of the service, if they were linked to follow-up services, and their overall impression of services.

Law Enforcement Interviews

The interviews with law enforcement discussed their involvement in crisis services, how mental health crises were handled when mental health personnel were not present, their experience collaborating with mental health services, and their impression of the impact that crisis services had on both their role and the community.

For detailed methods of the qualitative interviews and the analysis plan, see **Appendix 4**.

Quantitative Data Collection Procedures

The evaluation team designed two program surveys completed by SB-82 grant recipients to collect program-level information (e.g., hours of operation, services provided) and aggregated data on program staff employment, client counts and demographics, referrals to and from programs funded by SB-82, and service provision and utilization. Data from the program surveys were also used to provide information about SB-82 grant recipient sustainability plans and the adoption of telehealth during the COVID-19 pandemic.

The first survey collected data from the beginning of the adult/TAY programs funded by **SB-82** through December 31, 2020. The second program survey — which included additional questions about staffing, peer specialists, community partners, cultural diversity, and other topics — collected data from January 1, 2021, to December 21, 2021. Final program surveys 1 and 2, and the unique final surveys for City of Berkeley and Los Angeles County can be found in Attachment 1.

Survey 1 was disseminated to 13 grant recipients in April 2021. Two grant recipients did not receive the program survey during round one: Los Angeles County and City of Berkeley. Due to substantial differences in two programs (Berkeley and LA County), and delays in implementation in LA County, unique surveys were developed for these programs during round two of data collection.

The updated version of the program survey for round two of data collection was sent to 13 grant recipients in February 2022 and separate, unique surveys were sent to the City of Berkeley and Los Angeles County in March 2022.

For the detailed quantitative methods and analysis plan analysis, see **Appendix 4**.

Other Sources of Data

Other key sources of data were obtained to inform the formative design, including questions asked in the qualitative interviews and incorporated into the program survey. These data sources included program memoranda of understanding (MOUs), county demographic data, community-centered data, webinars, quarterly MHSOAC meetings, and a ride-along with a

county law enforcement program. The sources of data used to inform each key formative evaluation domain are detailed in **Table 2** below.

Table 2. Summary of Data Sources of Key Evaluation Domains

Key Domains	Data Sources
SB-82 Grant–Funded Program Structures and Contextual Factors	• Review of each county's grant proposal • Review of "Summary of Changes" document • Review of county census data • Qualitative interviews with individual programs • Quantitative data from the program surveys • Webinars • Quarterly MHSOAC Meetings • Community Advisory Board meeting
Services Delivered and Populations Served	• Quantitative data from the program surveys • County demographic data from the *ACS Demographics and Housing Estimates* table of the 2019 1-year sample of the *American Community Survey*
Impact of Services from the Perspective of Community Partners	• Qualitative data from the provider interviews • Qualitative data from law enforcement interviews • Qualitative data from client interviews
Barriers, Facilitators & Community Partnerships	• Qualitative data from the provider interviews • Qualitative data from law enforcement interviews • Qualitative data from client interviews • Quantitative data from the program surveys • Review of MOUs

Key: MHSOAC = Mental Health Services Oversight and Accountability Commission; MOUs = memoranda of understanding.

RESULTS

Qualitative Interview Participant Demographics

SECTION SUMMARY

There were three groups of individuals who participated in the qualitative interviews: 1) program providers, 2) law enforcement partners who worked with adult/TAY programs funded by SB-82, and 3) clients of the funded programs. Overall, **50 individuals participated in interviews** (30 providers, 10 law enforcement partners, 10 clients). Following the first-round interviews in 2019, 24 providers were interviewed in 2021, including six (25%) clinicians, nine (37.5%) managers, four (16.7%) peer advocates, and five (20.8%) case managers. The providers interviewed represented diverse ethnic backgrounds, and two-thirds had at least 10 years of experience delivering mental health services.

Both clients and law enforcement partners were interviewed in the latter half of 2022. Most clients interviewed were male (60%) and identified as Hispanic (50%), and the education history ranged from most who had attended some college (60%) to one who attended until 2nd grade (10%). All law enforcement partners interviewed were male and had received crisis intervention training. They represented diverse ethnic backgrounds and the majority (70%) had at least 15 years of experience.

Provider Interviews

In the first round of interviews, approximately 30 providers were interviewed to obtain a baseline understanding of each of the program structures (two providers from each of the 15 participating counties). Interviews took place in the summer of 2019 and included individuals in various staff roles across services (e.g., service providers, data analysts).

Source: Shutterstock.com

Provider Recruitment: Between March 24, 2021, and November 19, 2021, 24 providers were interviewed to explore their experiences of delivering crisis care. Provider demographics are presented in Table 3.

Table 3. Sociodemographic Details of Provider Interviewees

Variable	N=24	%
Gender		
Female	17	70.83
Male	6	25.00
Gender Fluid	1	4.17
Race		
Black	1	4.17
White	19	79.17
Native American or Alaskan Native	1	4.17
More than one race	3	12.50
Ethnicity		
Non-Hispanic	19	79.17
Hispanic	5	20.83
Education		
12th Grade	1	4.17
Some College	2	8.33
Associate's Degree	1	4.17
Bachelor's Degree	3	12.50
Some Graduate School	1	12.50
Master's Degree	15	62.50
PhD	1	4.17
Experience in Mental Health Work		
<5 Years	3	12.50
5-10 years	10	41.67
11-15 years	6	25.00
16+ years	5	20.83
Role		
Management	9	37.50
Clinician	6	25.00
Mental Health Worker	5	20.83
Peer Specialist	4	16.67

Note: Data are from the second round of provider interviews only.

Client Interviews

Client Recruitment: Client interviews took place between June 14, 2022, and November 16, 2022. All 15 grant recipients were invited to support the recruitment of current and former clients of the funded program. The evaluation team met with 11 clients from five of the 15 participating counties (San Francisco, Sacramento, Butte, Ventura, and Alameda). One client declined after a review of the consent form, resulting in a final sample of 10 clients. Client interviewee demographics are presented in **Table 4**.

Table 4. Sociodemographic Details of Client Interviewees

Variable	N=10	%
Gender		
Female	4	40%
Male	6	60%
Race/Ethnicity		
Hispanic	5	50%
Caucasian	2	20%
Black and Filipino	1	10%
Black and Asian	1	10%
Unknown	1	10%
Highest Level of Education		
Some Graduate Education	1	10%
Some College	6	60%
12th grade	1	10%
10th grade	1	10%
2nd grade	1	10%

Law Enforcement Interviews

Law Enforcement Recruitment: Law enforcement interviews took place between August 23, 2022, and December 1, 2022. The evaluation team conducted 10 interviews with law enforcement partners from four counties. Sociodemographic information of the law enforcement sample is presented in **Table 5**.

Table 5. Sociodemographic Details of Law Enforcement Interviewees

Variable	N=10	%
Gender		
Male	10	100%
Race/Ethnicity		
White	7	70%
White and Asian	1	10%
Hispanic	1	10%
Black	1	10%
Years in Law Enforcement		
20+ years	4	40%
15-19 years	3	30%
10-14 years	2	20%
Less than 10	1	10%
Attended Crisis Intervention Training		
Yes	10	100%

Select quotes from the qualitative interviews are presented in the sections below.

Program Structures and Contextual Factors

SECTION SUMMARY

Despite varying differences among programs, services fit into **four broad categories: prevention services, crisis access and lifeline services, mobile crisis assessment and triage, and postcrisis follow-up services.** Most programs provided mobile crisis assessment or triage services and postcrisis follow-up, while fewer programs focused prevention and crisis access and lifeline services. **Only three programs provided services 24/7** while nine programs offered services during various hours, Monday through Friday. Programs offered similar services (e.g., crisis intervention, case management, assessment), provided services in similar settings (e.g., community clinics, hospitals), and provided similar interventions during client encounters (e.g., de-escalation techniques, psychoeducation, peer support).

Most programs were either expansions of existing programs (e.g., extended operating hours or additional staff) or new services integrated within existing programs. As of January 1, 2022, 14 grant recipients employed a total of 198 individuals and 123.5 full-time-equivalent (FTE) employees. Most staff were peer coach/advocates (53 total staff; 34 FTE) or clinicians (47 total staff; 31.25 FTEs), while only four FTE counselors were reported across the 14 programs. Most grant recipients supplemented SB-82 funding with Medi-Cal billing for services and planned to continue to rely on Medi-Cal and future MHSA funding for the continuation of services.

Identifying contextual factors was critical to understanding reasons underlying heterogeneity across programs and will be important to inform the analysis of outcomes across programs. Select contextual factors identified with community partners and program providers included county population size and geography; transportation infrastructure and public transportation; socio-demographic makeup of the population served; services available within the county; availability of training for service providers; recruitment and retention of mental health workers; county rules (e.g., county-mandated law enforcement co-response to crisis assessments); availability of culturally and linguistically diverse services; and the impact of COVID-19.

To address these contextual factors, data were collected to understand county-level characteristics. Population size where programs operated ranged from 45,670 people to 10.2 million. Between the seven programs (46.7%) operating in rural areas and eight programs (53.3%) located in urban areas, there were large differences in the infrastructure and resources available to the program (e.g., availability of psychiatric beds).

This section describes the structure and implementation of the new and expanded services created by SB-82 grant funds across each program, and important county-level contextual factors. This work was conducted to serve multiple functions:

1. Understanding the nature of the services delivered was critical to identify appropriate metrics to evaluate the successful implementation of programs, and to determine the most appropriate outcomes to assess impact. For example, what constitutes an appropriate outcomes evaluation of a crisis hotline may be different from the evaluation of a post-crisis case management program.
2. Identifying potential commonalities across disparate county programs is a necessary part of enabling a statewide approach to the evaluation of services.
3. A significant driver of why counties adopted different approaches to utilizing SB-82 crisis funds relates to broader, county-level factors that impact the programs' services, interventions, and data collection processes and abilities.

Understanding these contextual factors was critical to understanding why such differences may exist, to explain variability in outcomes, and to inform when and how it may be appropriate to compare outcomes across programs.

Structure of Services Funded by SB-82

The SB-82 funding mechanism afforded flexibility in how the funds could be used, enabling grant recipients to allocate grant funds to focus on crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and/or mobile crisis support teams. This enabled California's diverse counties to utilize funds to address each county's unique needs and to tailor the implementation of the expanded services most appropriately to their context. This flexible approach resulted in considerable heterogeneity in the nature of the developed services, which can present challenges to a statewide evaluation of programs funded by SB-82.

Source: Shutterstock.com

Across the 15 programs, despite notable heterogeneity, the different services corresponded to four broad categories: prevention services, crisis access and lifeline services, mobile crisis assessment and triage, and post-crisis follow-up services. **Table 6** specifies the services delivered by each program. Below is a summary of how these categories were defined.

Service Categories Delivered by Grant-Funded Programs

Prevention Services: Providers worked with individuals identified as being at high-risk of experiencing a future crisis event based on their history of engagement with law enforcement and behavioral health services. These typically included those that had frequent interactions with the justice system due to their severe behavioral health concerns, or individuals in Full-Service Partnership (FSP) programs[‡] who experienced frequent, recent behavioral health crises. Services provided typically included case management, with a focus on engagement and de-escalation with the aim of reducing the frequency of crisis events.

Crisis Access and Lifeline Services: Individuals potentially in crisis could contact call centers to receive emotional support, and if necessary, call center personnel arranged for an in-person emergency crisis response with a behavioral health provider.

Mobile Crisis Assessment and Triage: Mobile crisis assessment teams engaged with individuals in the field to conduct a crisis assessment, de-escalated the crises, and triaged individuals to the appropriate level of care based on need.

Post-Crisis Follow-up: These programs provided services to individuals who received a crisis assessment and either not did not meet criteria for hospitalization or were recently discharged from hospital, with the aim of facilitating linkage to ongoing, recovery-oriented behavioral health services, including intensive case management.

[‡] "Full Service Partnership" means the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals (9 Cal. Code. Regs. § 3200.130).

Table 6. Categories of Crisis Care Delivered Utilizing the SB-82 Grant Mechanism, by Program

Grant Recipient	Prevention Services	Crisis Access and Lifeline Services	Mobile Crisis Assessment and Triage	Post-Crisis Follow-up
Alameda	X		X	X
City of Berkeley		X		
Butte			X	X
Calaveras	X		X	X
Humboldt		X	X	X
Los Angeles			X	X
Merced			X	X
Placer			X	X
Sacramento	X	X		X
San Francisco			X	X
Sonoma			X	
Stanislaus				X
Tuolumne			X	X
Ventura	X		X	X
Yolo			X	X

Program Descriptions

A brief summary of each program is detailed below (see **Appendix 9** for more details of each program).

Alameda County

Alameda County Behavioral Health Care Services (BHCS) SB-82 adult/TAY triage grant supported three programs:

- ***Post Crisis Follow Up/Crisis Connect Team:*** A team of behavioral health clinicians and mental health specialists provided follow-up services via telephone to clients who were recently in crisis. This program was for non-high utilizers who may have needed to be connected to any services, whether that be ongoing mental health services, housing resources, or SUD programs.
- ***Community Connections Team:*** Behavioral health crisis intervention specialists and mental health specialists focused on clients with serious mental illness and provided outreach in the field. Staff partnered with Healthcare for the Homeless and other community providers to link clients to on-going mental health services.
- ***Familiar Faces Team:*** Behavioral health clinicians and mental health specialists conducted services in the field for those considered high utilizers, including follow-up visits, care coordination, and linkage to ongoing care or resources.

City of Berkeley

SB-82 triage grant funds helped the City of Berkeley staff operate the Crisis, Assessment, and Triage (CAT) Line to provide clinical support to individuals. The telephone line helped individuals experiencing a crisis and for people concerned about loved ones. Staff provided crisis de-escalation, connection to resources, and support if an in-person evaluation was needed due to safety concerns (e.g., suicidal/homicidal ideations, attempts). Since the City of Berkeley is located in Alameda County, it is important to note Berkeley residents also had access to the services in Alameda County.

Butte County

The SB-82 triage grant expanded the Mobile Crisis Team (MCT) pilot program, a collaboration with the Chico Police Department, by establishing a South County Mobile Crisis team with the Butte County Sheriff's Office, covering all unincorporated areas of the county. The South County MCT provided rapid response to crises in the community utilizing mental health professionals in partnership with law enforcement. MCT counselors provided immediate assessments and coordinated placement, as necessary. MCT peer specialists — individuals with lived experience with mental illness — provided emotional support, shared knowledge, practical assistance, taught skills, and connected people with resources. MCT staff coordinated client placement and transport, as needed. For the next 30 days, MCT staff provided follow-up, problem-solving, and encouragement of engagement in outpatient services.

Source: Shutterstock.com

Calaveras County

SB-82 grant funds allowed Calaveras Behavioral Health Services to hire an adult triage case manager/nurse as part of the Calaveras Behavioral Health Crisis and Outreach Unit, which provided crisis interventions in the community. The adult triage case manager — whose services involved community outreach, stabilization services, and linkages to services — was located at the Sheriff's Office, in order to provide immediate response to crises in the

community. The case manager responded to requests from community agencies and to dispatch calls with potential 5150 holds and provided co-response with law enforcement. The case manager and peer specialist provided follow-up crisis stabilization services.

Humboldt County

SB-82 grant funds supported additional staff for Humboldt County's mobile response team, which assisted individuals in gaining access to effective outpatient and crisis services in the least restrictive manner possible. Clients included individuals in a pre-crisis state and those being discharged from inpatient care. The field-based Mobile Response Team engaged in proactive case management, peer support and clinical care before, during and after a mental health crisis.

Los Angeles County

SB-82 grant funds supported outreach and triage teams in Los Angeles County, which were contracted mental health agencies that provided immediate intervention to assist TAY and adults (16 and older) who were evaluated by psychiatric mobile reports teams and/or law enforcement teams and determined not to meet criteria for involuntary hospitalization. The teams' goals were to connect clients to services and support to avoid hospitalizations. Six contracted agencies served six service areas in Los Angeles County.

Source: Shutterstock.com

Merced County

SB-82 grant funds supported the Mobile Triage Team (MTT) in Merced County, which provided crisis intervention services and mental health evaluations to individuals in the community experiencing a psychiatric emergency. They responded to local EDs within the cities of Los Baños and Merced, and provided crisis intervention services to individuals who were referred by Los Baños Memorial Hospital and Mercy Medical Center. MTT staff determined the level of crisis and need for services, aiming for the lowest level of care possible, ranging from utilizing

psychiatric hospitalization to referring and linking individuals to appropriate services within the Merced County Behavioral Health and Recovery Services system and/or other community resources.

Placer County

SB-82 grant funds supported the hiring of a mental health nurse to join the Placer County Physical and Behavioral Health Mobile Crisis Triage Team (P/B MCT). With a qualified nurse on scene as part of the P/B MCT team, the County addressed the imminent physical health needs of clients, assessed for physical or medical concerns that could complicate the presenting mental health symptoms, and assisted with linkage to medical treatment, if necessary. The P/B MCT team was deployed at the request of law enforcement partners, clients and their natural supports, county and community treatment providers, and community members.

Sacramento County

SB-82 grant funds in Sacramento supported the Youth Help Network (YHN). YHN staff provided a combination of street outreach and co-location at organizational sites that served TAY who were experiencing or were at risk of experiencing a mental health crisis. YHN site–based staff and street teams provided on-demand crisis intervention and linkage services.

San Francisco County

SB-82 triage crisis funding supported a program providing mental health linkage and support services specifically for TAY in San Francisco County. The program focused on youth-specific, developmentally appropriate crisis intervention and stabilization services that both augmented and complemented the area's existing crisis intervention programs.

Sonoma County

The SB-82 triage grant supported the expansion of the Mobile Support Team, a partnership with law enforcement jurisdictions that served the West County. They provided field-based support to requesting law enforcement officers responding to a behavioral health crisis. Staff provided mental health and substance use disorder

Source: Shutterstock.com

interventions to individuals in crisis, including an evidence-based assessment to determine if the individual should be placed on an involuntary hold. They also provided crisis intervention, support, and referrals to medical and social services, as needed. Follow-up services were provided by certified peer specialists to help link community members to ongoing care and treatment to mitigate future crises.

Stanislaus County

The SB-82 adult/TAY triage grant in Stanislaus County supported a program through which staff provided a wide range of triage services to adults and TAY with mental illness or emotional disorders requiring crisis intervention, including those who were homeless or at risk of homelessness and those that were assessed for a 5150 hold but did not require hospitalization. Staff conducted assessments for specialty services and provided support and assistance with systems navigation, referrals, and linkages to appropriate community services in the community for triage clients.

Source: Shutterstock.com

Tuolumne County

SB-82 grant funds supported the expansion of Tuolumne County's Mobile Triage Response Team. The team partnered with community members and law enforcement to provide immediate in-person responses to individuals aged 16 or over experiencing a mental health crisis in the community with access to crisis intervention and/or alternatives to psychiatric hospitalization. Teams included law enforcement liaisons and peer specialists. Post-crisis, staff could help individuals obtain behavioral health services; access community resources, agencies, and benefits; and provide information about community housing, programs, and other services.

Ventura County

The SB-82 triage grant expanded the pre-existing RISE Program offered by Ventura County Behavioral Health (VCBH) by adding two additional teams to serve the adult/TAY population,

particularly the hard-to-reach persons and high utilizers. For the Law Enforcement Partner Team, Community Services Coordinators partnered with law enforcement agencies to provide field-based assessments, interventions, treatment planning, and case management. The TAY Engager Team consisted of two behavioral health clinicians, two community service coordinators, two peer recovery coaches, and one parent partner. They provided outreach and engagement, risk assessment, safety planning, mental health treatment, intensive/targeted case management, linkage to VCBH services, and rehabilitation services to the TAY population.

Yolo County

In Yolo County, the adult/TAY triage grant supported services focused on providing prevention, early intervention, triage, and crisis response services to individuals aged 16 to 29 years residing in Yolo County. Services were provided to youth that presented to the emergency department or to a Yolo County Behavioral Health facility. A clinician provided assessments, de-escalation, developed action plans, and made linkages to mental health services.

Service Delivery

Hours of Operation

Only three of 15 programs (Alameda, Merced, and Stanislaus) provided services 24/7. An additional three programs (Butte, Humboldt, and Ventura) provided services 7 days a week. The program in Placer County provided services Monday through Saturday, with limited hours on Saturdays. The remaining nine programs offered various hours Monday through Friday (see **Table 7**).

Table 7. Program Hours of Operation

Programs Open 24/7	Programs Open 7 Days A Week	Programs Open M-F
Alameda	Butte	City of Berkeley
Merced	Humboldt	Calaveras
Stanislaus	Ventura	Los Angeles
		Placer*
		Sacramento
		San Francisco
		Sonoma
		Tuolumne
		Yolo

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
**The program in Placer County provided services Monday – Saturday, with limited hours on Saturdays.*

Types of Services Offered

The most common service types provided by 14 programs included crisis intervention (14/14), case management/brokerage (13/14), gathering collateral information (12/14), assessment (11/14), outreach/engagement (11/14), rehabilitation (10/14), and plan development (9/14).

Butte, Los Angeles, Merced, San Francisco, and Yolo also offered individual, family, and/or group therapy services. Butte, Los Angeles, Merced, Placer, and Ventura reported offering medication support. For additional details, see **Table A2** in **Appendix 6**.

Service Settings

As shown in **Table 8**, all grant recipients reported that their services could be delivered in the community (church, private business, street, a field, etc.). Six grant recipients (Calaveras, Los Angeles, Merced, Placer, Stanislaus, and Ventura) specified additional community sites (e.g., schools, shelters, and licensed community care facilities like group homes or board and care). Nearly 86 percent (12/14) of grant recipients reported that their services could be delivered in EDs/hospitals, private residences, or by phone; 79 percent (11/14) reported that their services could be delivered in program clinics; and 64% (9/14) reported that their services could be delivered by video.

Table 8. Service Settings

Grant Recipient	Emergency Dept/ Hospital	Program Clinic	Private Residence	Phone	Video	Community*
Alameda	X	X	X	X		X
Butte	X	X	X	X		X
Calaveras**				X		X
Humboldt	X	X		X	X	X
Los Angeles**	X	X	X	X	X	X
Merced**	X	X	X		X	X
Placer**	X		X	X	X	X
Sacramento	X	X	X	X	X	X
San Francisco	X	X	X	X	X	X
Sonoma			X			X
Stanislaus**	X	X	X	X	X	X
Tuolumne	X	X	X	X		X
Ventura**	X	X	X	X	X	X
Yolo	X	X	X	X	X	X

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: The adult/TAY program in the City of Berkeley was a telephone hotline only and was not asked this question.
**Community includes church, private business, street, a field, etc.*
***Reported "Other" setting not listed.*

Interventions During Client Encounters

All grant recipients surveyed (13) reported providing the following types of interventions during client encounters: psychoeducation/resources, peer support, support coping skills, de-escalation techniques, safety plans, worked with family/support system, and coordinated care with providers (see **Table A3** in **Appendix 6**). Most programs also provided motivational interviewing (12/13), removed access to means of self-harm (9/13), and arranged for inpatient admission (11/13). Alameda, Butte, Calaveras, Merced, San Francisco, and Yolo also reported providing emergency medication and/or administration of Narcan.

Staffing

Table 9 reports the census of employment across all surveyed SB-82 grant recipients as of January 1, 2021, and January 1, 2022. The program surveys collected both the number of individual employees (N), as well as the number of full-time-equivalent (FTE) employees in programs funded by SB-82. For example, two part-time employees working half of a full-time shift (0.5 FTE each) are counted as two individual employees, but two 0.5 FTE employees are equal to 1 FTE employee. Hence, the number of FTE employees is always equal to or less than the number of individual employees. Six grant recipients contracted at least one adult/TAY employee using SB-82 funding. Contract employees are included in the table below.

As of January 1, 2021:

- Across 13 programs, 75 individuals (61 FTEs) were employed, an average of 5.8 individuals per grant recipient.
- Both the number of individuals and FTEs ranged widely across programs, with 67% of programs employing between 1 and 11 individuals and between 0.5 and 9 FTEs.
- Sacramento employed the largest number of both individuals and FTEs: 19 and 16, respectively. Yolo County, however, employed no individuals as they were unable to replace the employee funded by their SB-82 grant after the employee moved to another program.

As of January 1, 2022:

- Across 13 programs, a total of 198 individuals were employed, with 123.5 FTE employees.
- The number of individuals employed varied largely across programs; for example, Los Angeles employed 57.1% (113 individuals, 54.6 FTEs) of all staff in 14 grant-funded programs.
- Excluding Los Angeles, grant recipients employed a range of two (Calaveras and Placer) to 19 (Sacramento) individuals, with Stanislaus and Tuolumne reporting 0 employees as both programs' funding ended in November 2021. See **Figure 2** for funding start and end dates for all programs.

- The proportion of FTEs to a program's total number of employees also varied by grant recipient; for example, while all of Alameda, Berkely, Humboldt, Placer, and Ventura's staff were FTEs, only one (20%) of Sonoma's five employees was full-time.

Table 9. Census of Total Workers as of January 2021 & 2022 by Grant Recipient

	Total Number of Individuals Employed (N)		Total Number of Full Time Employees (FTE)	
Grant Recipient	**As of January 2021**	**As of January 2022**	**As of January 2021**	**As of January 2022**
Alameda	6	6	4	6
Berkeley	-	6	-	6
Butte	7	10	5	3
Calaveras	1	2	1	0.75
Humboldt	3	6	3	6
Los Angeles*	-	113	-	54.6
Merced	11	10	9	8.2
Placer*	2	2	2	2
Sacramento*	19	19	16	17.59
San Francisco*	6	4	4	3.4
Sonoma*	2	5	2	1
Stanislaus*	5	0	5	0
Tuolumne	4	0	2	0
Ventura	9	15	9	15
Yolo	0	-	0	-
Total	75	198	61	123.54

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis). Totals are evaluation team's tabulations of grant recipient–level data.
Note: Stanislaus, Tuolumne, Berkeley, Merced, Humboldt, and Ventura programs' funding ended November 2021.
**Grant recipient contracted at least one adult/TAY employee.*
"-" Indicates grant recipient was not surveyed.

Employment across programs varied by role (see **Appendix 6, Table A5** and **Table A6** for detailed staff census by role). Grant recipients primarily hired peer specialists (53 total staff; 34 FTE) and clinicians (47 total staff; 31.25 FTEs). Part-time roles were often undertaken by employees whose job duties included other roles (e.g., a manager may also undertake a role as a supervisor). Grant recipients also employed case managers, counselors, and employees engaged in outreach, which were mostly filled by FTEs. Sacramento employed at least one individual in each of seven roles, while Calaveras employed individuals in only one role.

Based on feedback from the CAB, the team sought to better understand the training and support available for peer specialists by adding questions related to training and benefits to the second version of the program survey. Ten of 14 SB-82 adult/TAY grant recipients reported working with certified peer specialists (Alameda, Butte, Humboldt, Los Angeles, Placer,

Sacramento, Sonoma, Stanislaus, Tuolumne, and Ventura). Eight of those 10 grant recipients reported offering financial support for career development opportunities (certifications, trainings, conferences, or postsecondary education). Additionally, five of those 10 grant recipients reported offering full benefits to peer specialists/advocates, including paid sick leave and vacation, medical, dental and vision insurance, and retirement. The Ventura program offered paid sick leave and vacation. Placer, Sonoma, and Tuolumne programs did not respond to this survey question.

How Programs Are Integrated within Other Established Clinical Services

As shown in Table 10, most grant recipients (11/14) reported using SB-82 grant funds to either expand an existing program (e.g., extend operating hours or hire additional staff) (6/14) or add new services integrated within another program (5/14). Sacramento County was the only grant recipient to report setting up a standalone/independent program with their own site, staff, and management. Butte and Stanislaus Counties reported that their programs were also standalone/independent programs; however, they were associated with established programs or agencies who provided oversight, support, and administration.

Table 10. Program Structures within Existing Clinical Systems

Grant Recipient	Standalone/ Independent Program	Standalone/ Independent Program Associated with Established Program/Agency	Integrated within Another Program	Expansion of an Existing Program, or Additional Staff
Alameda			X	
City of Berkeley				X
Butte		X		
Calaveras			X	
Humboldt				X
Merced				X
Placer				X
Sacramento	X			
San Francisco			X	
Sonoma				X
Stanislaus		X		
Tuolumne			X	
Ventura				X
Yolo			X	

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).

Supplemental Funding Sources

Data on SB-82 grant–funded programs' supplemental funding sources were collected through the program survey. All but one grant recipient reported supplementing SB-82 grant funds with at least one other funding source. The most common method of supplementing SB-82 funding was to bill Medi-Cal for services, indicated by 11 grant recipients, while four indicated using general funds to supplement SB-82 grant funding. Four grant recipients supplemented grant funding with more than one source — most often by billing Medi-Cal and utilizing general funds (see **Table 11**). Ten of 14 grant recipients reported prioritizing billing for services, when possible, though only one program billed private insurance. Six of the 10 grant recipients who reported prioritizing billing for services also reported billing for outreach and engagement activities and five of the 10 billed for screenings that did not result in an intake. No grant recipients reported using private grants, local government grants, or Community Mental Health Services Block Grant funds to supplement SB-82 funding.

Table 11. Sources to Supplement Grant Funding

Grant Recipient	Does Not Supplement	Bill Private Insurance	Bill Medi-Cal	State Gov Grant Funds	General Funds	Other
Alameda			X		X	
City of Berkeley			X		X	Mental health realignment funds
Butte	X					
Calaveras			X			
Humboldt			X			
Los Angeles			X	X		
Merced		X	X		X	
Placer			X			
Sacramento				X		
San Francisco			X			
Sonoma					X	Local tax measure; MHSA funds
Stanislaus			X			MHSA funds
Ventura			X			MHSA funds
Yolo			X			

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: The Tuolumne program did not respond to this survey question.
Key: MHSA = Mental Health Services Act.

Sustainability

Data on SB-82 grant–funded programs' sustainability plans were collecting through the program survey. Eleven grant recipients reported having a sustainability plan to replace SB-82

grant funds, or otherwise continue their programs. Grant recipients planning to replace grant funding most commonly reported utilizing Medi-Cal billing (7/11), future MHSA funding (6/11), and general funds (6/11) to replace existing SB-82 grants to continue their services (see **Table 12**). Aside from new funding sources, grant recipients reported considering other strategies to continue the services funded by SB-82 aside from simply replacing grant funding. Four grant recipients indicated they would consider reducing staff, one would consider reducing services, three may redistribute existing funding sources to sustain their program, and five would consider consolidating their SB-82 grant–funded program into other programs. Four grant recipients (Los Angeles, Placer, Stanislaus, and Yolo) reported not prioritizing replacing funds or otherwise continuing their SB-82 grant–funded programs.

Table 12. Plans to Replace Funding for SB-82 Grant-Funded Services by Grant Recipient

Grant Recipient	Private Insur	Medi-Cal	Local Gov Grant Funds	DHCS Funds	MHSA Funds	MHBG Funds	General Funds	Other
Alameda					X		X	
City of Berkeley		X			X		X	
Butte		X					X	
Calaveras		X			X			
Humboldt		X	X					
Merced	X	X			X		X	Replacement funding finalized
Sacramento								MHSOAC
San Francisco		X						Still identifying sources
Sonoma					X		X	Measure O funding
Tuolumne							X	Applying for grant to fund mobile crisis
Ventura		X			X			

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: Adult/TAY programs in Los Angeles, Placer, Stanislaus, and Yolo counties responded no to having a sustainability plan in place to replace SB-82 grant funds, or otherwise continue the program or the services it provides.
Key: MHSA = Mental Health Services Act.

County-Level Contextual Factors

During the evaluation team's outreach with community members — including initial interviews with program providers and the first CAB meeting — a series of contextual factors were identified as potentially relevant to the evaluation. These included clients' socioeconomic status, race, ethnicity; local transportation infrastructure; county policies regarding 5150s; county policies regarding law enforcement co-response; availability of county ED and emergency medical services (EMS); the local law enforcement's relationship with their community; and the impact of COVID-19. Attendees from webinars, program quarterly meetings, grant recipient personnel, and CAB meetings echoed similar sentiments about which contextual factors were most important in impacting services (see box to the right).

Contextual Factors that may Impact a Program's Delivery and Quality of Services

- Population size
- Geography (rural or urban setting)
- Transportation infrastructure and access to public transportation
- Demographics of the community and population served
- Availability and nature of other services available to crisis care services users in the county (e.g., housing services, community programs, law enforcement, EDs, inpatient psychiatric units)
- Wider availability of mental health resources and crisis training for providers, patients, and families
- Resources to support staff recruitment and retention
- County policies that impact the delivery of crisis care (e.g., county-mandated law enforcement co-response to crisis assessments)
- Availability of culturally and linguistically diverse services
- Impact of COVID-19

To address some of these contextual factors, data were collected to better understand county-level characteristics. Information regarding county population size, geography, and availability of psychiatric inpatient services is presented in **Table 13**. Seven grant recipients (46.7%) met the criteria of serving a rural county[§] while eight programs were located in urban areas (further exploration of the implications of serving a rural versus an urban county is found in **Barriers to Effective Program Delivery**).

[§] From section V.B.3.l. of the original grant recipient proposals submitted; grant recipients designated if their program would be implemented in a "rural community." Rural community" is defined on the proposal application as "counties with more than 80% of their land mass defined as rural or frontier".

Additionally, across the 15 grant recipients utilizing SB-82 funds to implement crisis services, there was a wide range in county population size from 45,670 people (Calaveras County) to 10.2 million (Los Angeles County). This resulted in large differences in the wider infrastructure and resources available to programs and clients. For example, while Los Angeles County reported having 1,984 adult psychiatric beds within their region, two counties (Calaveras and Tuolumne) reported having no beds within their counties. In these counties, providers reported needing to rely on services from neighboring counties, which could lead to challenges in care delivery, coordination, and the availability of inpatient data to evaluate outcomes.

Table 13. Population, Geographic, and Mental Health Infrastructure Information

Grant Recipient	Population	Rural Designation	# Adult Psychiatric Beds
Alameda	1,666,753	No	279
Berkeley City	121,642	No	N/A
Butte	231,256	Yes	49
Calaveras	45,670	Yes	0
Humboldt	136,373	Yes	16
Los Angeles	10,160,000	No	1984
Merced	272,673	Yes	16
Placer	386,166	No	16
Sacramento	1,531,000	No	343
San Francisco	884,363	No	237
Sonoma	504,217	No	75
Stanislaus	547,899	No	67
Tuolumne	54,248	Yes	0
Ventura	854,223	Yes	96
Yolo	219,116	Yes	31

County Variations in Mandate Law Enforcement Co-Response

During initial outreach with SB-82 grant recipients, it became evident that counties had different policies relating to whether law enforcement staff were mandated to co-respond to crisis calls. This was explored more systematically in the program survey, and as indicated in **Table 14**. Four of 13 grant recipients surveyed (Butte, Merced, Sonoma, and Ventura) reported that their county mandated a co-response or involvement of law enforcement when staff from their SB-82 program responded to mental health crises in the community. Four of the 13 grant recipients surveyed (Butte, Calaveras, Humboldt, and Sonoma) reported that their county mandated law enforcement to assist with the involuntary transport of clients seen by crisis services funded by SB-82. This is likely to have a significant impact on what extent these programs can reduce law enforcement involvement in crisis events, and so should be considered an important contextual factor when evaluating related outcomes.

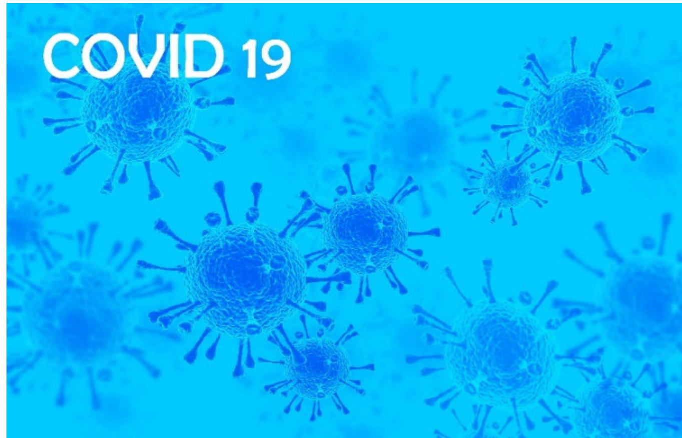
Table 14. County Mandates Regarding Law Enforcement Involvement in Crisis Care

Grant Recipient	Mandated Law Enforcement Co-Response in Crisis Assessments			Mandated that Law Enforcement Conduct Involuntary Transportation of Clients		
	Yes	No	Not Applicable	Yes	No	Not Applicable
Alameda		X			X	
Butte	X			X		
Calaveras		X		X		
Humboldt		X		X		
Los Angeles		X			X	
Merced	X				X	
Placer		X			X	
Sacramento			X			X
San Francisco		X			X	
Sonoma	X			X		
Stanislaus		X			X	
Tuolumne		X			X	
Ventura	X				X	

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: The adult/TAY program in Yolo County ended in 2020 so Yolo was not surveyed for 2021. The adult/TAY program in the City of Berkeley was a telephone hotline only and was not asked this question.

COVID-19 Impact on Service Delivery

At the beginning of 2020, the spread of COVID-19 and the subsequent shelter-in-place mandates resulted in substantial changes in the structure of grant recipients' service delivery. It is important to consider these changes when exploring both service delivery and outcome. A summary of these changes is presented below.



Source: Shutterstock.com

Changes in Crisis Service Delivery

One of the biggest changes brought on by COVID-19 was the expansion of remote telehealth services. Prior to the pandemic, outside of programs that operated hotlines only, Merced County was the only grant recipient offering telehealth. However, this shifted once social distancing policies limited provider and patient access to hospitals or other community agencies. Nine of

13 grant recipients reported adopting telehealth for client appointments as a result of the COVID-19 pandemic: two adopted phone appointments and seven adopted both phone and video appointments. Of these, five said they utilized telehealth for at least 40% of client appointments. Programs in Merced and Humboldt counties said they utilized telehealth in more than 80% of client appointments.

Source: Shutterstock.com

Advantages of Telehealth

Overall, most providers reported the transition to remote telehealth was better than expected. A main advantage of expanding telehealth services included improved efficiency, particularly in rural counties. By removing the travel time between appointments, providers were able to conduct more assessments than before. Many TAY clients preferred telehealth appointments, and across clients, attendance improved largely reported as a result of improved convenience of appointments. Additionally, telehealth made incorporating family members or other collateral informants into assessments much easier, aiding both in care planning and the quality of the assessment.

> *"It's worked surprisingly well. It's going to be hard to go back to going to the emergency rooms, if we ever get to that point, primarily because I can see a lot more people at my desk. I can get through many interviews."*
>
> *Provider Participant SB1002.*

> *"It's been a very high show rate because there's limited barriers. We're not talking about having to find a ride or childcare or things like that, or school scheduling. We can be really flexible as far as timing goes and work around that. So, people are stepping out on their lunch break, being able to talk on the phone versus having to figure out a place to meet and spending more time. So, I'm finding it's being a better show rate for that assessment piece."*
>
> *Provider Participant SB1001.*

Challenges of Telehealth

While delivering services remotely came with advantages, providers also identified drawbacks. For example, program providers reported that establishing rapport via telehealth was more challenging, impacting both the clinical assessment and program retention in follow-up care. Assessing nonverbal cues was also more challenging, especially for individuals experiencing more severe symptoms or significant paranoia. Other challenges included clients not having access to the appropriate technology and confidentiality concerns, particularly for younger clients. At the program level, the shift to telehealth impacted the ability to collaborate with community partners, resulting in fewer referrals, and a less coordinated response.

> *"There's a lot of folks out there who don't have phones, don't have access to a phone. And even if they do have a phone or access to a phone, [they] can't do a helping phone conversation well. Either because they don't use a phone well or because they're not easy to understand. They're not very lucid. Face-to-face, you get a lot more information."*
>
> *Provider Participant SB1010.*

> *"Well, in person we can ask the parent to leave. So that helps. They go to a waiting room. We can do the same with Zoom, but I don't know where they're going. So that would be if the child is concerned about talking about something they don't want their parent to hear, I could see they're not maybe being completely forthcoming for that reason."*
>
> *Provider Participant SB1001.*

> *"Everything went really well and then COVID changed everything because a lot of our live engagements had to stop as we weren't allowed to go out to the hospitals."*
>
> *Provider Participant SB1022.*

Most programs have continued a hybrid in-person and remote telehealth care model to harness advantages of remote working while mitigating the drawbacks. Program providers suggested utilizing telehealth for routine cases for efficiency and reserving in-person assessments for more complicated cases. With regards to prevention and post-crisis support, program providers suggested a flexible approach to best meet client needs.

> *"We haven't gotten too far ahead in planning, but I think that we could probably utilize a hybrid model, really triage each referral and determine what's going to be most appropriate. For those folks that are really cut and dry, and we're able to do a remote assessment, we may continue to do that. People that maybe need a more intensive interview, then maybe we would go in person for those."*
>
> *Provider Participant SB1000.*

Services Delivered and Populations Served

SECTION SUMMARY

Fourteen of 15 SB-82 adult/TAY grant recipients provided data on demographics and services in response to the evaluation surveys. These **14 grant recipients provided 81,643 services during 23,485 encounters with 17,408 individual clients** as from the beginning of their programs (see Figure 1) through December 31, 2021. Total encounters with clients increased from 2018 to 2021. More than half (56%) of encounters across all 14 programs involved adult clients (aged 26 to 59 years) and overall encounters were split almost evenly between clients who identified as male and clients who identified as female. The 14 programs **served a diverse population of clients**, which largely reflected the demographics of the counties in which they are located. However, individuals identifying as Asian were underrepresented in the total encounters provided by some programs, when compared to their county population.

More than half (approximately 65%) of total services provided by 14 grant recipients from 2018 to 2021 were case management/brokerage or outreach/engagement services. Of the grant recipients that documented client referral sources, the most common referral source was hospitals (emergency departments or other referred 33% of clients). Of the grant recipients that documented their program referrals to link clients with services, **36% of encounters resulted in clients being referred to outpatient clinics or services**. Based on data from 12 grant recipients, programs lost contact with 15% of clients, 17% of clients were referred to a higher level of care, 16% of clients were referred to a lower level of care, 4% of clients refused care, 4% of clients completed care, 3% of clients had an unknown outcome (as reported by the grant recipient), 1% of clients were referred out of county, and 39% of clients had dispositions labeled as other.

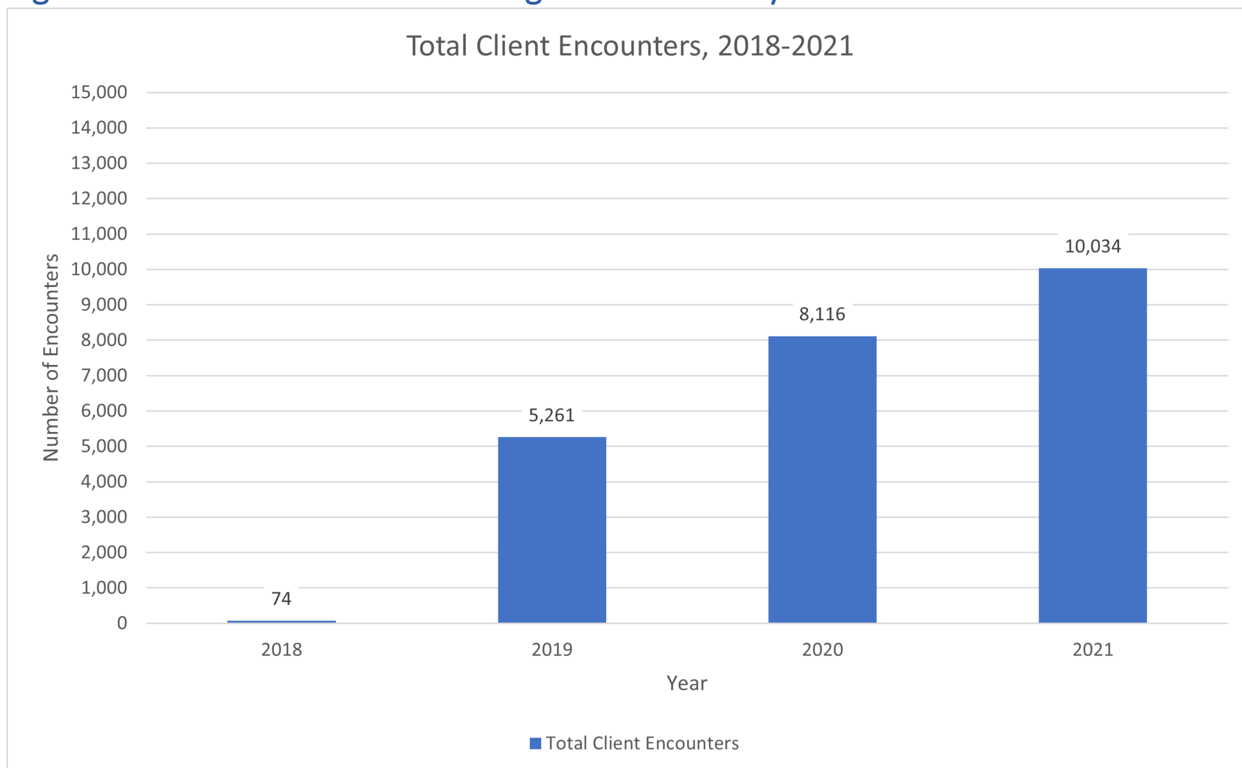
This section reviews the services delivered across programs, describes client demographics, and reports combined data from 14 grant recipients. Data for individual programs are included in **Appendix 7**.

As mentioned above, the diversity of California counties' infrastructure and geography resulted in notable heterogeneity in the composition of programs and services provided by all grant recipients. Data summarized across the 15 programs must be viewed with that heterogeneity in mind.

The 14 grant recipients surveyed (not including City of Berkeley) provided 81,643 services during 23,485 encounters (a definition for encounters can be found in the **Appendix 4**) with 17,408 individual clients as of December 31, 2021. Total encounters with clients by the 14 grant recipients increased from 2018-2021 (**Figure 3**). Eight of 14 grant recipients (Butte, Placer,

Sacramento, Sonoma, Stanislaus, Tuolumne, Ventura, and Yolo) saw fewer encounters in 2021 compared to 2020. However, funding for four of those programs (Stanislaus, Tuolumne, Ventura, and Yolo) ended in 2021 or earlier. Funding start and end dates for all programs can be found in **Figure 2**. Total award amounts for each grant recipient can be found in **Table 1**.

Figure 3. Service Utilization for Programs Funded by SB-82



Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.

See **Table 15** for a summary of total client encounters broken down by age, gender, ethnicity, and race. In summary:

- Across all SB-82 grant–funded adult/TAY programs, clients included a range of ages: children (0-15), TAY (16-25), adults (26-59), and older adults (60+), with more than half (approximately 56%) of encounters with reported ages being adults (26-59).
- While some programs encountered more clients identifying as males, encounters were split almost evenly between those identifying as male and those identifying as female. SB-82 grant recipients also served clients identifying as other genders during 90 encounters.
- SB-82 grant recipients served a diverse population of clients, which largely reflected the demographics of the counties in which they are located. However, individuals identifying as Asian were underrepresented in the total encounters provided by some

programs, when compared to their county population.

Table 15. Summary of Total Client Encounters, 2018-2021

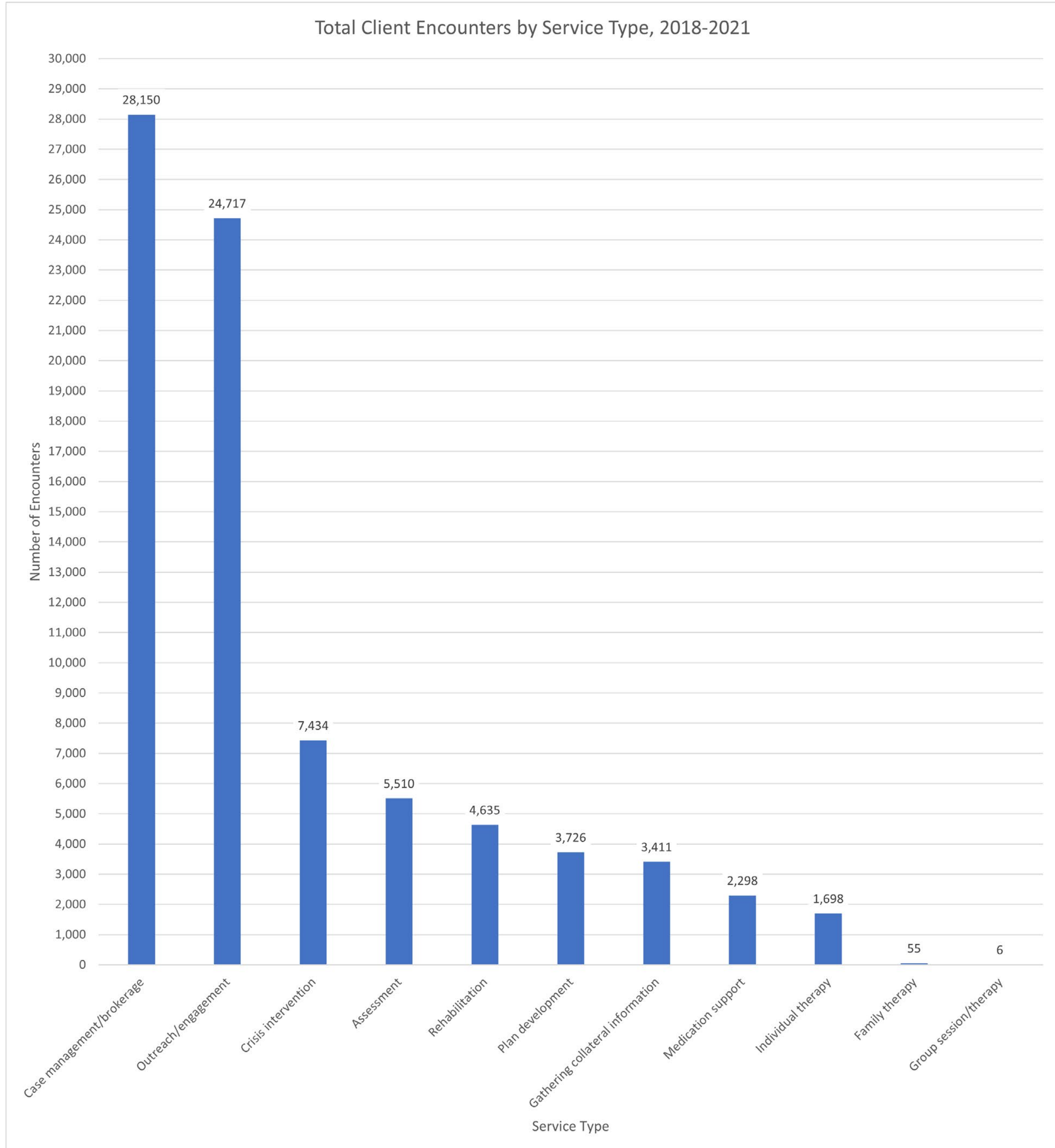
	2018	2019	2020	2021		
Age					**Total**	**% of Total**
Children (0-15)	0	555	422	669	1,646	7%
TAY (16-25)	42	1,386	2,248	2,466	6,142	26%
Adult (26-59)	27	2,727	4,448	5,788	12,990	56%
Older Adult (60+)	4	591	868	946	2,409	10%
Unknown/ Not Reported	1	4	133	3	141	1%
Gender					**Total**	**% of Total**
Female	36	2,569	3,662	4,207	10,474	46%
Male	37	2,737	4,312	5,002	12,088	53%
Other gender	0	24	37	29	90	0%
Unknown/ Not Reported	1	14	105	80	200	1%
Ethnicity					**Total**	**% of Total**
Hispanic/Latinx	15	1,847	2,158	2,611	6,631	29%
Not Hispanic/Latinx	41	2,640	4,526	5,623	12,830	56%
Unknown/ Not Reported	18	775	1,436	1,072	3,301	15%
Race					**Total**	**% of Total**
American Native	2	117	137	87	343	2%
Asian	1	53	122	582	758	4%
Black	5	329	1,169	2,020	3,523	16%
Hawaiian Native/ Pacific Islander	0	33	33	94	160	1%
Multiple	0	30	51	64	145	1%
Other	5	1,322	1,519	1,767	4,613	22%
Unknown/ Not Reported	18	697	884	823	2,422	11%
White	43	2,520	3,762	3,119	9,444	44%

Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.
Key: TAY = transitional age youth.

SB-82 grant recipients offered a wide array of services: assessment, case management/ brokerage, plan development, rehabilitation, outreach/engagement, gathering collateral information, crisis intervention, individual therapy, family therapy, group therapy, and medication support. Definitions of service types can be found in **Appendix 8**. Clients may have received one or more services during a single encounter. Overall service utilization grew for seven of 11 programs from 2018 to 2021. Calaveras, San Francisco, and Tuolumne counties only provided service data for 2021. More than half (approximately 65%) of services provided by SB-

82 grant recipients from 2018 to 2021 were case management/brokerage or outreach/engagement services. See **Figure 4**.

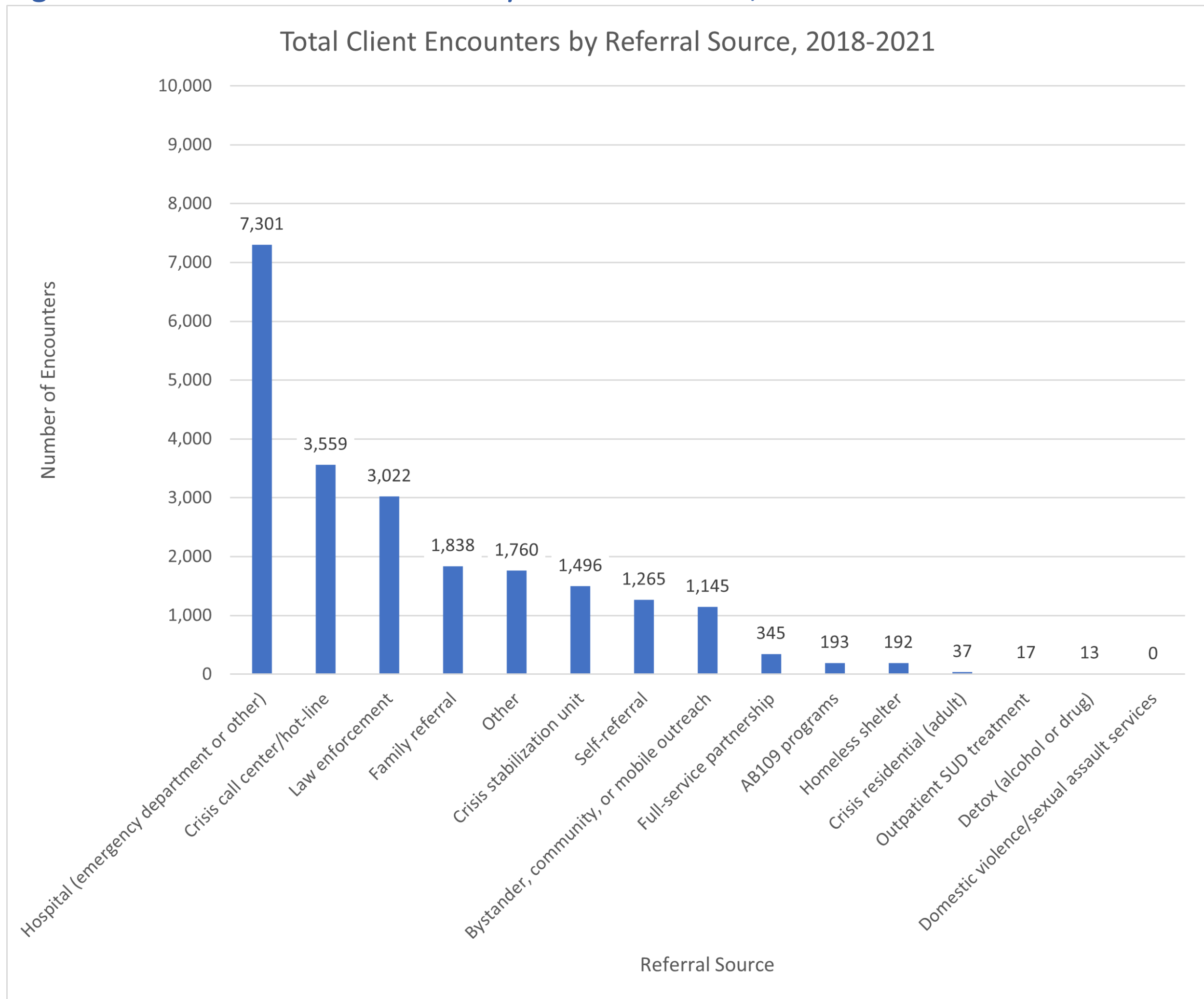
Figure 4. Total Client Encounters by Service Type



Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.
Note: Crisis intervention counts from Alameda County included assessments. Clients may have received one or more services during a single encounter.

Approximately 33% of client encounters came to SB-82 grant–funded programs through referrals from hospitals (emergency departments or other), 16% from crisis call centers, 14% from law enforcement, 14% from self- or family referrals, 7% from crisis stabilization units, 5% from bystanders, community, or other mobile outreach, 2% from full-service partnerships, 1% from homeless shelters, 1% from AB-109 programs (California Public Safety Realignment Act of 2011), and less than 1% from detox (alcohol or drug), outpatient substance use/dependency treatment, and crisis residential programs combined. Other referral sources accounted for 8%. See **Figure 5** below.

Figure 5. Total Client Encounters by Referral Source, 2018-2021

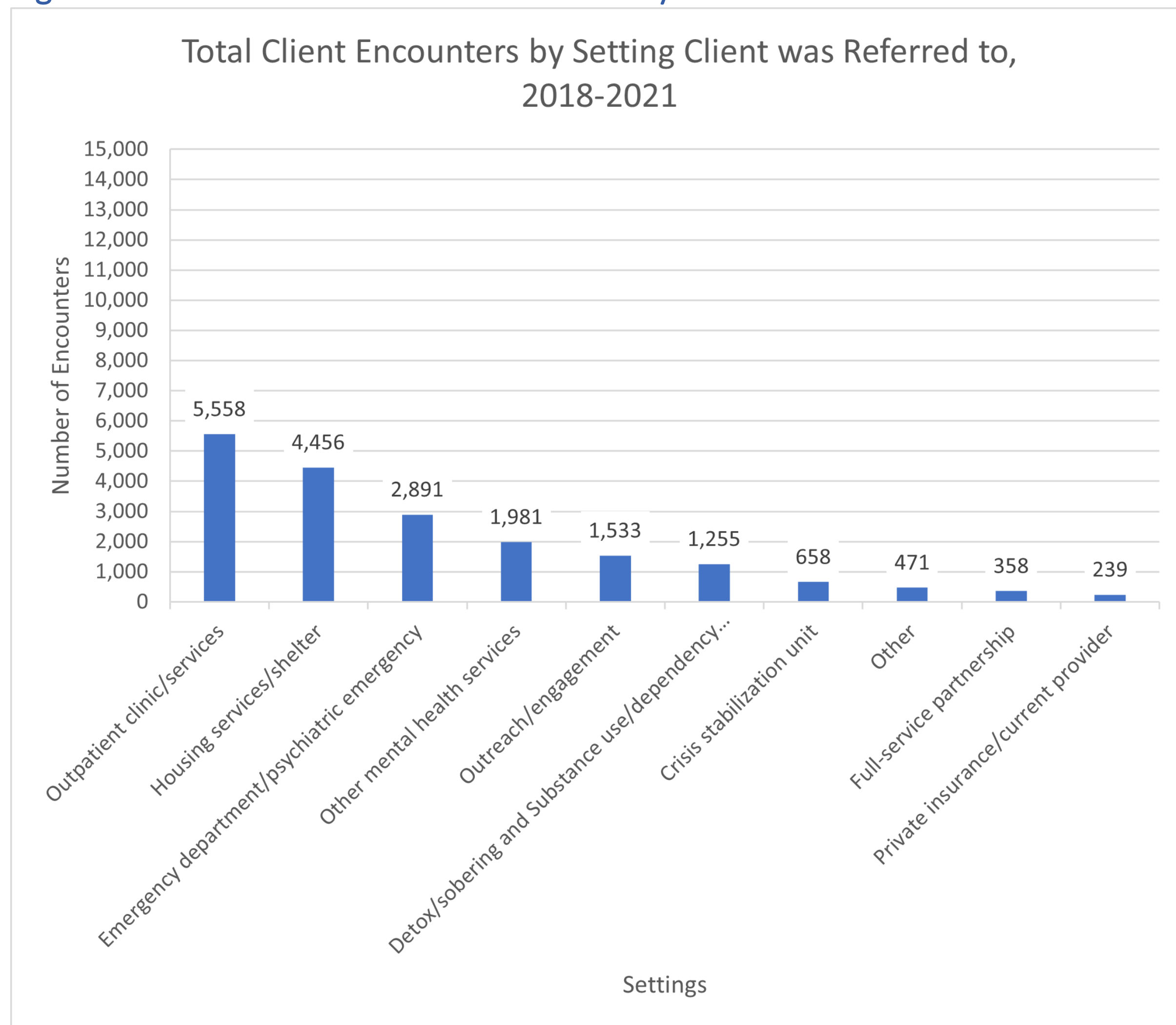


Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.
Key: SUD = substance use disorder.

Some grant recipients provided data documenting client referrals (**Figure 6**). Approximately 36% of encounters resulted in clients being referred to outpatient clinics or services, 19% to

EDs/psychiatric emergency centers, 13% to other mental health services, 10% to outreach/engagement, 8% to housing services/shelters, 4% to crisis stabilization units, 4% to detox/sobering and substance use disorder treatment, 3% to other, 2% to full-service partnerships, and 2% to private insurance or current provider.

Figure 6. Total Client Encounters Stratified by Client Referral

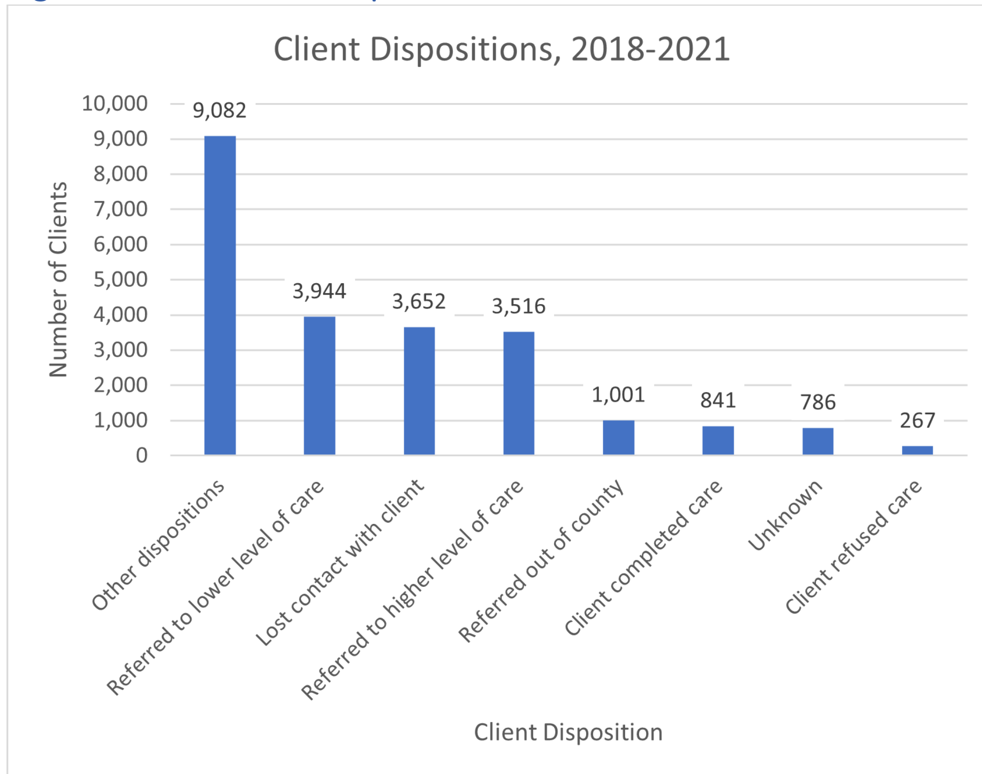


Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.
Notes: Client disposition data from Los Angeles County were categorized differently and were mapped to the most appropriate categories. Raw data from Los Angeles County is available upon request.
Housing services/shelter includes board and care, shelter (homeless, domestic violence, and other).
Detox/sobering and substance/use dependency treatment includes residential rehabilitation, detox/sobering, and substance use/dependency treatment.
Other includes programs written responses which included social services, community resources, mild/moderate mental health plans, employment services, medications services, and assessment.

Some grant recipients reported data on client dispositions or outcomes from 2018 to 2021 (**Figure 7**). Based on data from 12 grant recipients (Alameda, Butte, Humboldt, Los Angeles,

Merced, Placer, Sacramento, San Francisco, Sonoma, Stanislaus, Tuolumne, and Ventura), programs lost contact with 15% of clients, 17% of clients were referred to higher level of care, 16% of clients were referred to lower level of care, 4% of clients refused care, 4% of clients completed care, 3% of clients had an unknown outcome (as reported by the grant recipient), 1% of clients were referred out of county, and 39% of clients had dispositions labeled as other.

Figure 7. Total Client Dispositions



Source: Evaluation team's tabulations of available program-reported quarterly data obtained from surveys of 14 grant recipients.
Note: Client disposition data from Los Angeles County were categorized differently and were mapped to the most appropriate categories.

Service Impact from the Perspective of Community Partners

SECTION SUMMARY

Based on personal experiences of delivering or receiving care, providers, law enforcement partners, and clients interviewed reported that they believed **SB-82 grant–funded services had a positive impact** on many of key outcomes detailed in the original call for proposals. These included:

1. Reducing the number of psychiatric hospitalizations and holds,
2. Reducing referrals to psychiatric hospitals from the ED,
3. Reducing ED involvement in mental health crisis care,
4. Reducing law enforcement involvement in crisis care,
5. Increasing the rate of linkage to behavioral health services following an experience of crisis, and
6. Improving client experiences of utilizing crisis services.

In addition, participants suggested other areas where the services may be making positive impacts, such as supporting those currently unhoused, facilitating longer-term recovery, and reducing mortality.

Provider, client, and law enforcement partner interviewees attributed these positive outcomes primarily to two mechanisms. The first related to the **low barrier, rapid engagement model** of many programs funded by SB-82 that enabled early crisis intervention, effective triage, and direction of clients to their most appropriate care setting given individual needs. The second mechanism concerned the ability for the programs and providers to develop **positive therapeutic relationships** with individuals who had historically been highly ambivalent or actively resisted behavioral health services. These relationships were considered a critical factor in improving client satisfaction with services and facilitating engagement into longer-term care, in turn supporting the key outcomes of recovery and reduced relapses. Overall, these funded services were considered to offer more flexibility for clients, with the added benefit of freeing up ED resources.

As a formative evaluation, a comprehensive examination of SB-82 grant–funded service outcomes was beyond the scope of the present work. However, a qualitative exploration of service impact from the perspective of individuals who had either received or delivered services was conducted to inform future evaluation directions and efforts. Semi-structured qualitative interviews explored how successful the grant–funded programs were at meeting key outcomes including reducing psychiatric hospitalizations and involuntary holds, reducing referrals to psychiatric hospitals, reducing law enforcement involvement, increasing linkage to behavioral health services, and improving client experiences, as well as other potential impacts of the program at the client, system, or community-level.

Reducing the Number of Psychiatric Hospitalizations and Involuntary Holds

Reducing the volume of psychiatric admissions during periods of crisis was considered an important outcome by provider and client interviewees to improve client outcomes and experiences and to reduce health-care costs. Senior providers reported that over recent years their data indicated that fewer psychiatric hospitalizations were occurring, which they attributed at least in part to the impact of the SB-82 grant–funded crisis services.

Source: Shutterstock.com

Dependent upon at what point the SB-82 grant–funded services focused their efforts on the crisis continuum, interviewees proposed different mechanisms for the impact of crisis services. Amongst services that focused heavily on crisis prevention, provider interviewees suggested this earlier intervention supported de-escalation and led to fewer crisis episodes and thus a reduction in the need to place involuntary psychiatric holds. Across the continuum, interviewees suggested that the development of appropriate safety plans meant that hospitalizations were less frequently necessary. Additionally, post-crisis follow-up was considered an effective method to reduce readmissions among individuals who had previously experienced frequent episodes of hospitalization. It was suggested by some interviewees that if the post-crisis care facilitated the link to longer-term, recovery-oriented care, this could also potentially lead to fewer crisis events in the future.

"We track, for FSP clients. We have a whole system that tracks hospitalizations, and incarcerations. And from one year to the next year, we decreased our hospitalizations and incarcerations by about 99% and 89%, or something like that. And so I think that, honestly, a huge part of that was having this crisis clinician. [It] really, really positively impacted the decrease in hospitalizations."

Provider Participant SB1004.

"I think where we saw with our data the most change was the hospitalization rates, I believe, went down. [..] we're able to really work with them to develop a more safe, reliable plan than shifting them to a psych facility."

Provider Participant SB1005.

Reducing Referrals to Psychiatric Hospitals from ED and Law Enforcement Staff

> *"A larger pragmatic part is to free up the emergency rooms and to free up the [PSYCHIATRIC HOSPITALS], which because I'm seeing these people first, I can divert them away. So that's a big part of it, as well."*
>
> *Provider Participant SB1005.*

> *"I think that there may be people that really don't… that are kind of like frequent fliers. Is what I would say, that maybe don't need to have that hospitalization. And that there's a way to kind of intervene and set up a plan of supporting that ER, so that they can go home. And then I also think that people that maybe would have been cut loose to be sent home, but really needed to be on a hold. That there was more ability to support that process."*
>
> *Provider Participant SB1004.*

Officers interviewed reported that their departments almost exclusively transported crisis clients to the ED, rather than to psychiatric hospitals. Data was not available to determine whether this approach was consistent across all participating counties. However, if this approach was consistent across these counties, it suggests that aiming to reduce referrals to psychiatric hospitals directly from law enforcement staff may not be an appropriate outcome to evaluate the impact of SB-82 grant–funded services. Instead, there may be greater opportunity to reduce the volume of referrals to emergency partners by law enforcement officers, which has also been identified as a key outcome (see **Reducing ED Involvement in Mental Health Crisis Care** below for details).

When programs funded by SB-82 grants were integrated into EDs, multiple program provider interviewees suggested their work reduced referrals to psychiatric hospitals. However, one provider suggested that rather than reducing the *volume* of referrals from EDs to psychiatric hospitals, their major benefit was increasing the rate of *appropriate* referrals, which they considered a more appropriate metric of success.

Reducing ED Involvement in Mental Health Crisis Care

Reducing ED involvement in crisis care was seen as particularly important by most interviewees. Law enforcement partners and client interviewees reported mixed experiences of care during a period of crisis in the ED. While for some clients the experience was helpful, for most it was considered a highly challenging component of their crisis episode. Some law enforcement officers reported concern that the environment and staff who work in the space are not focused on supporting mental health wellness, with the issue particularly acute on weekends when psychiatry staff were typically not available. Additionally, interviewees suggested that taking clients to EDs was an inefficient use of resources, both for the EDs and the law enforcement departments. The situation was considered particularly problematic if clients are no longer in a state of crisis but had to wait for an involuntary hold to be released.

Source: Shutterstock.com

> *"You can't stay in crisis forever. So oftentimes they come out of it, then they're sitting in the ER, then they're getting antsy because they don't want to be there anymore. They're out of their crisis, they're not getting the services they need. They're occupying a law enforcement officer who needs to be on the street. They're occupying an ER bed that could be used for somebody else."*
>
> *Law Enforcement Participant LE1006.*

> *"So I think the crisis line, what I do, what my team members are doing, gives them more liberties and gives them more freedom into mapping out their plans. And just, also, realizes that every emergency call, an emergency might be for 60 seconds. Emergencies subside. Things subside. And I think it's so ingrained in us to call the police or go to the ER. I feel like that's an old-school approach. I think we're evolving, and the system is evolving, especially if you have programs like this, to kind of help with that evolution."*
>
> *Provider Participant LE1013.*

To address these issues, different SB-82 grant–funded services attempted to minimize ED involvement in different ways. For example, some providers suggested that services such as crisis lines and mobile response teams can help de-escalate in the moment and allow clients more autonomy in their next steps and care seeking plans that may divert from the ED. In situations where individuals in crisis did present at the ED, in some counties, providers in grant–funded programs were charged with taking over the care and

assessment of individuals in the ED in crisis, meaning ED staff could focus more on physical health emergencies. This was considered to result in a better allocation of resources, having mental health crisis staff focusing on mental health emergencies, while other ED staff could focus on physical health needs. In other counties, providers in grant–funded programs had been given the authority to rescind the hold following an assessment, meaning clients could be discharged from the ED earlier without either waiting for a psychiatrist to assess them, or to be transferred to a psychiatric inpatient unit. Overall, these grant–funded services were considered to offer more flexibility for clients, with the added benefit of freeing up ED resources.

Reductions in Law Enforcement Transferring Individuals to the ED

Source: Shutterstock.com

In the law enforcement interviews, it was reported that when officers attended to an individual in a mental health crisis, historically they would be transported straight to the local ED. However, law enforcement interviewees noted that on the calls when they collaborated with mental health crisis workers, clients were less likely to get transported to the ED and more likely to get sent home, relative to when they work alone. Three reasons contributed to this difference. First, multiple officers indicated that mental health workers typically have more options available to them as an alternative to placing a hold and transporting clients to the ED. Second, they suggested that mental health workers have more extensive experience to de-escalate a situation, assess risk, and develop safety plans in a way that creates more alternatives to an inpatient visit. Multiple officers suggested that their lower level of experience and expertise led to them being more cautious when mental health workers were not present to minimize the risk of a more negative outcome. Finally, some

> *"If I go to a call where someone says that their family member is suicidal and they've slit their wrists, my assessment is typically going to be obviously they've taken the next step and they have actually attempted. [...] So I would always determine - typically determine - this person is '5150' and they would need to go to the hospital. Now, the crisis team doesn't always do that. They will give them options. And maybe it's because they have a deeper understanding of what the behaviors are causing, or they've dealt with this type of stuff a lot more in an extensive manner, but they won't always place that person on a hold or take them to the hospital."*
>
> *Law Enforcement Participant LE1004.*

> *"Yeah, there's a lot of times when she's not there, let's say, on the overnight shift after 7:00 PM. Yes, there's a crisis situation, but in order to just make sure that they don't have to continually respond to something, then it might be just a knee-jerk and say, 'Okay, we're going to place this person on a hold just to take them to the hospital and be done with that situation.' So, it's almost like putting a band-aid on it and not really getting to the root of the problem or getting the resources there."*
>
> *Law Enforcement Participant LE1005.*

officers suggested that mental health staff are more motivated to find alternative solutions relative to some officers who may be less willing to pursue alternative solutions. More positively, many of the law enforcement officers interviewed felt collaboration with mental health workers contributed to a culture shift in their department, resulting in a more active pursuit of alternative solutions, and greater knowledge on how to support less restrictive outcomes for clients.

Reducing Law Enforcement Involvement in Crisis Care

Law enforcement and provider interviewees indicated while co-response models can increase the involvement of law enforcement in some situations, crisis services can substantially reduce the involvement of regular patrol officers in crisis care in multiple ways. This includes reducing the number of crisis-related 911 calls being made, reducing the proportion of crisis 911 calls that regular patrol officers need to attend, reducing the length of time the patrol officers need to attend during crisis situations, and reducing the number of crisis events that occur amongst those that frequently interact with law enforcement when in crisis.

Source: Shutterstock.com

> *"I think that the hotline was really successful in reducing demand on mobile crisis and law enforcement. Just by looking at the numbers of, like, almost none of our calls involve even reaching out to law enforcement for a consult or asking them to go out. So whatever percent of those calls would have been calls to law enforcement, they didn't happen. They came to us instead and law enforcement didn't even get the call."*
>
> *Provider Participant SB1010.*

> *"Before the Mobile Crisis Team existed, if I were on a call and somebody was on a mental health hold, I would put them in the back of my police car, I would drive them to the hospital, I'd be required to wait at the hospital until the medical staff released me. So this could take several hours. Now, literally the officer goes to the scene, the Mobile Crisis Team comes out, they take custody of the person and the officer leaves. So you're seeing more efficiency for our organization. You're seeing less police data, so less police reports. Then you can have the officers focusing on other police matters instead of mental health matters."*
>
> *Law Enforcement Participant LE1009.*

Provider and law enforcement interviewees suggested that reductions in law enforcement involvement could potentially be occurring via multiple mechanisms. First, many SB-82 grant–funded programs implemented a crisis hotline. This was considered an effective mechanism by which to reduce the number of people calling 911 for crisis-related issues, therefore removing law enforcement involvement from the outset. In some counties, crisis program personnel were authorized to respond to 911 calls without a law enforcement presence if there was no concern for danger, which interviewees suggested reduced the number of mental health–related callouts for law enforcement. In situations where a law enforcement presence was required either due to safety concerns or county policy, the crisis program was considered an effective method in which to reduce the length of time law enforcement officers were required to be on the scene as they could leave the scene earlier and let the crisis worker manage the scene if there was no threat to safety. Finally, several law enforcement interviewees indicated that the care and linkage provided by the crisis team had reduced the number of 911 calls made by individuals who had historically made very frequent contacts with emergency services. Collectively, this has the potential to reduce costs and allow law enforcement to focus on situations that benefit most from law enforcement involvement.

Reducing the Use of Force, Arrests, and Incarcerations

In addition to the reduction in law enforcement involvement in crisis situations, some law enforcement and provider interviewees also suggested that SB-82 grant–funded crisis services had led to a large reduction in arrests, court appearances, and jail time amongst the population

they work with. Additionally, some law enforcement interviewees noted that they were much less likely to use force in crisis situations with the mental health professional present, given they are typically able to lead the situation and effectively de-escalate the situation.

> *"In the experience that I've had during the time that we've been together, I think maybe only twice we've really had to forcefully have somebody go with us or place somebody in handcuffs. Usually, we can get them to calmly go and go to the hospital even though we're still going to place them on a hold. But as far as forcefully grabbing them and making them move from one place to another, very, very rare by having a counselor there. Because you can kind of take a few steps back."*
>
> *Law Enforcement Participant LE1005.*

> *"Somebody was throwing rocks at mailboxes, [law enforcement] went out there, that person ended up having to be put on a restraint system, the deputy was injured. I knew that person, I'd helped them go to the hospital about three months prior and be placed on a 5150 hold because they weren't safe with themselves. I feel like with that relationship, we've worked hard to establish a connection and rapport, so that we probably would have had a different outcome."*
>
> *Provider Participant SB1018.*

Interviewees identified two potential mechanisms by which reductions in the use of force, crimes, and incarcerations could occur. One important feature of crisis care is the fact that it enables mental health workers to develop relationships with those that experience frequent crises. Multiple providers suggested that through developing such a relationship, clients are more receptive to engaging with them, and better trust the outcome of the triage assessment. Second, for some clients the presence of law enforcement officers, and the policies they are typically required to follow, was identified as a factor in the escalation of crisis situations.

Increase the Rate of Linkage to Behavioral Health Services

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Another critical component of the SB-82 grant–funded services was the provision of linkages to other community services. Most client interviewees reported receiving linkage to longer-term care, as well physical health services and resources for daily living. Services reported include mental health care, community organizations, and support for obtaining benefits.

Furthermore, linkage was seen as a critical factor to supporting ongoing recovery and seeing improvements in key outcomes.

Mechanisms to Increased Linkage

Regarding how crisis services could potentially result in increased linkage to longer-term care, four mechanisms were proposed. These included: 1) crisis providers having greater knowledge of what services may be available; 2) the ability of service providers to support navigating what can be a confusing, complex system; 3) crisis services having expedited access to particular care systems; and 4) crisis programs supporting clients to engage once an appointment had been booked.

> *"She [the crisis case manager] started something. [...] I had to take care of myself to make myself better, to be on the right medication and stuff, to see the right doctors, to get on the right track. And once I started rolling along, then it kind of started falling into place. [...] She got me on that track to where I needed to be."*
>
> *Client Participant SU1006.*

> *"I know there's people that have gotten help, clinic, psychiatric, medical, those people that's gotten housing as a result of knowing who the clients are, knowing their stories, and just plugging away and continually trying to get to the next step with them. And we've had plenty of good success stories."*
>
> *Law Enforcement Participant LE1001.*

Multiple client interviewees reported having limited knowledge about available services and resources before being connected with their SB-82 grant–funded service provider. Interviewees also suggested that crisis service providers had a greater knowledge around the availability of services, relative to other professionals such as ED staff and law enforcement officers. In particular, peer specialists were considered to provide a unique insight as somebody who has also potentially utilized some of the services themselves. Even when clients

> *"The peers are amazing in knowing the community resources, and not just knowing them but having had utilized them at one time themselves, or continue to utilize them themselves, so knowing exactly where to pinpoint them or take them to those services. That makes them really amazing."*
>
> *Provider Participant SB1022.*

> *"Navigating all these different programs is exhausting. It's embarrassing. It's humiliating. And so, they definitely make me feel safer."*
>
> *Client Participant SU1009.*

> *"There were a lot of clients that ended up getting incorporated to services that otherwise would have likely not been incorporated into our services, or would have had to have a long, much longer waiting time. I think that the waiting time piece is one of the really big benefits of this position."*
>
> *Provider Participant SB1003.*

knew about care, many found it highly challenging to navigate access to services. Clients expressed needing support to navigate the care field, insurance, and advocacy to ensure they received needed care. Linked to this, both crisis care providers and law enforcement interviewees suggested that mental health workers were able to link clients to services easier and quicker than clients were able to manage independently. This was due to both their increased knowledge of the system and their established relationships with other community services. Lastly, crisis providers followed up with clients to ensure they successfully engaged in services. They often provided warm handoffs, set client appointment reminders, and assisted with transportation. This support was pivotal to clients' successful engagement in long-term services.

Improve Client Experience of Utilizing Crisis Services

Most interviews were with clients receiving post-crisis follow-up care, therefore, client experiences primarily focused on those services. Overall, service user interviewees consistently reported that they were very satisfied with the care that they received. These interviewees referenced the positive relationship they established with their crisis workers and frequently reported they felt like they were treated with respect, which at times contrasted with other service providers within the system. Multiple clients also highlighted crisis providers frequent contact and follow-ups with clients as a contributing factor to their high satisfaction with the services. Notably, when people were asked about how their experience of the interaction with the SB-82 grant–funded service could be improved, most could not identify anything.

> *"It's been like a guiding light. Somebody that doesn't really have a good connection with their parents, I feel like I'm taken care of and I'm considered, and I think I feel valued. I feel like my opinions are, they matter, and I don't feel like I'm just blowing in the wind, and I actually feel like a human being, or I'm starting to feel like it."*
> *Client Participant SU1000.*

> *"Really satisfied for sure. I feel like they helped with what I needed, and they were patient and kind, and that's the most important thing people need when they're in a crisis. They need someone who will be patient, understanding and giving the right resources and just giving compassion to people. So then I feel like overall I was really satisfied with the service."*
> *Client Participant SU1008.*

Other Perceived Positive Impacts of SB-82 Funded Services

In addition to the key areas of interest pre-specified in the **Logic Model**, several other longer-term benefits of crisis services were identified by clients, providers, and law enforcement interviewees. These benefits spanned from personal recovery goals met to improved trust in the system, which they reported led to expanded engagement in community resources.

Housing, Recovery, and Mortality

Interviewees across roles often described the crisis services as the first step in an upward trajectory to meeting longer-term recovery goals. For some, this meant access to housing after being homeless prior to starting SB-82 grant–funded services, for others this meant choosing not to end their life as a result of working with their crisis provider. Services that were intended to be short-term interactions ended up having substantial benefits for the clients' life at large.

> *"I've seen people thrive. I mean it's nice. We've been very lucky with some of the success stories we've had of people that were homeless and they were... Had mental health issues and the work that we put into that. I've gotten letters from parents. I've gotten calls from these people like, 'Hey, you helped me two years ago now I'm this. I'm not homeless anymore and I've gotten services now.' And that's super rewarding."*
>
> *Law Enforcement Participant LE1002.*

> *"I wanted to end my life. And I just couldn't deal with myself. But [provider] did help me in a good way, because she was trying to prevent something like this not to happen."*
>
> *Client Participant SU1006.*

Improving the Dynamic Between Clients and the System

> *"It seems like a lot of times when you have social workers, you're afraid to open up because you don't want to get in trouble or you don't want negative consequences for what you tell them. But I feel comfortable talking to her about anything."*
>
> *Client Participant SU1003.*

> *"It's like, oh, this 19-year-old who used to be in foster care is now homeless. Of course he hates our system. Now, [crisis program] can help rebuild those potentially really traumatizing, maybe irrational, thinking patterns about the system and how it could be helpful, and I think that's really important for just mental health recovery in general."*
>
> *Provider Participant SB1007.*

Several interviewees suggested the relationship that is developed through the course of follow-up care is a critical facilitator to improved perceptions of mental health treatment. Providers, clients, and law enforcements officers who were interviewed described clients as often highly traumatized and stigmatized by others, and so the opportunity to be treated with respect and dignity during the follow-up period led to increased satisfaction with services. During this period, many described a highly patient-oriented approach that supported the wider needs of the clients, which in turn developed trust in the service and opportunities for additional psychological education. This process was considered to result in clients being more receptive to engaging in longer-term behavioral health care in the future.

While the perspectives of interviewees detailed through this section are highly encouraging, it is important to note that it is unknown if results are generalizable because all interviewees were volunteers. See the **Limitations** section for more details.

Barriers to Effective Program Delivery

SECTION SUMMARY

Barriers to delivering crisis care were centered around **recruiting and retaining staff**, particularly licensed clinicians, behavioral health workers and peer specialists. Drivers behind these challenges included the high liability of crisis work in counties where providers have the power to rescind medical holds, perceived inadequate compensation and under-classification of the role, extended work hours that included evenings and weekends, increased staff caseloads, and the highly stressful nature of crisis work leading to burnout. Program providers reported that unexpected staff vacancies may result in an increase in staff work hours and caseloads (as reported by 69% of survey respondents), and a reduction in services, further exacerbating the issue.

Proposed solutions to barriers included **higher base-pay**, **collaboration** between providers to mitigate staff burnout, and identifying providers who excel within a highly stressful, community-based position, given the unique challenges associated with the role. Additionally, **increased supervision** and **training** in substance use disorders and harm reduction approaches, risk assessment and safety planning training, and motivational interviewing techniques could better equip providers to effectively manage common challenging crisis cases. Lastly, helpful trainings may include diversity training, cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) approaches, training in sex trafficking, solution-focused therapies, and more training in trauma-informed approaches.

The qualitative interviews focused on understanding how to effectively implement crisis services, including perceived challenges to achieving program goals, which the evaluation team defined as “barriers.” The qualitative data was augmented with quantitative data collected via program surveys. As a result, an array of barriers to effective crisis care were identified. These data are important in informing the design and development of new programs and refining the implementation of existing services.

Recruitment and Retention

The largest identified barrier to successful implementation of services identified by providers included the challenge of recruiting and retaining key clinical staff. Consequently, the evaluation team explored each grant recipient’s ability to recruit and retain program providers and some of the solutions to rectifying these challenges.

Recruiting and Retaining Clinician Providers

Source: Shutterstock.com

The primary challenge grant recipients reported were recruiting licensed clinical staff. While clinician recruitment was considered challenging across general mental health services, many providers suggested it was particularly difficult to recruit into crisis programs. Recruitment issues included extended work hours most clinics operated; increased risk, liability, and stress that accompanied working in crisis care; being primarily in the field rather than office based; the desire of many clinicians to deliver longer-term care; and being underpaid or under-classified given the inherent challenges of the position. The challenge to fill clinical positions was also recognized by collaborating law enforcement partners interviewed and was identified as one of the major barriers to the successful implementation of the co-response model.

> *"A challenge we always have is on the nocturnal shift because, for people who have master's degree and, or marriage and family therapy or social worker with degrees, licenses, and even nursing licenses and registrations, they tend to be less desiring of a position on the nocturnal shift. So that is usually an area of challenge, and of course we're delivering services 24 hours a day."*
>
> *Provider Participant SB1025.*

Identifying challenges behind recruiting individuals who would be the correct fit for crisis work were explored. Program providers reported the most important feature of a successful applicant was a clinician who had a *passion* for providing crisis services to highly vulnerable individuals. Additionally, clinicians with experience delivering crisis services and who have worked with complex cases more generally were also valued characteristics. Unfortunately, these combined interests and experiences were challenging to find from a licensed clinician. Two interviewees in management roles described their experience of exploring how candidates might respond to challenging situations and being transparent about the responsibilities and challenges of the

role during interviews to identify candidates with the desired skillset.

> *"When folks come out of high school or college, they might have a different picture of what doing social work means, or being a counselor means, and so it's kind of helping, finding the right people and being able to get that. So that's kind of where that has been a little bit of a challenge."*
>
> *Provider Participant SB1016.*

> *"We were very, I don't know, careful and the questions that we asked, we were really careful in the interview questions, so that we really created scenarios in the interview situation that could determine how the person would respond in those situations."*
>
> *Provider Participant SB1004.*

To address challenges related to recruitment, some grant recipients reported offering a higher base pay, while others have considered reclassifying the position as a more senior role to make it more attractive to potential recruits. In one program, a senior manager reported arranging for licensed crisis providers to have ongoing therapy clients to mitigate perceived negatives around the short-term nature of crisis work.

> *"Because we are nonprofit, specifically, I think we've struggled with offering a competitive salary. And also, this work is really challenging, so being a TAY Acute Linkage Program, there's high turnover, we're meeting TAY clients in crisis so I think it takes an individual who is passionate about this population and about the work. And, it's not for everyone, it's pretty high intensity work."*
>
> *Provider Participant SB1020.*

Similar to recruitment, retaining clinicians was challenging due to appropriate clinician fit and pay. While many providers were concerned about staff leaving, some suggested high staff turnover was not an issue in their program when the clinician was a good fit with the role. In one program where higher staff turnover was reported, the program provider suggested that the lower salary they were able to offer relative to private organizations was a significant factor, in addition to the challenging nature of the role.

> *"We're starting to explore pay differentials for staff that are part of the triage grant because there is a higher liability and risk involved. There's a lot of issues that we have to mitigate with the union and all the bureaucracy to make that happen, but we are starting to look into options for that."*
>
> *Provider Participant SB1000.*

Peer Specialist/Advocate Recruitment and Retention

In contrast to the recruitment experience of clinicians, most program providers suggested that the recruitment process for peer specialists and advocates was a less challenging experience. This was despite the fact that the difficult nature of crisis work may require more experienced peer specialists relative to other behavioral health roles. However, peer staff retention was considered a more challenging issue for programs to navigate. In many cases, program providers suggested turnover occurred due to peers returning to college or wanting to advance their careers. One grant recipient reported that as part-time workers, peer specialists did not receive benefits, which was a significant driver of higher turnover.

> *"It's pretty intensive work. You're working with somebody that just had a psychiatric crisis, so if we were to have somebody that was just an entry-level peer, it wouldn't be appropriate."*
>
> *Provider Participant SB1000.*

> *"The majority of them went off to full-time jobs. That probably, hopefully, pay better and... the county pays pretty good in terms of the hourly rate, it's just the benefit part … "*
>
> *Provider Participant SB1007.*

Staff Burnout

Across the various roles, due to the high volume of work and the intense nature of crisis work, burnout was identified as a primary concern amongst many but not all providers who were interviewed. Many reported that burnout may impact staff turnover and/or the quality of care delivered by programs. Five grant recipients reported being impacted by increased work hours for remaining employees, and nine reported increased caseloads.

> *"We've been lucky, the staff that we've hired actually are still part of the team, so we haven't had any turnover, which is great. But, I do worry, or I'm concerned about the turnover because of the high burnout. Yeah, it's a lot of people work, a lot of intakes, a lot of assessments, a lot of linking clients, and then kind of going through the crisis services again."*
>
> *Provider Participant SB1020.*

To minimize staff burnout, programs implemented a variety of strategies. Two grant recipients reported hiring temporary workers when an employee leaves. Five grant recipients reported reducing access to services, while seven grant recipients reported reducing non–crisis-related

> *"I just want to make sure that this stresses the importance of being able to take care of oneself in the position; recognizing that sometimes they're going to see clients in the midst of a suicide attempt and that can be really, really difficult."*
>
> *Provider Participant SB1003.*

services (e.g., peer support or outreach). None of the grant recipients surveyed planned to outsource services if a position was unexpectedly vacated. Ten of the 13 grant recipients surveyed also reported having a policy for how to adjust when an employee leaves. Program providers identified the following additional strategies as important to mitigate staff burnout: supporting a collaborative team structure that included program management, setting boundaries around work, and supporting self-care.

Other Barriers to Successful Service Implementation

In addition to recruitment and retention barriers, a series of other barriers were identified across client-level factors, service-level factors, and community or system-level factors.

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Client-Level Factors

Low Motivation

Clients who experienced low motivation to engage in services during crisis prevention and post-crisis follow-up was one of the most frequently reported challenges. In some cases, this was framed in terms of the "stages of change" model, where many of the clients who program providers encountered were in the pre-contemplative stage, meaning they were not yet ready to engage in services. Several factors impacting client motivation included negative prior experiences with either the crisis service specifically or the behavioral health system more generally, the level of insight of their mental health disorder, more severe psychotic symptoms, younger age, and ongoing substance use.

> *"I was still lost. I can't really blame it on the services. I would just have to say it was my mental state that didn't allow me to see the freedom that she may have been offering. Because it wasn't that she didn't offer, I was just sick and scared."*
>
> *Client Participant SU1007.*

> *"Something that we harp on a lot is; some of the new people, or whatever, might say something where they're making these promises and it's like, man, I really encourage you not to make those promises, because if you don't come through on something like that then they're going to always remember that. 'Oh, that's the guy who said that he was going to get me out of jail, and he didn't, and they're all like that.' So then it just kind of burns the bridge."*
>
> *Law Enforcement Participant LE1000.*

To mitigate the challenges of low client motivation, several providers and law enforcement partners reported the effectiveness of utilizing motivational interviewing approaches, and the importance of rapport and relationship building. Transparency, follow-through, and consistent follow-up were critical to develop trust both with specific providers and with the program. When trust was broken between client and provider, it could be a difficult barrier to repair for current and future engagement.

Homelessness

While some unhoused clients were motivated to engage in services to obtain housing assistance, most providers interviewed suggested that maintaining contact (e.g., finding the client, arranging meetings), due to clients not having a phone or changing phone numbers frequently, was a primary barrier to care. One suggested solution to address this challenge was to develop relationships with clients while they were still in the hospital. This may increase the likelihood of remaining connected to services following discharge. Another strategy included obtaining a phone for their homeless clients early during the engagement process to facilitate future linkage.

Source: Shutterstock.com

> *"I've tried to follow with that stuff, but it was like, 'Man, I just kept getting lost because I never stayed anywhere for longer than six to nine months.'"*
>
> *Client Participant SU1007.*

> *"Oftentimes with that population, there's a lot of homelessness and so people like, TAY young adults would end up hospitalized and then they would get set up these appointments. But they would never show up… and then they would never have a phone and you couldn't find them. And so, they would repeatedly end up hospitalized."*
>
> *Provider Participant SB1004.*

Client History

Program providers had concerns about how reliable information obtained was when trying to conduct a crisis assessment and develop a safety plan due to receiving minimal prior information about the client during crisis calls. Having less history about the client meant some providers found it more challenging to de-escalate the crisis situation.

> *"Yeah, when you have no history, you're going in blind, you're going in with just what the presenting issue is. And if you have a client that's resistant to talk to us, or we've seen uptake in transient calls to homeless people that may not have any support or collateral to contact. At that point, we have to go off of what we see and what the client is telling us, which may not always be the most reliable or valid information to make crisis-like decisions, so there is a struggle there."*
>
> *Provider Participant SB1005.*

Service-Level Factors

Three service-level barriers to effective care delivery were identified by provider interviewees. These included insufficient program funding and/or program capacity relative to need, a lack of clarity in program procedures or roles, and excessive bureaucracy or paperwork. Law enforcement partners reported a fourth barrier surrounding when mental health crisis workers could feasibly attend the scene of a crisis. A summary of each barrier is presented below.

Insufficient Program Capacity to Meet Service Demand

Many program providers reported that their program had experienced challenges due to insufficient funding and/or an *excessive demand* for the services they provided. Staff responsible for conducting assessments, co-working with external agencies, and providing follow-up support generally reported feeling overwhelmed with the volume of work. Notably, this was not experienced among the two provider interviewees that were primarily responsible for operating the hotlines. Some providers suggested that insufficient staffing to meet the demand for services hindered outreach and follow-up efforts.

> *"So we do follow-ups. I wish we would do more. It's just that we're so busy throughout the day with just mental health calls that we just can't get to the follow-ups or when we do get to the follow-ups, it's maybe a week out, two weeks out because we're catching up on other follow-ups, we're taking mental health calls."*
>
> *Law Enforcement Participant LE1007.*

> *"As I mentioned, we're still having capacity issues. We're finding creative solutions outside of the SB-82 grant to meet that need in the community but, if we had more staff, more funding for staff, we would be able to meet that need better."*
>
> *Provider Participant SB1000.*

Excessive Paperwork or Bureaucracy

Excessive paperwork and bureaucracy were identified as one of the most significant barriers to effective service delivery. Some program providers reported that the paperwork to meet county requirements was excessive and an inefficient use of time, resulting in less availability for direct service provision. For more senior staff, some reported that excessive bureaucracy limited their ability to refine the service, determine a clear pathway for service billing, or address other challenges in care delivery. For example, one challenge for grant recipients who contracted with outside providers to deliver services described difficulties around having reduced access to records relative to county providers. Overall, the bureaucracy inherent to working in crisis programming was considered a source of stress, and a contributory factor both to increased burnout and lower staff retention.

> *"Part of that was the services the county would even consider billable, in the beginning, it was very restricted. We sort of couldn't prove the need for the program because it was so restrictive, of who we could enroll and how we enrolled people. That was kind of, for me, showing those discrepancies to the county. 'You're asking us to provide a low barrier outreach program, but you're requiring us to do all of this paperwork and gather all this information from people.' Those two things don't align."*
>
> *Provider Participant SB1015.*

To mitigate these challenges, providers highlighted three potential solutions:

1. The team approach where a set of individuals could cover service provision for a set period while others catch up on paperwork;
2. Collaboration with information technology departments, producing an electronic health record system able to capture the data needed by the state; and
3. Flexibility around requirements at the county level.

> *"I don't know how familiar you are with county mental health, but they require a lot of paperwork. And I feel like they're not using their resources appropriately, because as clinicians I would rather see more clients and use that few hours to see more clients than do paperwork. So, if there was a way to avoid that or have someone else be able to do that, I think that would be more effective [use] of our time and resources."*
>
> *Provider Participant SB1001.*

Lack of Clarity Around Program Procedures or Roles

> *"[Hospital] Staff didn't know who we were, they had never heard of us, there were already other programs that sounded like they did what we did. So, it took a lot of time. And we ended up with a discharge form with a list of clients that had been discharged, so that we had names that we could collect and say, 'These are the people we're looking for.' But we would never see them. We could never find them because they were already gone from the hospital. So, it wasn't until our current supervisor came on, who was a social worker at the psych hospital, that we learned that there was a report that came out every morning with a list of all the people that were currently on the unit [...] And that's where I think the ball really started getting rolling."*
>
> *Provider Participant SB1008.*

> *"The communication is super-critical. The contract monitor role is so critical. You don't really get to talk to anybody else. That's your only person."*
>
> *Provider Participant SB1013.*

The third service-level barrier identified related to the lack of clarity in the program aims, the provider role, and the procedures and protocols of partnering agencies. Some providers expressed frustration at the lack of clarity around their specific role. For some, it took extensive time to understand the policies and procedures of other agencies, impeding clinicians' ability to effectively fulfill their own role. In most cases, these issues were particularly acute during the initiation of the project.

When programs experienced clear processes and procedures from the outset, many reported an important facilitator to this was the effective communication with state sponsors, contract monitors, partnering agencies, and good communication within the crisis team from the outset. Having a sufficient period of planning time prior to the initiation of services was suggested by providers as a possible facilitator to refining program procedures and minimizing the challenges arising from a lack of clarity in operations.

Lack of Availability of Mental Health Providers During Moments of Crisis

A fourth barrier to effective crisis care was identified by law enforcement officers. They discussed experiences when mental health crisis workers would not be able to respond to a crisis call. This was often due to long wait times, and at times the situation was resolved before the mental health worker could arrive. This is an important consideration for large rural counties, where there were typically fewer resources spread over a large geographic area. Additionally, most crises occurred

> *"When available, we'll call that mobile crisis worker out and the mobile crisis worker will do what the CSU did, which is amazing. The problem being that those mobile crisis workers are only available banker's hours. That is one of the major drawbacks."*
>
> *Law Enforcement Participant LE1006.*

either late at night or on weekends when many programs were not open. One solution suggested by law enforcement officers was for crisis programs to operate as a 24-hour service. Opening hours of case management were less of an issue.

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Community and System-Wide Factors

The broader, system-wide barriers identified included the lack of wider service availability, mandated law enforcement co-response presence, liaising with services outside the county system, inappropriate referrals, and unique challenges of delivering care in rural or small communities. A summary of each is presented below.

Lack of Wider Service Availability

Regarding wider system-capacity issues, the most frequent challenge identified by providers was the **severe shortage of housing options** for their clients.

> *"We didn't realize the amount of housing resources that are needed for youth, and that has been the number one linkage request for youth, which is really sad and telling to what's happening with our youth in our community."*
> *Provider Participant SB1016.*

Additionally, the **lack of capacity in the wider county behavioral health system** led to providers retaining clients on their caseload for longer than would be optimal. This exacerbated challenges around having sufficient capacity to meet the needs of the community and was reported to lead to lower client satisfaction with services and an increased likelihood that the client would drop out of care due to frustration or relapse. A common yet inherently difficult proposal was to increase service capacity. Other helpful solutions included escalating issues related to clients transitioning off caseloads when care goals were achieved and utilizing alternative community support to maintain client stability while they wait for long-term care.

> *"Even if you get into services, the wait time for an actual therapist could be long. Access to psychiatry is a long wait. Trying to keep people stable while they're waiting for everything to fall into place, which sometimes could be a few months, can be a challenge."*
> *Provider Participant SB1015.*

> *"We utilize other resources in the community to try to wrap around the youth and keep them as stable as possible, while they're waiting for whatever the long-term is going to be."*
> *Provider Participant SB1015.*

County-Mandated Law Enforcement Co-Response

Across the different programs involved in the evaluation, some counties required a law enforcement co-response for crisis assessments in the field, while others did not. Mandated law enforcement co-response for all crisis assessments was considered appropriate and important by some providers, particularly those who frequently worked in areas that were geographically isolated and or potentially dangerous. Other providers who worked in places where a co-response was mandated suggested it would be feasible to identify cases where law enforcement would not be necessary beforehand (e.g., clients who were frequent utilizers of the service and were known to present a low risk).

Source: Shutterstock.com

Notably, in counties where crisis assessments were occurring without a mandated law enforcement co-response, this was not identified as a significant issue. As noted previously, the ability to co-respond in unknown or potentially dangerous situations was considered important for the safety of those at the scene. However, the ability to also provide services without the presence of law enforcement was considered to have multiple advantages. Providers indicated that removing the mandated law enforcement component resulted in fewer barriers to access into care, was a more efficient use of law enforcement resources, and in most cases was preferred by the clients in crisis, which was echoed by law enforcement partners.

> *"That being said, it's hard. I see the need for that, but because the calls that I go on are so volatile a lot of the time, I can't imagine going to those calls without police."*
> *Provider Participant SB1021*

> *"We don't yet have a system in place for if law enforcement doesn't go out on these crisis calls. And my thoughts about that are, we should. We should. It's not okay that law enforcement is going out on situations, in my opinion, where it's a situation that could be handled by a social worker kind of intervention."*
> *Provider Participant SB1010.*

Challenge of Liaising with Service Providers Outside of County System

A third system-wide barrier identified involved liaising with providers outside of the county. SB-82 grant–funded crisis programs provided services to all clients regardless of insurance status. While this was important to reduce barriers to access and to ensure an urgent need was met, it may lead to challenges in linking clients to longer-term care. For example, many clients had out-of-county Medi-Cal in programs located near county lines and could not be linked to the crisis program's county services. Although clients could transfer their care to the new county, this can be a slow and bureaucratic process.

> *"When we get clients with those [out of] county Medi-Cal, we can only link them to their services, they can't really come through ours. And that's just part of how the state Medi-Cal system is set up right now. And that, I think, is one of our biggest roadblocks to getting people to appropriate care."*
> *Provider Participant SB1005.*

> *"I think it's just sometimes we have a lot of challenges with Kaiser. People who have Kaiser, it's very specific, you can only go through Kaiser. A lot of times, people can't get the level of care they need."*
> *Provider Participant SB1015.*

To address this challenge, developing positive relationships with neighboring counties was essential to ensure appropriate linkage to follow-up care. In cases where these relationships were not formed, client care was considered compromised as a result. Additionally, providing follow-up services to clients who had medical insurance with integrated managed care consortiums (e.g., Kaiser Permanente), where care is only available exclusively through their system, proved challenging. In these cases, arranging entry into care was a slower and more complicated process, typically resulting in substantial barriers to care.

Source: Shutterstock.com

Inappropriate Referrals

A fourth system-wide barrier identified included programs receiving inappropriate referrals. This often resulted in provider caseloads filling with clients who could be better served in the regular behavioral health outpatient service, leading to less time available for individuals truly in crisis. In contrast, some program providers reported receiving referrals to intervene in situations that were not safe or appropriate for behavioral health providers. On occasion, this was considered to result in tense situations between the program and the collaborating partners who submitted the referrals. To address these challenges, some program providers emphasized having clear policies and procedures around the program's inclusion and exclusion criteria, which for some, were codified in their MOUs. Others emphasized the importance of outreach and training to ensure that their partners have a clear understanding of the crisis program policies.

> *"I got a phone call from my manager saying that one of the sergeants wants somebody who's combative bumped to the front of the line, and I'm glad I don't have to deal with that type of stuff because it doesn't work like that. This guy was in the emergency room with six law enforcement officers, whereas my attitude is you got to medicate this person. He's not interview-able if he requires six law enforcement officers."*
>
> *Provider Participant SB1002.*

> *"The goal was for us to really start doing some outreach to those different entities to explain what services we can provide and to build those relationships because in the beginning, we were getting calls for all kinds of things that really weren't needing the level of response that we provide. It was sometimes homeless outreach type things, or somebody with a low-level mental health condition that really should go through the regular outpatient service system. We really wanted to do that outreach to help educate our partners about when it's appropriate to call us."*
>
> *Provider Participant SB1000.*

Challenges of Delivering Crisis Care in a Rural or Small County

Among services that operated in remote or rural locations, a series of additional barriers were identified.

> *"It's also a challenge because our county, although small in population, is large geographically. We have four hospitals that we serve. One of them is about an hour and a half drive away, so if we were to send a person down there, that's almost half of their day to see one person."*
>
> *Provider Participant SB1000.*

Slow Response Time: In rural counties, the large geographic area programs often cover typically translated to slower response times. These delays often led to a less efficient program (e.g., providers could see fewer clients per shift due to the travel times) and poorer quality care due to lengthy wait times. In some cases, crisis partners — particularly law enforcement — were less likely to contact the program for services due to pressure to respond resolve situations quickly. Interestingly, these challenges were found to be alleviated, at least to some extent, by the switch to telehealth resulting from the COVID-19 pandemic, although this came with other additional challenges. In some cases, these improved relationships and allowed for a more flexible approach to crisis work, affording better outcomes for the clients served.

Source: Shutterstock.com

Lack of Community Services: Another challenge identified related to the lack of community services. For example, some smaller counties did not have a psychiatric hospital and contracted care to neighboring counties. The quality of care that clients received was often impacted due to the distance between services and fewer outpatient options. Additionally, some provider interviewees suggested that in the very small counties, law enforcement teams were often so small that they did not have sufficient personnel to effectively co-work with crisis providers. Alternatively, other provider interviewees suggested that by the nature of their teams being much smaller, individuals and agencies were more likely to know each other, which could in turn facilitate effective collaboration.

> *"We're able to keep our clients in their home county when they need that intense level of services. Whereas [SMALL COUNTY] doesn't. They ship all their clients to other cities, to other psychiatric units, which might have its pros, but when I had my own caseload having to travel an hour just to go see my client in a psych hospital, say, in [BIG COUNTY] or something, it wasn't good client care."*
>
> *Provider Participant SB1005.*

> *"I think that's what the beauty is with our rural counties, because you know people. You have a face to name, they can make a phone call, you can make a phone call and say, 'Hey, this guy's not doing well. How can we help them?'"*
>
> *Provider Participant SB1018.*

Remote Terrain: The final challenge of providing crisis services in a rural county was the terrain, which can be particularly difficult to navigate. Additionally, there are areas with poor lighting and no cellphone reception creating challenges for providers to find clients, liaise with colleagues, and coordinate with crisis response partners. These challenges can create significant safety issues. In such situations, co-response with law enforcement was considered essential.

> *"We were walking around, trying to call the hospital. We have no cell phone reception. We can't even see two feet in front of our face. It's just, I don't know. I mean, it's pretty wild. I was thinking, "I don't even know how we would contact dispatch if we needed to." […] That's why, out there in particular, I don't know how it would work, responding without law enforcement. That would make me a lot more nervous in those areas, than it would in a suburb or a city or something like that, where you have access to people, or cell phone reception even, or can change locations easily.*
>
> *Provider Participant SB1021.*

Facilitators to Effective Program Delivery

SECTION SUMMARY

Notable facilitators included the following:

Addressing basic needs (e.g., food, clothes, housing) was critical to assess prior to clients' being able to focus on longer-term needs including treatment.

Effective provider skills included empathy, use of destigmatizing language, follow-up, awareness of the power differential between the client and an individual who has the power to place a hold, and delivering services with a client-oriented and client-directed focus. Additional provider skills necessary for crisis care included effective de-escalation skills (e.g., neutral tone, respect for personal space), highly developed risk assessment skills, and the use of motivational interviewing.

To increase engagement, strategies included delivering services within the community (e.g., schools, transitional housing programs, drop-in centers) and warm handoffs to follow-up care. When working with **TAY clients**, engagement was increased when programs had an active social media presence, used nonstigmatizing language, and used text rather than phone calls.

Optimal crisis program structure included providing services 24/7, as a substantial proportion of crisis incidents typically occur either late in the evening or during weekends. Additionally, 10 of 14 SB-82 grant recipients reported that working with certified peer specialists helped to normalize and destigmatize mental illness, decrease power differentials, navigate community resources, and authentically relate to clients which led to increased client trust, engagement, and follow-up.

Increasing **staff training** is also an important facilitator, particularly in SUDs and harm reduction approaches, risk assessment and safety planning, and motivational interviewing techniques through shadowing senior colleagues, role play, and including patient advocates in appropriate trainings (e.g., 5150 courses).

A primary facilitator to effective crisis care included the development of effective collaborations with community partners, described in detail in the next section.

Other facilitators identified included respect and collaboration among the care team, extensive support and supervision for clinicians, laptops with necessary paperwork available within the community, uniforms, mobile phones that have signal in highly rural areas, vehicles that could navigate the terrain in rural areas, standardized assessments to identify client referral needs and structure the risk assessment, incorporating physical health providers, and bilingual providers.

The qualitative interviews aimed to understand how to effectively implement crisis services. This included understanding what factors led to improved service delivery, addressed perceived challenges, and/or supported improved outcomes. These were collectively defined as "facilitators." The qualitative data was augmented with quantitative data collected via the surveys to better understand meaningful collaborations and other facilitators identified.

From the evaluation team's preliminary engagement with grant recipients through webinars and the MHSOAC quarterly meetings, it became evident that effective collaborations with community partners represented a primary facilitator to effective crisis care delivery. Due to its importance, it is explored in depth below in **Community Partnerships**. In addition to the importance of successful collaborations with other community agencies, multiple other facilitators were identified by interviewees as described below.

Meeting Basic Needs

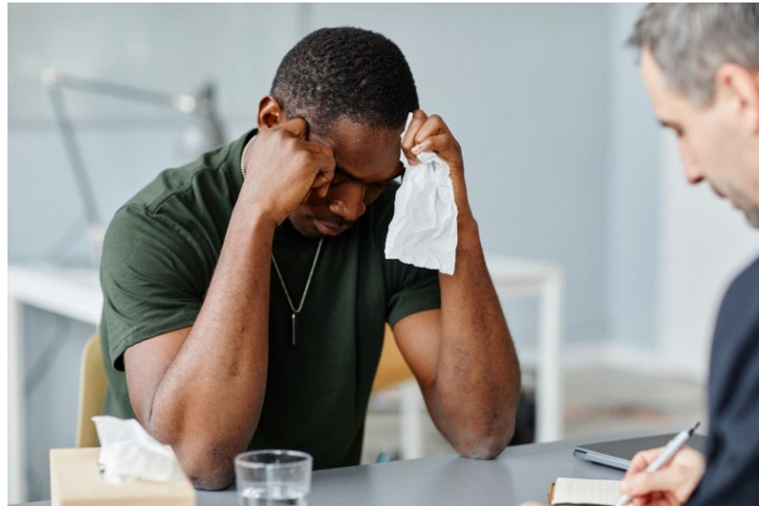
Many providers discussed the critical role that their program has served in addressing the basic needs of their population. This has included help with addressing immediate needs such as food, clothes, and housing; help with employment; support navigating the justice system; and enrolling clients in Medi-Cal and other benefits. Providing this level of care has been found to serve a number of critical functions. Providers described how addressing individuals' primary needs for food and water was an effective method to de-escalate crises and develop rapport. With basic needs addressed, clients could focus on longer-term needs including treatment. To address these aims, some providers suggested that carrying food and water in cars while on outreach was one simple way in which to work towards meeting these basic needs.

Source: Shutterstock.com

> *"A lot of what I see, finding food is a very immediate need and will reduce a lot of the crisis. Because people are hungry, and thirsty and once you meet that need... And I travel with the food in my trunk. But once you meet that need, all of a sudden people calm down and then you can really start looking at, okay, long term, what that's going to link you with."*
>
> *Provider Participant SB1018.*

Optimal Provider Approach to Crisis Service Delivery

Developing rapport and trust with severely ill individuals and their families was considered to be one of the most critical skills of a crisis provider. The following were critical in developing strong client-provider relationships:



Source: Shutterstock.com

- The use of destigmatizing language around mental health and substance use;
- Empathy and humanity towards individuals in need;
- Follow-up once a plan was agreed upon;
- An awareness of the power differential between the client and an individual who has the power to place an involuntary psychiatric hold; and
- Focus on delivering services with a client-oriented and client-directed focus.

When helping distressed clients, it was particularly important to utilize de-escalation skills including:

- Adopting a neutral tone and body language;
- A respect for personal space;
- Adopting a calm, patient, empathetic and nonjudgement approach; and
- Setting clear boundaries.

> *"I think a lot about equality and about power, and I'm very much aware that I have authority when I come into the room, and that these people have had their civil rights taken away and likely have been handcuffed in the process. The thing I do is I learn their names and I decrease the power differential as much as possible by saying that I'm here to help, 'what do you need?' versus coming in, 'Okay, I'm going to do this assessment. You're on a 5150,' and shame them or put pressure."*
>
> *Provider Participant SB1002.*

Other important provider skills to employ during crisis work included having highly developed risk assessment skills and motivational interviewing techniques for clients resistant to care. Finally, while some program providers considered a solution-focused approach to care delivery to be important, other program providers cautioned against trying to utilize that approach too early at the risk of invalidating the client or not giving them sufficient space to articulate their challenges and needs.

Active Engagement and Accessibility

To improve engagement in follow-up crisis services, multiple providers emphasized the importance of a warm handoff, when the crisis provider assists in the introduction to follow-up care. In situations where clients needed hospitalization, providers suggested the optimal model would be to meet the client on the inpatient unit prior to discharge so that the client could familiarize themselves with the outpatient team and the services they could provide. This often positively impacted the likelihood that the client would successfully engage in follow-up. Notably, during COVID many hospitals did not permit crisis workers on inpatient units, which was considered to have negatively impacted the likelihood that the clients utilized crisis services.

> *"We would try to schedule that right there with them on that first initial hand-off, just because we found that if we're not able to do that warm handoff, a lot gets lost after that. The warm handoff increases engagement."*
>
> *Provider Participant SB1024.*

Other strategies that were considered important in engaging TAY clients included an active social media presence, using non-stigmatizing language, and using text rather than phone calls to engage in clients. To refine program engagement and messaging with youths, one program emphasized the importance of soliciting feedback from TAY individuals via advisory boards.

> *"Something I would continue always is having youth involved in the decision making. Every single billboard we've done, every single flier we've done, it's been vetted by youth, and they've critiqued it or given their stamp of approval, and so that's been really, I think, helpful, and I work with all the TAY programs in [COUNTY] [...].*
>
> *Provider Participant SB1016.*

> *"One of our biggest things that we keep in mind is meeting a client where they feel comfortable, coming into a sterile mental health building to come meet with a crisis worker might not be the most beneficial. They might be a little bit more on alert, or a little bit more reluctant to speak. But if we go meet them out at their park, or at a coffee shop, or at their home, or, wherever they want to meet, they might have their guard down a little bit and be a little bit more forthcoming, so we could best support them and help them where they're at."*
>
> *Provider Participant SB1005.*

Additionally, almost everyone interviewed emphasized the importance of providing crisis services, including crisis prevention and post-crisis engagement, *in the community*. Delivering services in the community was critical to ensuring program access and minimizing the unnecessary involvement of other agencies (e.g., law enforcement). Providers reported that many of the clients they engaged in prevention and postcrisis work were typically ambivalent about services and reluctant to attend scheduled appointments at county behavioral health clinics. Therefore, engaging clients in environments where they feel comfortable was seen as critical to improving engagement in the service.

Lastly, providing services in spaces such as schools, transitional housing programs, and drop-in centers was reported to lead to more effective partnerships with other community providers. One provider reported that due to the success of the mobile crisis delivery model implemented by one SB-82 grant–funded program, their county behavioral health service was planning to expand the model to encompass all their crisis work going forward. Providers also emphasized the importance of being part of the community, as it facilitates trust and in turn engagement, and promotes knowledge of community services.

> *"We worked with transitional housing programs, residential school programs, LGBT centers, youth homes, youth drop-in centers, just kind of a lot of places where the youth in our age range were already accessing services. Everybody was really struggling with youth in crisis, how to support that, and navigating county mental health. We were able to come in and partner with them and say, 'Hey, let's literally be on a team together and do case management together, figure out what's not working, and get them where they need to go.' We would send teams of staff to each site that regularly worked at that site. That really fostered that relationship."*
>
> *Provider Participant SB1015.*

Engagement of the Clients' Support System

Providers emphasized the importance of the clients' support system, both in the crisis assessment and in follow-up care. Support persons were seen as both able to provide

comprehensive case histories and assist in safety planning after a crisis. Particularly, providing psychoeducation and teaching simple techniques around how to discuss suicidality can help equip support people to help their loved ones.

> *"It should be a choice for sure. Like a questionnaire, whether or not you're safe with your family and if you want them involved."*
>
> *Client Participant SU1008.*

> ***Interviewer:*** *"So it sounds like because your parents were there, they talked to you less and coordinated with your parents instead."*
>
> ***Participant:*** *"True, and that's a case of not feeling like I had a say in my own treatment."*
>
> *Client Participant SU1000.*

Importantly, while some clients reported their family involvement being helpful, others reported a more complex dynamic with their families, such as their families being largely absent, or family interactions contributing to their mental health challenges. These dynamics were important for clinicians to be attuned to.

Optimal Crisis Service Structure

Key features that provider either identified in their service, or wished they could implement into their program if they had the resources to do so are detailed below.

Extended Service Hours

The ability to provide crisis services outside of standard office hours was critical because a substantial proportion of crisis incidents typically occur either late in the evening or during weekends. Operating within limited business hours was likely to have a negative impact on key program outcomes. For example, when crisis services are not available, crisis calls are often diverted to law enforcement, negatively impacting the reductions in law enforcement expenditure and increasing interactions with the justice service. In one county where the

> *"So, we could not be responsible for phone calls later in the day with just as few staff as we had, but it really should have been a hotline that operated at least until like 10 or 11 or 12 o'clock at night because it's like "Why are you operating this hotline for crisis during daytime hours when people don't have crisis? And only on weekdays, not on weekends when people have crises on weekends?"*
>
> *Provider Participant SB1010.*

> *"It's frustrating sometimes with my partners that work maybe the graveyard shift where the only option is the hospital because these programs are not open 24 hours and they can't go to these places after 5:00 PM, 7:00 PM, or 9:00 PM or whatever the case may be. So the only option is the hospital if they meet that criteria."*
>
> *Law Enforcement Participant LE1007.*

program was responsible for conducting crisis assessments in the ED setting, clients who arrived outside of crisis program hours were typically placed on a 1799 medical hold and required to stay in the ED overnight before they could be assessed by the crisis provider the next day. These extended stays in the ED were considered inefficient, highly expensive, and at times highly distressing for the client.

Source: Shutterstock.com

Peer Specialists

Ten of 14 SB-82 adult/TAY grant recipients surveyed reported working with certified peer specialists (see **Table 16**). Sacramento County had a unique structure where they worked with both certified peer specialists and volunteer peer advocates, further highlighting the importance of peer partnership within their program.

Table 16. SB-82 Grant–Funded Adult/TAY Programs with Peer Specialists

Adult/TAY Programs with Peer Specialists	Adult/TAY Programs without Peer Specialists
Alameda	City of Berkeley
Butte	Calaveras
Humboldt	Merced
Los Angeles	San Francisco
Placer	
Sacramento	
Sonoma	
Stanislaus	
Tuolumne	
Ventura	

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Key: TAY = transitional age youth.

Peer specialists were considered an integral part of service delivery, whose ability to draw from their lived experience led to unique advantages. For example, many providers indicated that through sharing their lived experience, peer specialists were a critical part to normalizing and destigmatizing mental illness and behavioral health services. Linked to this, some providers indicated the importance of peers in helping to address the evident power differential present in crisis care and assessment. This ability to relate to clients in an authentic way was also considered to be a significant factor to supporting ongoing engagement and retention in services, particularly for clients who may be new to behavioral health, and those that might have had negative experiences of care that left them more wary of behavioral health services. Additionally, some peers reported that the shared experience between them and clients often meant clients were more trusting of the peers and consequently more willing to disclose experiences not previously shared with others. Finally, another strength identified by providers related to the fact that many of the peers were extremely knowledgeable of community agencies and local available supports, which they may have utilized themselves in the past. Notably, when asked, both clients and providers alike could identify few drawbacks to utilizing peers in the crisis setting. Overall, most indicated that peer specialists brought huge benefits to the programs.

Source: Shutterstock.com

Interviewer: *"What do you think some of the strengths, if there are any, are about utilizing peers in crisis?"*

Participant: *"Well, it's that power differential. It normalizes the situation. These are people who can say, 'I've been there.' I try to do that, also, when it's appropriate, but the peers, their whole thing is to walk in and say, 'I've been where you've been and this isn't always going to be this way. Let me help you.' So, I think it's a very valuable part for people who are not connected to services."*

Provider Participant SB1002.

Team Approach and Supervision

Given the high-stress nature of crisis work, a strong team approach with extensive support and supervision was considered essential. Utilizing the support of a team could also be considered a critical way to alleviate staff burnout and to help providers manage difficult circumstances. This strong team approach with extensive supervision was particularly important for peer specialists and other nonclinical staff to support staff wellness, and to help problem-solve cases.

> *"She would come in and assist with the family if I was having a tough time, if I wasn't able to make some movement or it was a very high-risk client that I was unable to stabilize for safety planning or whatever it is that I was doing, she would come in. And that worked really effectively. I really, really felt like I always had support. I was never like, 'Oh gosh, if this doesn't work out, what am I going to do?' I always felt like, 'Gosh, this clinician has my back as a CSC.' As a BSW There's only so much I felt I can do, I know my limitations. And so that worked really, really well I felt."*
>
> *Provider Participant SB1006.*

> *"I do think that peers definitely need a different level of supervision. And so, whether it's somebody who maybe is a little bit fresher into their recovery, could possibly get triggered a little bit more from experiences that they have with others, and it can be really overwhelming sometimes."*
>
> *Provider Participant SB1007.*

In co-response models between mental health providers and law enforcement officers, the notion of a team approach was particularly important. It fostered more effective care delivery, meant the team could address different aspects of the situation, and was particularly helpful when family members were present and also needed support. That team approach gives crisis workers more options to address challenges in the field (see ***County-Mandated Law Enforcement Co-Response*** for more details).

Linked to the importance of the team approach to crisis care, some providers also highlighted the value of crisis program supervisors and managers being experienced clinicians who were also actively providing crisis care. This team structure was considered to be advantageous for multiple reasons, including further strengthening the team dynamic, improving supervision and teaching opportunities through modeling optimal care delivery, and having a better

> *"It's very beneficial because a lot of times when we go into a situation like that, my partner can ... One of us will maybe talk to maybe the person in crisis, while the other one talks to the family and vice versa and switch roles. It's really nice having a partner there to help with that because while he or she's able to offer those resources... I'm able to maybe de-escalate a situation. [...] The partnership's been really great."*
>
> *Law Enforcement Participant LE1003.*

"I think it's very important that the person who is supervising the service also does the service. [...] I think that in general, that's important. Because I think then it helps with your rapport with your staff because they see that you're actually doing the work and you're not just leading based on your theories about what's going to work better, but you actually are dealing with it and you know how difficult it is to do the three things that you're asking your staff to do."

Provider Participant SB1010.

understanding of what was happening on the ground. Supervisors and managers who were involved in care delivery were particularly important during the project start-up phase, where providers required more support to follow new protocols and models of care most effectively.

Resources that Support Crisis Services Delivery

Community-Based Resources

Specific resources were helpful in aiding delivery of care. For example, given the majority of SB-82 grant–funded programs delivered services almost exclusively in the community, having laptops with all the necessary paperwork immediately to hand out was considered critical to improve the efficiency of care delivery. Other providers highlighted the value of having uniforms that clearly identified who they were and their role, distinguishing them from law enforcement given concerns that could create additional barriers to engagement. Finally, one provider identified the importance of mobile phones that have signal in highly rural areas and access to vehicles that could navigate rural terrain.

"Somebody having a laptop and somebody having some of those resources are really important. Because you're doing stuff out in the field and if you always have to come back to the office to do whatever notes or paperwork or things like that. That's just a whole another layer of difficulty."

Provider Participant SB1004.

"So, the concern was, that we don't want to come off as being law enforcement, because that is triggering for clients. Like, part of the reason why we're doing it is to decrease stigma and increase access. But we also didn't want people to confuse us with like a family member or like a bystander. So, we wanted something that identified us very clearly, so that's why we have the polos. And it's non-threatening, which is also why we have the polos."

Provider Participant SB1011.

Assessment Tools

Other providers highlighted the importance of utilizing standardized, comprehensive assessment tools that adequately fit the experiences of the population. For example, standardized assessments that helped to identify client referral needs and structure the risk assessment, such as the Columbia-Suicide Severity Rating Scale, were considered useful and improved assessment outcomes.

> *"We had a couple outcomes that weren't great and could have been mitigated by having a more thorough risk assessment tool. We ended up adjusting our assessment form to include a thorough risk assessment for danger to self, danger to others. We looked at other counties' tools that they were using and read about what tools were most effective. I think if we would have thought through that in the beginning, that would've been helpful."*
>
> *Provider Participant SB1000.*

Physical Health Providers

Finally, multiple providers highlighted the importance of medical support. This included strong collaborative relationships with prescribers within the county system so that their clients could receive prescriptions quickly. Another model is to incorporate physical health providers in their community response which was reported to improve the quality of the services by the ability to immediately respond to physical conditions, to review client medications and possible interactions that may be pertinent to the crisis assessment, conduct drug screenings, and to effectively triage physical from mental health challenges such as differentiating symptoms associated with diabetes from psychosis-related disorientation. Lastly, one program integrated a nurse practitioner into their crisis response team, and the providers from this service were highly positive about the contribution of this role on the service.

> *"It's awesome. I think we're still developing it. One of the things that having a nurse respond on our teams has been most helpful is determining if someone's going through a physical health emergency, to where we get on scene, they can do the blood pressure, they can ask those questions that we could ask but are out of our scope of practice, and determine, 'Okay, this person is actually not disoriented, they're going through a diabetic seizure or something like that like hypoglycemic issue.' And that way we can get them immediate medical attention."*
>
> *Provider Participant SB1005.*

Linguistically and Culturally Appropriate Materials

Linguistically and culturally appropriate materials and access to translation services was noted as an important resource for crisis response. All grant recipients surveyed reported offering at least one form of accommodation to Limited English Proficient (LEP) individuals and people with disabilities including interpreting services, translation of documents, and assistance with questionnaires (**Table 17**). However, in the qualitative interviews, while these services were appreciated and considered helpful, providers emphasized the importance of having representative and bilingual providers given the concern that utilizing translation services can impact rapport building, particularly with family members.

> *"We get by, and I'm thankful for those expensive services. I'm thankful for them, but we definitely... I think it's a huge part of rapport building too with a family. If you're using a translator, you can't build a rapport with a translator. It's very difficult to, unless you've got a pretty dynamic, I guess, personality."*
> *Provider Participant SB1006.*

Table 17. Accommodations to Limited English Proficient Individuals and People with Disabilities

Grant Recipient	Translated Documents	Interpretive Services	Bilingual or Multilingual Staff	Questionnaire Assistance
Alameda	X	X	X	
City of Berkeley	X	X	X	
Butte	X	X	X	
Calaveras		X		
Humboldt	X	X	X	
Los Angeles	X	X	X	
Merced	X	X	X	X
Placer	X	X	X	
Sacramento	X	X	X	X
San Francisco	X	X	X	
Sonoma		X	X	
Stanislaus		X	X	
Tuolumne		X	X	
Ventura	X	X	X	X

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs(UC Davis).
Note: The SB-82 grant–funded adult/TAY program in Yolo County ended in 2020 so Yolo was not surveyed for 2021.
Key: TAY = transitional age youth.

Staff Training

There was a notable range of suggestions with regards to the training providers valued or wished they had received to improve the delivery of crisis care. Multiple providers reported wanting additional training in SUDs and harm reduction approaches, risk assessment and safety planning training, and motivational interviewing techniques. Less frequently endorsed areas included additional diversity training, cognitive behavioral therapy and dialectical behavior therapy, training in sex trafficking, solution-focused therapies, and trauma-informed approaches.

> *"Because these people are survivors, they're not going to tell us they're being trafficked. If I could just know more of the signs of what to look for, and if there are more services available to those folks, to target them, I feel like we'd be able to catch more of them."*
> *Provider Participant SB1023.*

Providers also discussed the optimal structure to receive training. In many cases, providers reported that training was often obtained via shadowing senior colleagues, which was considered useful. When the training was more formal, role play was an effective method of learning.

Regardless of the method, ongoing training including refreshers of key skills was considered important by providers to ensure the staff remained aware of best practices and to ensure continual development of one's skillset. Finally, one provider described the value of including a patient advocate in county-wide 5150 training courses. The patient advocate was considered critical to explaining the patient experience of undergoing the process and supporting those writing the holds to be able to do so more effectively and compassionately.

> *"We didn't have formal training, where it was like sit down, watch this lecture, or whatever like that. It was really hands-on training. When I came on, everyone was very helpful. We did the ride-alongs. We went to the detox center. I did a shadowship with the detox center, the crisis stabilization unit. You kind of see where we're taking people, how they operate. A lot of it is on the job learning."*
> *Provider Participant SB1023.*

> ***Interviewer:*** *"So, what do you think about the training made you like it so much? What about it was effective?"*
>
> ***Participant:*** *"I think the role playing, and anticipating certain calls, certain emotions. You might get mad people, upset, suicidal, very sad, saying really provocative statements. And if somebody calls you and say, 'I'm going to kill myself,' how would you approach the situation? How delicate are you going to be? How are you going to pose certain questions without setting people off? So I think that was good for me to have."*
> *Provider Participant SB1013.*

Community Partnerships

SECTION SUMMARY

Development of effective collaborations with community partners such as local law enforcement, emergency departments, other county behavioral health teams, and other community agencies were key facilitators to effective crisis care. These collaborations were considered **critical to the delivery of safe and effective care**, to ensure crisis services were able to **meet the need in the community** and to **connect clients post-crisis** through linkage with longer-term care. Yet building these collaborations could be challenging and required balancing competing priorities between mental health providers and law enforcement co-responding to the same client, rules and regulatory barriers, patient confidentiality, and mental health stigma. Outreach, respect, and knowledge of a collaborating provider's role; trust; defined expectations; and clear communication are all important factors that foster effective working relationships in the high-stress environments of crisis care.

Developing Effective Collaborations with Community Partners

To understand the importance of effective collaborations, both qualitative data collected during the provider and law enforcement interviews and data collected via the quantitative surveys were utilized. This section is focused on understanding the collaborations between SB-82 grant–funded crisis programs and community partners; why these relationships are important; how relationships develop; and the benefits, challenges, and potential solutions to establishing effective partnerships.

Source: Shutterstock.com

Interviewer: *"Do you collaborate with any other entities or different agencies, like the hospitals or law enforcement, or anything like that?"*

Participant: *"Yes, all of the above. Hospital, law enforcement, housing agencies, a homeless action center for benefits sometimes, like Social Security. All of that, yeah."*

Provider Participant SB1013.

SB-82 grant–funded services reported collaborating extensively with community organizations (see Table A4 in Appendix 6). However, there was notable heterogeneity in the number and type of community partnerships. For example, the Los Angeles County program reported actively engaging with all 14 types of

organizations included in the survey, while the program in Calaveras reported collaborating only with their county sheriff's department. This heterogeneity is likely related to the scope of activities each program aimed to deliver. Overall, the top three community partners programs reported interacting with regularly were: law enforcement partners, EDs, and community-based mental health services.

Benefits of Collaboration – Program Provider Perspective

The benefits of effective collaborations with community partners in the delivery of crisis services was a consistent theme during the qualitative interviews conducted with program providers. Such collaborations were considered critical to ensure the appropriate flow of referrals into the program or calls-out to crisis events; to ensure clients were successfully linked to long-term services for ongoing recovery; and — in the case of collaborations with law enforcement partners — to ensure services could be delivered in a safe and effective manner.

Increase in Program Utilization

The most frequently cited benefit of developing community relationships was that it created an important pathway into crisis care. For programs who were able to develop strong links with other community providers, almost all reported this led to a noticeable increase in program utilization. In programs where they felt they were being underutilized, provider interviewees believed this was because other agencies were not aware of their existence and therefore did not refer clients appropriately.

Source: Shutterstock.com

Additional Benefits

For many programs, strengthening the collaboration between agencies led to *better quality care* for the client, both in

the crisis situation and in linkage with long-term care. For other programs, community partners were considered to be a good *source of information about the client*, which was helpful to improve the quality of the crisis assessment, and for locating clients in follow-up. Finally, both law enforcement partners and providers emphasized the importance of their collaboration to enable care delivery in the community in a safe manner.

> *"So we do provide a lot of crisis support. I would just say it's typically not really through the warm line. The county thought initially that we'd be getting all these crisis calls and de-escalating on the phone. That's not typically what happens. It's usually youth that are already connected to us, or a community partner calling and asking us to come out."*
> *Provider Participant SB1015.*

> *"It was great, and it was an awesome collaboration, because they were able to come out, help me assess the individual. The individual did not really want to work with me, so I stepped myself out. Let them deal with them. And we had an ambulance respond, and we had the fire department respond. It was just a really great collaboration, because the individual was placed on a hold, was treated and heatstroke or heat exhaustion was prevented."*
> *Provider Participant SB1018.*

Benefits of Collaboration — Law Enforcement Perspective

Law enforcement interviewees described a series of benefits derived from collaboration.

Improved Mental Health and Law Enforcement Services

First, multiple officers suggested that crisis care collaboration enabled a closer link between mental health and law enforcement services, which many considered critical given the volume of mental health cases they manage. Co-responding, as opposed to managing a crisis event alone, could shift the dynamic of the interaction from a law enforcement interaction to a mental health one. This shift was considered to better meet the needs of the client and improve the perception of law enforcement in the community. Overall, the collaboration with mental health workers was considered a valuable solution to address a situation that was becoming untenable for law enforcement to deal with alone.

> *"I think it helps when people, especially for our community, know that CIT is in existence, that they know that we're trying to do different things as opposed to just enforcing. Instead, we're trying to look at it from that kind of wraparound service of, 'Hey, we're not just here to patch this thing up. We want to help in the long-term.' And so, our community understands that."*
> *Law Enforcement Participant LE1008.*

Improved Learning

The collaboration between mental health specialists and law enforcement partners created opportunities for learning, which was another important benefit. This was notable among those who frequently served as a point of contact with mental health crisis workers. Interestingly, these point people in turn became resources for other law enforcement officers to improve their own handling of mental health cases, broadening the impact of this collaboration.

Learning to adopt a mental health–focused approach was important both to improve service delivery to those in crisis and to foster a less punitive culture within law enforcement regarding mental health. Notably, in one interview the law enforcement officer attributed their close collaboration with mental health specialists as an important facilitator to help break the stigma their team had around addressing their own mental health challenges that can be caused or exacerbated by the stressful and oftentimes traumatic nature of police work.

Improved Quality of Care

Partnerships could lead to a better standard of care provided to individuals in crisis, relative to when law enforcement officers respond alone. Law enforcement partners noted they were often limited to assisting clients to the emergency department or doing nothing. In contrast, most law enforcement partners recognized that mental health workers had more expertise in managing mental health crises, better knowledge of services in the community and how to navigate them and had greater flexibility in how they could respond to crisis events, allowing for a greater range of options for the client. The onsite mental health expertise was particularly helpful when communicating with family members. In these situations, mental health workers were typically better able to explain what their loved one may be experiencing, next steps for the care they would be receiving, and why.

> *"I think we've taken the sting away from having someone with a mental health disorder even within our own ranks. [...] We have realized that there's trauma that is caused by years and years of doing our job. So, there is that increased relationship [with the crisis counselor] where it gives us buy-in, understanding that mental health hits all of us in different places, in different times, and sometimes within our own families."*
> *Law Enforcement Participant LE1008.*

> *"What our mantra here is trying to get the right people to handle those types of situations. So, an example would be the 20 hours of training I received in the police academy 23 years ago, versus a clinical social worker that's got a master's degree, 3,000 hours of training: Who do you want going when your loved one's in crisis?"*
> *Law Enforcement Participant LE1009.*

Challenges to Collaboration with Law Enforcement

While every law enforcement officer interviewed reported that their collaboration with the mental health workers was positive and beneficial, some challenges to effective collaboration were also identified. These issues often concerned one of two themes: challenges that could arise as a consequence of contrasting approaches and priorities, and rules/regulatory challenges that law enforcement officers frequently experienced. While these issues are significant, it was notable that the majority of the law enforcement interviewees did not identify negatives to the collaboration.

> *"I truly only think that's a help. I don't think it's a negative that she's in briefing, or that she's out in the field. Trying to think of any other negatives that have come up, but none really are coming to my mind."*
>
> *Law Enforcement Participant LE1001.*

Different Approaches and Priorities

Both law enforcement officers and mental health providers emphasized that they had contrasting approaches to dealing with mental health crises. These differences were attributed to differences in training, the contrasting requirements of their respective roles, and the personality traits of individuals who gravitate to towards mental health versus law enforcement positions.

Varying Approaches to Addressing Mental Health Crises:
Law Enforcement Vs. Mental Health Providers

Time Spent on Crisis Call: The law enforcement role often required officers to resolve a situation quickly to stay on top of the call volume. Mental health providers reported less pressure in this regard, affording them more time to bring the crisis situation to a careful resolution.

ED Referral: Law enforcement officers typically do not have the training to conduct detailed onsite assessments, meaning in cases of ambiguity, officers often transport the individual to EDs where detailed assessments can be made. In contrast, one of the primary aims of mental health crisis work is to divert individuals from ED when appropriate, meaning more time is typically spent on assessment to minimize inappropriate referrals.

Safety vs. Triage Outcome: Officers frequently approached a crisis situation with a priority on safety — for the individual in crisis, for others on the scene, and for themselves and the mental health workers. While this was also of critical importance to mental health workers, during the interviews with providers a greater emphasis was placed on ensuring the most appropriate triage assessment outcome.

> *"When you sign up to be a police officer, you want to chase the bad guy around all the time. And at this [is] a lot more... You have to spend more time, you have to talk, you have to engage those people. And then a lot of officers, it's like, 'Ah, that's just not for me. Let's just skip this. Let's be done with us and move on. It's not police work.'"*
>
> *Law Enforcement Participant LE1005.*

> *"Anytime you have multiple different agencies working together, you have multiple different missions. So a law enforcement purpose is different than a mental health purpose, like a Health and Human Services purpose."*
>
> *Law Enforcement Participant LE1009.*

To address these challenges, both law enforcement and program providers described the importance of **personnel fit, leadership support** to address potential conflicts, and **communication** to clarify responsibilities and to preserve a possible crime scene. Interestingly, while differences in perspectives might be evident, for most law enforcement partners this was not considered a problem, and in some cases was considered a learning opportunity and a strength.

Rules and Regulatory Challenges

Enforcing 5150 Involuntary Holds

> *"Getting the wrong people is a recipe for disaster. And we kind of see that a little bit. I saw that a little bit in [CITY] where 'Hey, we have this behavioral health person and they didn't connect.' The officers there and her didn't connect. So they're out there trying to arrest their way out of homelessness and mental illness and she's like 'Well no, let's just try to help them.' So it just didn't work. It didn't work that great because - it's funny because I'll hear like, 'Oh [CITY] Police department says their program's crap and doesn't work out great.' I'm like, 'Well how could that be?'"*
>
> *Law Enforcement Participant LE1002.*

> *"I really liked it. I liked having someone else in my thing. I liked showing somebody who was in mental health who dealt with the same people that I dealt with, but it was cool to show him, 'Hey, this is how we deal with this person.' And he'd be like, 'Well this is how we deal with the same person.' So it was really cool to show someone to integrate that person into my world. And it was cool to be integrated into their world to see how it all worked. And I learned a lot from that."*
>
> *Law Enforcement Participant LE1000.*

One area that was frequently identified as a source of tension by both law enforcement and provider interviewees concerned the challenge of enforcing a 5150 involuntary hold when the client was in their own home and not presenting a danger to anyone else. Interviewees described that while law enforcement are permitted to use reasonable force to implement a hold under certain circumstances, law enforcement cannot enter a person's home without permission if no crime is being committed. As a result, officers reported that they would not attempt to enter a person's home

to enforce the hold if nobody else was at risk, and particularly if there was a risk that entering the premises could escalate a situation.

Law enforcement officers reported that this course of action was decided primarily to reduce the risk of what they described as "suicide by cop," and to minimize the risk to those on the scene. However, some mental health providers expressed concern that this approach leads to more people dying by suicide. To address this situation, both law enforcement and program providers suggested that additional guidance is necessary at the political level to address these inherent tensions.

> *"For a situation like a barricaded subject with a firearm, if the whole family's out of the house already and the subject is the only one in the house, we are probably going to tactically disengage and not force the situation. Whereas behavioral health obviously comes from a different school of thought where it's like 'Hey this person's in crisis, we need to go in there and help them.' So I know there has been some clashing at times on what's the best course of action at that point."*
> *Law Enforcement Participant LE1000.*

> *"Law enforcement are under a lot of pressure, because Governor Newsom released a mandate that if their presence on site at a mental health emergency is going to make it worse, they're not to go, because suicide isn't a crime. Yes, that's true, but we can't break down a door. So, how do we collaborate with our community partners, and how do we train our staff how to collaborate with our law enforcement partners?"*
> *Provider Participant SB1025.*

Patient Confidentiality

The second regulatory issue reported by law enforcement officers was that mental health providers are bound by patient confidentiality. While most recognized that this is necessary to appropriately conduct mental health related work, in some case this impeded police investigations. As a consequence, one officer reported that their department intentionally did not contact their mental health crisis providers in situations that may represent crime scenes until all the necessary evidence was collected. By contrast, in other departments officers saw mental health providers as a potential benefit in such scenarios, where the presence of crisis workers could facilitate greater trust in the system, resulting in potential witnesses being more receptive to engaging with law enforcement officials and supporting investigations.

Source: Shutterstock.com

The inability of mental health providers to share information with law enforcement attending to clients in crisis was a barrier particularly when

law enforcement considered that additional information would better help officers support the individual in need.

To address these concerns, **release of information (ROI) protocols, clear communication** between law enforcement and mental health providers to support each other's efforts, and an **awareness of mental health staff not to impede investigations** were important to mitigate the impact of these issues from the perspective of law enforcement partners interviewed.

"Because they're so strong on, 'Hey, I cannot break my patient confidentiality,' we just don't go to those calls. […] We allow the deputies to do their part and do their investigation. And then how we train the deputies we'll go, 'Hey, we do have a CIT unit, a mobile crisis unit that can come after we're done that maybe we could do follow-ups to that person to get them the resources that they need.'"
Law Enforcement Participant LE1007.

"So, our Health and Human Services has moved where they're now trying to embed that [ROIs] in the processes when they're talking to their clients like, 'Hey, would you mind if we share information with the hospitals, the police department staff?' And obviously it's like this, it's consent. If the person says no, they don't. But if they do, it makes it a little bit easier to transfer information."
Law Enforcement Participant LE1009.

Challenges to Collaboration with Other Community Partners

Unique challenges were described when program providers collaborated with ED staff and other community partners. In ED settings, the main challenge related to **stigma around mental health.** Some ED staff did not consider mental health challenges a medical issue, while others suggested that ED staff were more likely to quickly release people into the community when the providers believed further interventions were required. In collaboration with other behavioral health providers, challenges arose about other providers not submitting referrals appropriately and difficulty obtaining requested documents to aid in care planning.

In [COUNTY], one of the emergency rooms, they did not view psychiatric issues as being a medical issue. They were very adversarial about having people on 5150s in the emergency room. I'm very happy up here that we don't [have] animosity, we don't have that pressure."
Provider Participant SB1002.

Facilitating Collaboration between Agencies

Several strategies were identified to facilitate partnerships and overcome challenges. The primary facilitators in effective collaborations were outreach and training, emphasizing the mutually beneficial aspect of collaborations, fostering relationships across management levels between agencies, prior knowledge and connections with community partners, effective communication, and collaborative approach to co-working.

Outreach and Training

While outreach and training were time-intensive, it was identified as serving multiple important functions. First, it improved awareness of the program in the community, critical to both increasing the number of referrals into the program and reducing the number of inappropriate referrals. Secondly, it improved the coordination of care across multiple agencies. Finally, in one interview a provider described how outreach led to the program obtaining access to the county's Homeless Management Information System, which meant they could provide housing services to their clients outside of regular hours when the local shelter programs were closed.

Mutually Beneficial Relationship

Recognition that each agency brings something of value to the other was important. For example, understanding shared goals (e.g., improved outcomes for those in crisis in the community) among crisis workers facilitated building mutual respect and value among partners. Linked to this, program providers suggested that once partnering organizations were able to see these benefits, this was a motivator to refer and engage with the crisis program more actively. When a community agency struggled to identify the benefits of the partnership, they were less likely to refer to their program.

> *"Over time, we've showed that our services can be of use to them [local police department], that they're valuable, that their outcomes are better long term."*
> *Provider Participant SB1018.*

Fostering Relationships Across Management Levels Between Agencies

Collaborations between senior management were considered important to initiate the relationship between agencies and to resolve challenges. Additionally, positive relationships between frontline staff were considered critical to effectively deliver services.

> *"Then we also really try to facilitate not just a manager to manager, because that's not really helpful, but a staff to staff. That has been really helpful, to have the staff, the actual line staff know each other, from program to program. It just creates such a more cohesive collaboration."*
> *Provider Participant SB1015.*

Prior Knowledge and Connections with Community Partners

> *"One of them had been in the mental health business in some capacity for 25 years. He knew a lot of people. He knew a lot of mental health clients when they were kids and it had come all the way up. He had all that stuff. He'd already built trust before he came here."*
>
> *Law Enforcement Participant LE1002.*

Most providers reported having longstanding roots in their community, living and working in the area prior to transferring to the crisis program. As a result, many had relationships with various community agencies based on earlier work, which was considered invaluable to their current role. Other providers reported having previously worked in other roles across mental health services, social work, law enforcement, and in homeless shelters, giving them greater insight to the partnering organizations and helping to facilitate more effective collaborations. In situations where programs did not have the same prior experiences, leveraging existing relationships that other providers within the same organization developed could be considered a viable alternative.

Effective Communication

Trust, communication, and frequent collaboration between agencies was critical for developing relationships and effective co-working. To develop this trust between agencies, one provider highlighted the importance of identifying individuals that were most receptive towards collaboration within both agencies. To facilitate this ongoing communication, some programs advocated for regular meetings between primary collaborating agencies, while others utilized social media.

> *"There's a lot of stigma towards mental health, but there's also a lot of stigma towards law enforcement, so finding the individuals that are capable and willing to build those bridges is huge. Our law enforcement agencies are starting to understand that as well, so they've started to develop specialized teams within their departments that are sort of the behavioral health liaisons within their departments. I think that's key, identifying people that are able and willing to be collaborative."*
>
> *Provider Participant SB1000.*

> *"I think what's helped with this program, and with the building of this program, and also, the growth of this program, and the support of our clinicians is that every week we actually meet with other TAY programs, and we all provide similar but different services, but we're all kind of working with the same client. So, we've been able to foster these relationships with the community, I think that's been really important."*
>
> *Provider Participant SB2020.*

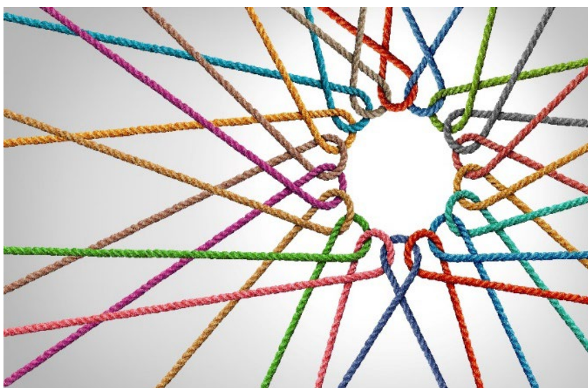
Developing Effective Collaborations within Law Enforcement/Mental Health Provider Co-Response Models

Given the unique nature of law enforcement and mental health provider co-response models, developing effective collaboration within these services was particularly important. The law enforcement officers interviewed emphasized the importance of trust, given the situations they operate in together can be unpredictable, and at times dangerous. Most law enforcement officers indicated that trust was built over long periods of time, highlighting the importance of consistency and continuity within each unit. Linked to this, some officers suggested that frequent ride-alongs are critical to establishing this relationship as it results in both partners working for long periods of time together. Finally, some law enforcement officers emphasized the benefits of fully integrating mental health workers into the law enforcement team. This included organizational factors such as having a desk and access to the law enforcement facilities, but also socially, where the integration of the crisis worker resulted in them being perceived as part of the "family" by other officers.

"The clinician needs to ride with the officer because it builds trust. What I've seen from other agencies who do not deploy their clinicians with their deputies is there's not the relationship. But when you're spending 10, 12, 14 hours sometimes in a car together, there's no secrets. There is only trust because you get out of and get into sticky situations where you have to depend on the other person. The other person needs to depend on you."
Law Enforcement Participant LE1008.

"One of the things why I love the way we run it here is because our clinicians are right there. They see the same things, they talk to the same people, they're part of our family. We've kind of absorbed them as that whole screwed up law enforcement family that we have. We don't look at them as separate entities, but instead they're part of us."
Law Enforcement Participant LE1008

Formalized Community Partnerships through MOUs



Source: Shutterstock.com

Formalizing partnerships with MOUs for collaborative crisis work was not needed for the success of many programs. Across the 15 SB-82 grant–funded programs, six (40%) reported executing a MOU that detailed activities between the SB-82 grant–funded crisis program and a community agency. Programs most frequently completed MOUs with their local police and sheriff's departments (5 of 6

counties; 83%), community hospitals, advocacy groups, community centers, and offices of education.

For some programs (Placer County), existing MOUs between county behavioral health and community partners were considered sufficient to codify the relationship. For others, an agreement was not considered necessary due to existing, informal relationships (Tuolumne County, Calaveras County, City of Berkeley). Additional reasons for not formalizing the working relationship with an MOU included community partner reluctance and the complexity and time-consuming nature of the administrative county process. Notably, in many cases the effectiveness of the collaboration between program and partnering agency was not impacted without an MOU. These findings highlight that MOUs may not represent a critical component to effective crisis care collaboration.

Interviewer: *"What was the process of setting that MOU up like?"*

Participant: *"They wanted us, and we were more than willing to be involved, so it was actually very smooth."*

Provider Participant SB1025.

"I think we had intended to develop multiple MOUs with our partners, and we came across some challenges with that with our law enforcement partners. The way that our county executes MOUs, there's a template for all of the legalese that must be included in the MOU. Some of our law enforcement agencies were not willing to sign those MOUs, so we weren't able to execute MOUs with all of our partners. That being said, we still work with them, we just don't have a formalized MOU in place."

Provider Participant SB1000.

DISCUSSION

CHAPTER SUMMARY

In total, over $33 million was invested into building and expanding TAY and adult mental health crisis services across California as part of the second round of SB-82 funding. Collectively, these funds led to the provision of over 81,000 services to 17,408 clients from 2018 to 2021. The initiatives served a diverse population of clients, largely reflecting the demographics of the communities they served. From the perspectives of those delivering and receiving care, these services were considered to play an important role in supporting key outcomes such as improving the client experience of care, reducing incarcerations, and supporting linkage to longer-term behavioral health services among those experiencing mental health crises.

Regarding the implementation of these services, recruiting and retaining mental health clinicians was the largest barrier to program success, primarily due to low pay for clinicians and the inherent risk of the work. Key facilitators included developing strong community partnership with local agencies, incorporating peer specialists in the programs, and focusing efforts on delivering services in the community during extended hours of operation (ideally 24-hours, 7-days a week).

These findings can serve as an informative foundation to concurrent efforts to improve mental health in California as well as informing the ongoing summative evaluation to further assess the overall impact of programs funded by SB-82.

This statewide formative evaluation of crisis triage funded by SB-82 for 15 adult/TAY programs provides important insights concerning the design and delivery of mental health crisis programs, the impact of the programs, and perspectives on how to effectively implement crisis services. These findings can inform both programs in development, and established programs looking to refine crisis care delivery. Recommendations and key lessons learned from this formative evaluation are highlighted below.

Key Lessons Learned and Recommendations

Key Lessons Learned Overview
• **Over $33 million** was invested in 15 adult/TAY mental health crisis programs during the second round of SB-82 funding. • **81,643 services were provided to 17,408 clients** from 2018 to 2021.** • **The programs served a diverse population** of clients, which largely reflected the demographics of the counties in which they were located. • **A one-size-fits-all crisis care model will not meet the needs of individual counties** due to unique challenges and opportunities present within each county. • **Program sustainability is a significant challenge.** Initial program planning and design should identify mechanisms to sustain crisis programs beyond the grant funding period.

Crisis Care Delivery

- **Deliver crisis care through a transparent, empathetic, and person-centered approach.** The most valuable skill reported for a crisis provider was the ability to establish rapport and trust with individuals and their families. Providers and law enforcement participants emphasized the importance of showing empathy and humanity, the use of destigmatizing language, awareness of the power differential between the client and an individual that has the power to place an involuntary hold, rapid follow-up on the established plan and delivery of services with a person-centered focus.

Source: Shutterstock.com

- **Care across the crisis continuum should be delivered *in* the community.** "Meeting the people where they are" as a low-barrier alternative to clinic or facility-based services was

**Data is based on 14 programs. City of Berkeley was not included due to the unique nature of being a telephone hotline only.

considered necessary to successfully identify those in need and to support ongoing engagement in care.

- **Offer linguistically and culturally appropriate services.** Making appropriate materials and translation services readily available is critical during a crisis response.
- **Utilize social media, non-stigmatizing language, and texting rather than calling when supporting TAY clients.** Program providers reported that these strategies were important to connect with TAY clients and increase engagement.
- **Provide post-crisis follow-up support and coordinate with community-based services.** Provider and law enforcement participants indicated that providing support post-crisis was essential to facilitate client engagement in longer-term care, which in turn can promote recovery and reduce the risk of future crises. Additionally, a greater proportion of clients were successfully linked to longer-term care if crisis service providers utilized warm handoffs with community-based service partners and actively supported them in attending their first session.

Program Structure

- **Extend mobile crisis availability outside of standard office hours.** Only three programs (20%) provided services 24/7. Funding and recruiting providers to deliver services at night and on weekends can be challenging, but both law enforcement and SB-82 provider interviewees reported that this is when a disproportionate amount of crisis events occur. The lack of availability of crisis triage services during these periods may limit the ability of programs to meet crisis needs in their communities, and lead to increased involvement of law enforcement and emergency departments.
- **Incorporate peer specialists into crisis care programs.** In the qualitative interviews, peer specialists were identified as critical to improving engagement in care through normalizing and destigmatizing mental illness, decreasing power differentials between clients and providers, and fostering trust in services.
- **When conducting mobile crisis work, provide for basic needs (e.g., food and water).** Multiple providers suggested that having water and food on hand during crisis assessments can be a highly effective tool to de-escalate a challenging situation and facilitate client engagement in the process.
- **Use technology to create efficiencies.** Providers reported it was helpful to deliver services via telehealth in routine situations when rapport has already been established. Programs also described optimizing electronic health record systems to easily capture needed data and streamline information sharing.

Crisis Program Staffing

- **Utilize a higher base pay and/or a higher classification title to improve recruitment and retention of mental health clinicians.** Recruitment and retention of mental health clinicians were reported as the *largest barrier* to program success. Increased salary and/or a higher classification title is important to offset both the increase in liability crisis workers face and the need for extended working hours.
- **Address provider burnout.** Senior staff cited burnout as a high area of concern, and a factor in the challenge around staff retention. To reduce staff burnout, support clinician retention, and improve clinician competency, program providers identified the following strategies: offer trainings to enrich professional development, collaborate between providers, increase supervision, set boundaries around work, and support self-care.
- **Increase training and support for providers.** Amongst staff interviewed, areas of training-need identified most frequently included the management of SUDs, harm reduction approaches, additional risk assessment training, safety planning, and motivational interviewing.
- **Offer full benefits for peer specialists.** Programs faced challenges with retaining peer specialists due to peers wanting to advance their careers, seek full-time employment, and/or receive benefits. Offering full benefits to peer positions may decrease turnover.

Partnership with Law Enforcement and Community Organizations

- **Foster effective collaborations with community partners.** Trustworthy, respectful collaborations with community partners were identified as critical to ensure programs received referrals, enabled access to spaces that may be unsafe without law enforcement support, optimized care delivery, and facilitated linkage to longer-term recovery-oriented services. Law enforcement officers interviewed reported a *culture shift* in their department when they collaborated with mental health workers on crisis calls, resulting in considering alternative solutions and greater knowledge of how to support both clients and themselves.
- **Identify scenarios where law enforcement would not be necessary before responding (e.g., clients who were frequent utilizers and were known to present a low risk)**. While the co-response model was important for safety in potentially dangerous situations, the ability to provide services without the mandated presence of law enforcement was often preferred by clients and was supported by provider staff. This approach could allow for a more efficient use of law enforcement resources, and potentially decrease barriers to crisis care.

Sustainability

- **Identify long-term sustainability plans prior to funding.** Various strategies were considered to sustain programs, including utilizing Medi-Cal billing, future MHSA funding, general funds, reducing staff, reducing services, redistributing existing funding sources, and consolidating SB-82 grant–funded programs into other programs. Despite the variety of strategies, programs identified challenges with sustaining programs after the grant funding ended. Anticipating common challenges outlined in this report, building infrastructure that supports program facilitators and identifying sustainable funding streams from the outset may decrease the likelihood of the difficult cycle of establishing and closing programs often experienced with cyclic grant funding and improve the overall mental health program landscape in California.

Implications for Future Crisis Services in California

The recommendations developed from key lessons learned highlighted above provide a **critical foundation to inform future implementation and expansion of crisis services** in California. At the local, state, and national levels, crisis services are being prioritized with significant investments being made. These include:

- Increased federal government support through the Substance Abuse and Mental Health Services Administration (SAMHSA) including:
  - Direct funding of the 988 Suicide and Crisis Lifeline program, including more than $200 million in new funding as of May 2023;
  - Set aside of 5% in new Community Mental Health Services Block Grant funding specifically for crisis services; and
  - Funding of new Cooperative Agreements for Innovative Community Crisis Response Partnerships (including one awarded to Imperial County);

Source: Shutterstock.com

- California's participation in the planning grant and implementation of the new opportunity from the Center for Medicare and Medicaid Services to pursue an enhanced federal match on Medicaid funding for mobile crisis services, as authorized under the American Rescue Plan Act of 2021;

- California Assembly Bill 988 (AB-988), which authorizes the state to collect a telecom fee to support 988 call centers as well as other crisis service providers;
- Upcoming modernized and transformative investments in California's behavioral health system through the Behavioral Health Services Act (SB-326) and the Behavioral Health Infrastructure Bond Act of 2023 (AB-531), both pending approval via a statewide ballot measure in March 2024; and
- The investment by multiple California counties in crisis service capacity expansion, including Los Angeles, San Diego, San Francisco, and others.

As these new initiatives roll out and intersect, it is important to learn from the lessons revealed by the present evaluation. For example, our analysis of contextual factors indicates that there are marked differences in mental health infrastructure across counties. Program needs will differ for rural versus urban counties, such as safety concerns when there is a need to respond to crisis calls in rural areas without cell phone service, widely varying accessibility to long-term mental health providers, absence of inpatient mental health care in some rural counties, and county-specific regulations (e.g., co-response mandates) that can have a major impact on the desired programmatic outcome of reduced law enforcement involvement in crisis care. Given this variation, allowing for flexibility in how funds are spent to meet unique county needs is essential. Some tailoring of program outcome metrics may be needed.

As described in this evaluation, addressing the staffing recruitment and retention challenges facing crisis programs is critical. Recruiting and retaining staff was the single largest barrier to program success. Without alleviating administrative barriers (e.g., excessive paperwork), significantly increasing crisis worker support, managing workloads, addressing burnout, and increasing compensation, programs may continue to struggle with staffing and achieving their desired impact. Future programs should carefully plan how to address these challenges.

As California prepares to rollout additional crisis care programs, specific lessons about sustainability should also be considered. Grant funding requires substantial time and resources for program start up and close down, and if other sustainable sources of funding are not identified, the overall impact of the program will be limited. This was challenging for many grant recipients, and future discussions around how to support such programs are needed.

Lastly, given the minimal scientific literature on crisis service best practices, additional evaluation and research to inform planning is essential to continue to improve the delivery and outcomes of community mental health crisis care. The findings from this formative evaluation could guide future programs to anticipate challenges, build infrastructure that supports

program facilitators, and encourage programs to work towards identifying sustainable funding streams earlier. Additional research is needed to provide evidence on mental health outcomes to guide future program implementation and to identify new challenges as the mental health landscape continues to evolve.

Strengths

This formative evaluation utilized a broad range of data. The high participation rate from each county and the diverse data sources created a clear picture of the crisis programs' implementation. Such an approach enabled the evaluation team to analyze data with a wider perspective and validate findings.

Source: Shutterstock.com

Furthermore, extensive feedback from community partners during the survey and interview development process allowed a broad array of voices to be both heard and understood. The team strived to ensure the evaluation aligned with community members' priorities, leading to meaningful and relevant findings.

Limitations

While the evaluation team was careful to select and implement a rigorous methodology, there are notable limitations.

Qualitative Interviews

The primary source of data in the formative evaluation was qualitative interviews with providers, law enforcement, and clients. While data from law enforcement and clients bring valuable insights on SB-82 grant–funded programs to the evaluation, the evaluation team is unable to determine how generalizable the experiences of interviewed law enforcement and clients are to their respective populations. The law enforcement officers most willing to participate in interviews were also individuals selected to collaborate most extensively with grant-funded crisis providers. These were typically officers that were considered the best "fit" for crisis care collaboration with mental health providers. Hence, their views may not be representative of the views of law enforcement officers more generally.

Similarly, the clients who agreed to be interviewed were typically actively engaged in their crisis triage program, with the opportunity to participate in the study presented by their case manager. Consequently, the views and experiences of clients who disengage from crisis care early or were considered too unwell to participate were less likely to be included in the participant sample. Despite these limitations, given the paucity of both law enforcement and client perspectives in the literature, these data provide novel and critical insights into client and law enforcement perspectives amongst those that most actively engage with the programs.

Regarding provider interviews, it is possible participants may have tried to communicate what they perceived to be acceptable answers, rather than expressing true barriers or concerns they experienced, given the evaluation team's link to the funder (the MHSOAC). Participants may have felt uneasiness around the evaluation and its potential impact on their program. To mitigate this, the evaluation team employed strategies to address this issue, such as emphasizing the anonymity of the interviews, being transparent about the process, and building rapport at the outset of the recruitment process and interviews.

Program Survey

The quantitative analysis of program data was limited primarily by the nature of the data available to the formative evaluation team. The survey of SB-82 grant–funded programs was tailored based on input from program staff to reflect differences in the structures of the different programs and from experts in the delivery of mental health services to ensure usefulness and relevance of the data. To protect client privacy, data were provided as aggregate data directly from grantees; the evaluation team did not receive any client-level data. The evaluation team reviewed surveys to identify missing or inconsistent data and communicated with programs about these issues, but the evaluation team was not able to verify with certainty that final counts were complete or unduplicated. Quarterly data were summed to estimate annual counts; encounters were likely underestimated due to quarterly unduplicated counts and should be considered a lower bound on the true number of encounters.

Many programs experienced personnel changes between rounds 1 and 2 of program survey data collection. The evaluation team consulted with program staff on multiple occasions during development and distribution of the survey to ensure questions were as clear and specific as possible. However, the evaluation team cannot rule out potential bias due to changes in personnel experience pulling data or interpretation of the data requested. Additionally, changes in some programs led to specific data no longer being collected or available to share

(e.g., data on client dispositions or client demographics).

Lastly, variations in county program structure and county population demographics, combined with relatively small program-level client numbers prevented meaningful comparisons of demographics across programs. To advance health equity in crisis care and ensure services reach those most in need, collecting client-level demographic data and assessing client engagement by demographics is needed. Collaboration with individuals with lived experience in evaluation and research of crisis care will also serve those efforts.

Conclusion

The results of this evaluation suggest programs funded by SB-82 were successful at delivering a variety of crisis services. Providers were able to identify a series of facilitators to effective crisis care delivery, such as strong community partnerships, the use of peer specialists, and operating 24/7. Qualitative interviews suggest programs reduced hospitalizations and incarceration and highlighted the benefits of collaboration between mental health service providers and law enforcement during implementation. These findings can serve as an informative foundation to concurrent efforts to improve mental health in California as well as informing the ongoing summative evaluation to further assess the overall impact of programs funded by SB-82.

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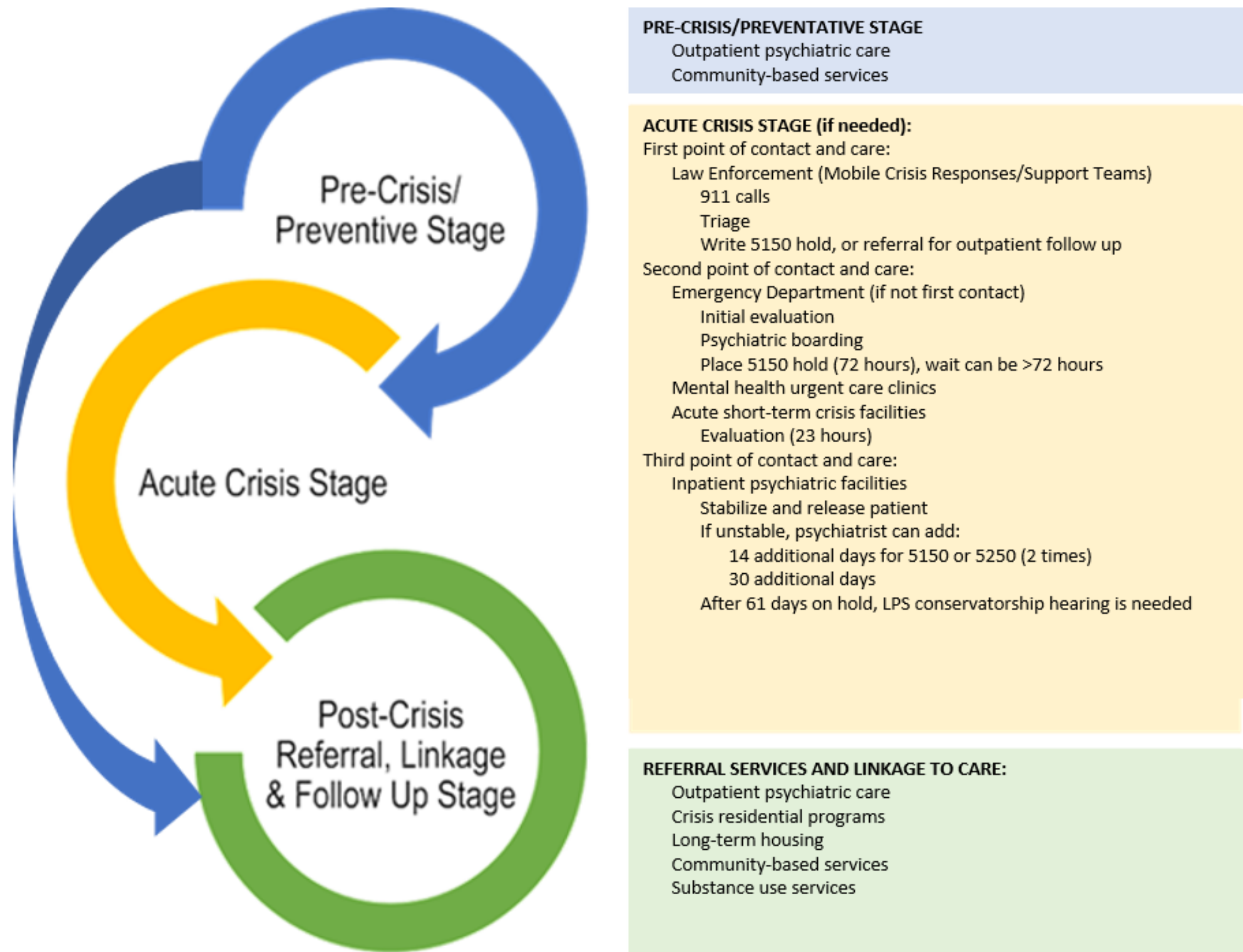
APPENDICES

Appendix 1.Crisis Continuum

Figure A1. Continuum of Adult/TAY Crisis Interventions



Appendix 2. Literature Review

Findings from the literature review of 17 studies were categorized using a conceptual framework reflecting the continuum of crisis care (see Appendix 1): pre-crisis (preventive) interventions, first-contact interventions (e.g., co-responder interventions), acute crisis services, and post-crisis linkage and follow-up interventions. Results indicated few high-quality studies on the effectiveness of crisis interventions. There were few tangible findings, which are detailed below.

- ***Pre-Crisis Preventive Interventions:*** Limited literature on pre-crisis interventions suggested that the addition of case management or customized plans for individuals with high utilization of crisis services may not be effective in reducing emergency department visits or hospitalizations. A review of studies on crisis hotlines did not identify effective intervention strategies.
- ***First Contact Crisis Interventions:*** Co-responder models with collaborations between mental health workers and law enforcement officers varied widely in the literature reviewed. No randomized controlled trials had been conducted although results from observational studies suggested that co-response model interventions may reduce arrest rates of people in crisis. Results were mixed on whether co-responder interventions reduced hospitalizations or improved first responder or patient safety.
- ***Acute Crisis Services:*** Acute crisis services offered in emergency departments were among the more promising models based on available evidence. For individuals receiving crisis services in the ED, a specialized mental health triage unit reduced ED wait times and hospital admissions.
- ***Postcrisis Period:*** Two small, randomized trials suggested that follow-up to primary care and outpatient psychiatric care could be improved by patient navigators and mobile crisis follow-up teams. In a retrospective analysis of a mental health services database, the use of peer specialists showed increased outpatient service use for individuals on involuntary holds compared with controls not using peer specialists. Lastly, peer support services in a claims-based observational study were associated with reduced hospitalization and greater use of crisis stabilization.

An updated search of the literature, including 32 studies from 1999 to 2021, confirmed the lack of tangible, high-quality evidence on the effectiveness of crisis intervention programs.

Appendix 3. Logic Model

The logic model for the formative evaluation of the SB-82 grant–funded adult/TAY crisis programs (**Figure A2**) details the original five project aims, as specified by the MHSOAC from the outset of the project. In this formative evaluation, the evaluation team will detail how each grant recipient's implemented program has met these stated goals ("activities"), and measure how successful the programs have been at delivering these programs ("outputs"). As a formative evaluation, a detailed evaluation of the outcomes is beyond the scope of this deliverable. However, a range of outcomes were evaluated qualitatively from the perspective of clients, providers, and collaborating law enforcement partners, in view of informing the analysis and interpretation of the findings detailed in the summative evaluation.

Figure A2. Logic Model of the Formative Evaluation of SB-82 Grant–Funded TAY/Adult Crisis Programs

Project Aims	Activities	Outputs	Outcomes	Beneficial Impacts
1. Expand crisis treatment services.	1. Develop MOUs with community partners to facilitate co-working/linkage.	1. Total number/types of services delivered.	1. Reduce number of psychiatric hospitalizations.	1. Positive client experience of services.
2. Improve experience and recovery outcomes.	2. Implement prevention/early intervention services in community.	2. Total providers recruited/role.	2. Reduce number of referrals to psychiatric hospital from ED & law enforcement.	2. Reductions in crisis service utilizations.
3. Reduce hospitalizations and inpatient delays.	3. Improve crisis services access.	3. Patient-level summary of service utilization.	3. Reduce time spent in ED providing care to individuals in crisis.	3. Improvements in client outcomes.
4. Reduce recidivism and law enforcement expenditure.	4. Deliver mobile crisis triage services.	4. Guidelines for successful implementation.	4. Reduce law enforcement time spent with crisis clients.	4. Reductions in ED, law enforcement involvement and associated costs.
5. Expand crisis recovery-oriented early intervention and treatment options.	5. Facilitate linkage to BH services.		5. Increase rate of linkage to BH services following crisis.	
	6. Provide post-crisis care/follow-up.		6. Improve client experience of utilizing crisis services.	

Key: BH = behavioral health; ED = emergency department; MOUs = memoranda of understanding; TAY = transitional age youth.

Appendix 4. Detailed Methods

A mixed-methods design was used for the formative evaluation of 15 SB-82 grant–funded adult/TAY programs. A detailed description of the methods used is presented below.

Qualitative Data Collection Procedures

Semi-structured qualitative interviews were conducted to explore provider, client, and collaborating law enforcement partner experiences of delivering and receiving care, as well as the barriers and facilitators of successful implementation. The process was approved by the UC Davis Institutional Review Board and when required, interviewees provided informed consent. The process for implementing the qualitative component of the evaluation was completed across three steps: 1) the development of the interview guides, 2) the recruitment and completion of the interviews, and 3) data analysis. All interviews were audio recorded, and recordings were transcribed, cleaned, and coded prior to analysis.

Interview Guide Development: The first draft of the interview guides was developed by the qualitative team (Lindsay Banks [LB] and Mark Savill [MS]) based on the key formative evaluation questions. This draft was then reviewed and refined by the wider evaluation team, which included researchers and clinicians with experience of frontline delivery of crisis services. Next, the interview guides were reviewed by the CAB. Recommendations from both reviews were incorporated into the guides before the start of interview. The interview guides were then adapted iteratively based on experiences in the interviews and preliminary findings.

Provider Interviews: Two rounds of interviews were completed.

First Round: The goal of the first round of provider interviews was to obtain a baseline understanding of each of the program structures. In preparation for the interviews, the evaluation staff reviewed the original grant proposals and Summary of Changes[††] document and extracted all relevant information to complete the Program Summaries spreadsheet (**Appendix 9**). County demographic data was added based on a by-county review of census data. Finally, the primary program contact was invited to participate in a brief interview with the qualitative team to better understand the program structure, review the collected program information, and confirm if additional changes were needed. Each interview was transcribed, and the information obtained was added to the Program Summaries spreadsheet (**Appendix 9**).

[††] Summary of Changes was a document drafted by the grant recipients that details any amendments to the programs from the original grant proposals.

Second Round: The goal of the second round of provider interviews was to gain a deeper understanding of program structures, challenges, and successes. Providers included program management, frontline licensed clinicians, case managers, and peer staff.

Program leads connected the evaluation team with two to three individuals who were either involved in program implementation, service delivery, or both. All interviews were conducted via the secure teleconference system, Zoom. Each interview followed the interview guide and lasted approximately 1 hour. The focus of the interview was dependent upon each program's structure and by the interviewee role (e.g., interviews with management focused on implementation, training, and recruitment, whereas interviews with peers focused more on prevention, linkage, and post-crisis follow-up).

Client Interviews: Program staff helped to identify clients to be interviewed. Clients were provided with a study brochure that included the evaluation team's contact information so that clients could reach out if interested, or else were connected directly with the evaluation team by the program staff at the clients' discretion. Interviews were conducted by a member of the qualitative research team (LB). Topics included how clients accessed services, who they encountered as part of the service, if they were linked to follow-up services, and their overall impression of services.

Law Enforcement Interviews: The evaluation team contacted a representative from each of the 15 counties to obtain contact information of their law enforcement partners. Once connected with the law enforcement team, the evaluation team sought approval for staff to participate in interviews from the department leads. Once approved, the evaluation team was connected with officers who worked with their county's SB-82 grant–funded program who were then invited to participate in an interview. The interviews took place over Zoom and topics discussed included the law enforcement partner's involvement in crisis services, how mental health crises were handled when mental health personnel were not present, their experience collaborating with mental health services, and their impression of the impact that crisis services had on both their role and the community.

Qualitative Data Analysis Plan: A directed content analysis approach was used to analyze the transcripts.[‡‡] The framework was constructed with specific reference to the key formative evaluation questions.

[‡‡] Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qualitative Health Research. 2005; 15(9):1277-1288.

The qualitative lead researcher (MS) conducted the analysis. All transcripts were coded using NVIVO 12.[§§] First, MS reviewed the transcripts and developed a preliminary coding framework. This preliminary coding framework was then analyzed primarily by MS and reviewed by the wider SB-82 evaluation team.

Some quotes detailed in this deliverable were amended by the authors to anonymize responses, remove crosstalk, and to elucidate pronouns. In these instances, the edits were denoted though the use of square brackets ("[ ]").

Detailed Qualitative Interview Guides

Below are the guides utilized for the qualitive interviews, including detailed questions asked.

Provider Guides

DEMOGRAPHIC QUESTIONS

- How would you identify your gender?
- How would you identify your race and ethnicity?
- What is the highest level of education you have completed?
- How many years of experience do you have working in the mental health field?

INTRODUCTORY QUESTIONS

- What is your role in this crisis program?

PROGRAM SETUP

Were you involved in setting up of the program? [IF YES]

- How did you determine what the service should look like?
- What were the main challenges you experienced in setting up the program (if any)?
    - What steps were taken to help mitigate those challenges?
- Did any part of the set-up process go more smoothly than you expected? How so?
- Having now gone through the process, is there anything you've learned that you wish you knew back then?

[§§] QSR International Pty Ltd. NVivo (Version 12). 2018. Available at: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Are you involved in staff recruitment or training for the program? [IF YES]

- What has been your experience of recruiting providers?
- Has there been anything that has made the process easier?
  - Incentives for high-risk work? Bonuses?
- How has staff retention been in the program?
  - Do you have any thoughts about why it has been good/bad?
  - Do you have any thoughts about how to improve it further?
- Has staff burnout been a concern in your program?
  - Has anything been effective at reducing burnout in your team?
- What has your experience been of training the providers working in your program (licensed BH clinicians, health care workers, peers, etc.)?
  - Has the training all been conducted in-house, or have you used some external support in this area?
  - Has there been anything that has been particularly helpful or unhelpful?

CRISIS PREVENTION

Thank you. Now I would like to talk about the care that your service provides. Is your program involved in the prevention of crisis situations (i.e., outreach, facilitating engagement with outpatient care, peer support and self-management support)? [IF NO, MOVE TO 4]

- Could you talk a little bit about what this piece of your program looks like?
- Are there any parts that have gone particularly well?
- Are there any parts that have been more challenging?
- Can you think of anything that might help mitigate those challenges?
- What do you think has been the impact of this work?
- What could improve the prevention work in your program?

IMPROVING ACCESS INTO MENTAL HEALTH CRISIS CARE

Is your program involved in improving access to crisis care (for example: hotlines, links to agencies such as ED or law enforcement, other forms of outreach)? [IF NO, MOVE TO 5].

- How is your service typically made aware of a crisis situation that requires intervention?
  - What has been significant in improving access to mental health crisis services? Why?
  - Have there been any potential referral sources where you have not received the volume of referrals that you thought you might? Why?
  - Do you have any thoughts about how access into crisis care services could be improved?
- Are there some populations that your program is better at reaching than others?

- When you get a referral, do you receive adequate information or is it often a partial report?
  - [if appropriate] What is the information that you would like but to not often get?

CRISIS ASSESSMENT AND SHORT-TERM CARE

Does your program conduct assessments of people in mental health crisis?
[IF NO, MOVE TO 6]

- Please tell us about the crisis assessment services your program provides.
- Where do these assessments take place?
- When clients are highly agitated, distressed, and/or disorganized, how do you approach these situations?
  - Are there any strategies that have been particularly helpful or unhelpful?
- Does your service typically engage with support systems (family members, partners, friends, neighbors) during a crisis assessment?
  - What approaches with the clients' support system do you think is helpful, unhelpful, or could be improved?
- Does your service have the authority to place or rescind involuntary psychiatric holds?
  - What challenges, if any, do your providers face when placing or rescinding someone on a 5150? What might mitigate those challenges?
- In cases where clients do not meet criteria for a 5150 hold, what services (if any) are available?
  - Do you think this is adequate for the population you serve?
- What are the typical options you have for disposition? Are these options adequate or do you often have to settle for less-than-ideal referrals and plans?
  - What additional options (e.g., crisis residential services) would have a positive impact on outcomes if they were available?

POST-CRISIS LINKAGE TO LONG-TERM CARE

Does your service provide post-crisis follow-up support? [IF NO, MOVE TO 7]

- What does the post-crisis linkage you provide typically look like?
- In your experience, are clients typically engaging in community services post-crisis?
  - What do you think impacts the likelihood of clients engaging in community care post-crisis?
- What have been some of the challenges to supporting clients to engage in care post-crisis?
  - What might mitigate those challenges?
- Is it more challenging to facilitate engagement in some services relative to others? Why?

COLLABORATION WITH EXTERNAL PARTNERS

- Does any of the work you describe involve collaborating with other agencies? (law enforcement, ED's)? If so, what does this look like?
- Do you think the collaboration works well?
- How did you develop the collaboration?
- Is there anything that has been particularly important in developing or improving the collaboration?
- Has there been anything that has been challenging around the collaboration?
  - Do you have any thoughts around how to mitigate those challenges?
- Are there any collaborations with other agencies you do not currently have but think would be helpful?
- Is there anything that could be improved with regards to the collaboration?

INVOLVEMENT OF PEERS

Does your service include peer specialists? [IF NO, MOVE TO 8]

- In what roles are peers involved in your program?
- How are they recruited and trained?
- What are the strengths (if any) of utilizing peers in the crisis program?
- What might be some of the challenges (if any) of utilizing peers in the crisis program?
  - [if any exist] What are some ways to mitigate these challenges?
- Do you think the involvement of peers impacts the outcomes of the program?

FINAL QUESTIONS

- What do you think the impact of this program has been in your county? Do you think this service is impacting client outcomes in any ways?
- What else might make a service like this work better to meet the needs of clients?
- Do you feel your team has adequate capacity to meet the demand? Where is it currently short?
- Do you have a plan for this project once the grant ends?
  - Have there been any thoughts with regards to the sustainability of the project?
  - How do you plan to fund it?
- What trainings would be helpful for your team to strengthen your program?
- Is there anything else you think might be important for us to consider when trying to understand your experiences of delivering crisis services?

- Is there anything else important for us to consider when we think about the impact of this program on clients and their families?

Client Guides

DEMOGRAPHIC QUESTIONS

- How would you identify your gender?
- How would you identify your race and ethnicity?
- What is the highest level of education you have completed?

INTRODUCTORY QUESTIONS

- Have you ever received an assessment from the county crisis triage program or known someone who did? (INCLUDE NAME OF PROGRAM – PROVIDERS IF NECESSARY)
- How many times?

ACCESS

- How did you come in contact with the service the first time? (Did you call someone? Did they approach you?
- How did you come into contact with the service on subsequent occasions?

[IF THEY HAVE EVER REACHED OUT TO SERVICE]

- How did you find out about the service?
- What was your experience of getting in contact with them?
- Do you feel like they responded quickly enough?

[IF THERE HAVE BEEN OCCASIONS WHERE THEY HAVE NOT REACHED OUT]

- Did you know about the service beforehand?
  - IF YES: Was there anything that stopped you from reaching out to them?
- Is there anything the program should be doing to make sure that more people do know about it?
- Do the potential costs associated with receiving care usually play a role in your decision to seek or avoid crisis service, or is that not relevant to your decision?

5150

- Have any of your crisis assessments led to an involuntary 5150 psychiatric hospital

admission? If so, how many?

- Could you tell us a little bit about how the assessment(s) from the crisis triage program went on each occasion [IF VERY HIGH NUMBER, EITHER GENERALLY OR JUST THE PARTICULARLY NOTABLE ONES]?
- On these occasions, were you already receiving mental health services prior to the crisis?

CRISIS TRIAGE ASSESSMENT

- Did you have any contact with the police, ED staff, or crisis program members while you were experiencing a crisis?
- Were the [ED, police– ASK FOR EACH THAT THE CLIENT HAD CONTACT WITH] helpful or unhelpful? In what ways?

- ***During the assessment with the crisis team:***

  - What went well (if anything)?
  - What did not go well, or could have gone better (if anything)?
  - Do you feel like you received the support you needed?
  - Do you feel like the crisis team listened to you?
  - Did the crisis team seem to understand what you needed? Dependent upon what your needs were at the time, were they helpful with mental health concerns, and/or substance use difficulties?
  - Did they also help with social services needs like housing, food access, etc.? If not, do you think that they should?
  - Were your opinions on what needed to happen taken into account?
  - Do you feel like the opinions of your family/loved ones (if present) were considered?
  - On the occasions when you've received an assessment from the crisis program was a family member, friend or loved one present at the time?
  - How did the crisis team interact with your family/friend or loved one?
  - Was this helpful or unhelpful?
  - Do you think having a family member there changed the nature of the care you received? If so, how?
    - Did it change it for the better or worse?

DEPENDENT UPON RESPONSES ABOVE

- ***On the occasions that you were hospitalized [IF APPLICABLE]:***

  - Did you agree with the decision at the time?

- Did you agree with the decision now?
- If they were present, did your family/loved one agree with the decision?

- ***On the occasions that you were not hospitalized [IF APPLICABLE]:***
    - Did you agree with the decision at the time?
    - Did you agree with the decision now?
    - If they were present, did your family/loved one agree with the decision?
- Have there been times when you have experienced a crisis and seen either the police, ED staff, or somebody similar but NOT a mental health crisis provider?
    - In those occasions what was different (if anything)?
    - What was the outcome?
    - Did you go on to receive any additional behavioral health or social services? If so, what?
    - Comparing the different situations, on what occasion do you think your needs were served better? Why?

LINKAGE

[ASK APPROPRIATE QUESTIONS DEPENDENT UPON HOW CLIENT ANSWERED PREVIOUS QUESTION: "WHAT HAPPENED AT THE END OF THE ASSESSMENT?"]
First, I would like to talk about the time(s) you were admitted to hospital following the mental health assessment.

- How were you transported to hospital? Do you consider this to be the most appropriate method, or would you have preferred something else?
- Did you speak to anyone from the crisis team after you were discharged from the hospital?

[IF YES]

- What was the purpose of that contact?
- How did they get in contact with you (call, text, in-person)?
- Was the contact helpful?
- Did they link you to any form of community care (provide contact info, make you an appointment, introduce you to a provider, etc.)
    - Mental health treatment (intensive outpatient, outpatient therapy, med management, groups, peer support, etc.)?
    - Substance use difficulties (if appropriate)?
    - Social services (housing, food access)
        - How long did you receive these services for?
        - Did receiving these services lead to any changes in your life, either positive or

negative?
    - Were there other services that you would have liked to receive, but were either not referred to or did not receive?
        - Why did you not receive them?

[IF NO]

- If you did not speak to anyone from the crisis service, where you referred on to any other service by somebody else? Who? What services did you receive?
    - Mental health treatment (intensive outpatient, outpatient therapy, med management, groups, peer support, etc.)?
    - Substance use difficulties (if appropriate)?
    - Social services (housing, food access)?
    - How long did you receive these services for?
    - Did receiving these services lead to any changes in your life, either positive or negative)?
- Were there other services that you would have liked to receive, but were either not referred to or did not receive?
    - Why did you not receive them?
- Would you have wanted somebody from the crisis team to help link you to services?

[IF NOT ADMITTED TO INPATIENT]
Now I would like to talk about the occasions when you were not admitted to hospital.

- After the assessment, did they refer you on to additional services (i.e., community care)?

[IF YES]

- What services were you referred to?
- Did you go on to receive any of these services?
    - Mental health treatment (intensive outpatient, outpatient therapy, med management, groups, peer support, etc.)?
    - Substance use difficulties (if appropriate)?
    - Social services (housing, food access)?

- How long did you receive these services for?
    - Did receiving these services lead to any changes in your life, either positive or negative)?
    - Do you think you would have come into contact with these services without the

referral from the crisis team?

[IF NO]

- How did your interaction with the service end?
- Did they attempt to contact you at all (via text, call, or in-person)?
- Do you think you would have benefited from additional services at that time? If so, what services?
- Were you able to receive these services a different way?
- Do you think you were able to get the care that you needed at the time?

FINAL QUESTIONS

- Overall, how satisfied were you with the care you received from the crisis team?
- Was there anything, in particular, that you liked?
- Was there anything that you didn't like, or think could have been better?
- Did you experience any discrimination or prejudice during the crisis encounter? If so, what happened?
- What do you think about the police getting involved in mental health crisis response?
- Is there anything else you think might be important for us to know to understand your experience better?
- Can you think of anything that might make a service like this work better in the future?

Law Enforcement Guides

DEMOGRAPHIC QUESTIONS

- How would you identify your gender?
- How would you identify your race and ethnicity?
- How long have you been a law enforcement official?
- How many years of experience do you have working with the [COUNTY SB-82 PROGRAM NAME] team, or other mental health crisis teams like them?
- Have you received either Crisis Intervention Training (CIT) or something similar, to provide guidance around how to manage mental health crisis situations in the field?

INTRODUCTORY QUESTIONS

- How many times do you think you have been involved in a situation where you suspect that the person you're interacting with is experiencing a mental health crisis?

- What proportion of those interactions have involved providers from teams like [COUNTY SB-82 PROGRAM NAME] on the scene?
- In what Counties/states have you served as a law enforcement official?

[IF ONLY ONE COUNTY/STATE]

- How are involuntary mental health admissions (5150s) typically handled in the county you work in?
  - Tell me about your experience with 5150s.
  - What works well?
  - Could anything be improved?

[IF MULTIPLE COUNTIES/STATES]

- Were there any differences between how the counties/states handled involuntary mental health admissions situations (5150s)?
- Did you notice any strengths or weaknesses to each approach?

WITH CRISIS SERVICE INVOLVEMENT

Thank you. Now, it would be helpful to understand what the collaboration between you and the mental health crisis services personnel looks like from your perspective.

- So, in cases where a member of the [COUNTY PROGRAM NAME] team is involved in a mental health crisis situation, could you talk a bit about what that looks like? So, who typically arrives on the scene first, who call who, and who does what?
- If it is established that its more appropriate for the individual to receive mental health services, as opposed to enter the justice system, what is your role then?
- At what point would you typically disengage from the situation?

WITHOUT CRISIS SERVICE INVOLVEMENT:

Next, I would like to talk through what the process might typically look like when the mental health crisis services personnel are not present.

When you are dealing with an individual experiencing a suspected mental health crisis the typical outcomes would be that the client is left at site; goes back home or with family; or they are taken to the emergency department, a crisis facility, or is booked into jail. Are there any other dispositions that are available to you? Are there other dispositions that you believe should be available to you?

- How do you determine which is the most appropriate disposition?
- Do you think you typically make the same or different judgment calls as the mental health crisis services personnel?
- Are there any disposition options that are only available to mental health crisis services personnel that are not available to you? Is this an issue?
- How do the individuals in crisis typically respond to you when you are trying to make these determinations without [COUNTY PROGRAM NAME] team members being present? Is that the same or different from the way they typically respond to [COUNTY PROGRAM NAME] team members?
- Does dealing with these situations without [COUNTY PROGRAM NAME] team providers take more, less, or the same amount of your time relative to when they are present?
- Do mental health crisis situations in the field without support from mental health crisis providers impact the potential need for use of force?

COLLABORATION WITH CRISIS SERVICE PROVIDERS:

- What has working with the [COUNTY PROGRAM NAME] program in mental health crisis situations been like for you?
- Has working with the mental health crisis services personnel made your role easier/more efficient?
- Has working with the mental health crisis services personnel caused any additional challenges for you in your job?
    - What might mitigate those challenges?
- What is the communication between you and the mental health crisis services personnel like?
    - Do you think that impacts the service delivered at all? If so, how?
    - Has this changed at all over time?
- What, if anything, would you change about the collaboration with mental health crisis services personnel?
- Do you think having crisis service personnel present impacts the likelihood that the use of force may be required?

PROGRAM IMPACT

- Do you think the mental health crisis situation you are charged with dealing with typically goes better or worse when the [COUNTY PROGRAM NAME] team is present? Why?

- Do you think this program affects the immediate outcome for the person in crisis? For example, do you think they are they more or less likely to go to jail, the ED department, the psychiatric hospital, or to go home?
- Do you think this program impacts the longer-term outcomes for the person in crisis? For example, the recurrence of crisis, engagement in care, recidivism, etc.?
- Does having a crisis team like [COUNTY PROGRAM NAME] ever lead to more negative outcomes?
- Do you think existence of the crisis service program changes the demands on you as a law enforcement officer? Has it increased or decreased the volume of work you have to do?
- Since working with [COUNTY PROGRAM NAME], has this changed how you interact with individuals who are experiencing a mental health crisis during the course of your job?

WORKING WITH FAMILIES/CAREGIVERS

- Do you typically come into contact with the families of individuals who are experiencing a mental health crisis?
- Does having a [COUNTY PROGRAM NAME] team member change how the situation goes with family members at all?

FINAL QUESTIONS

- Is there anything else you think might be important for us to consider when trying to understand your experiences of working with mental health crisis services personnel?
- Can you think of anything that might make the program work better for mental health crisis services personnel, clients, or law enforcement partners?

Quantitative Data Collection Procedures

The evaluation team designed two program surveys completed by SB-82 grant recipients to collect program-level information (e.g., hours of operation, services provided) and aggregated data on program staff employment, client counts and demographics, referrals to and from SB-82 grant–funded programs, and service provision and utilization. Data from the program surveys were also used to provide information about SB-82 grant recipient sustainability plans and the adoption of telehealth during the COVID-19 pandemic. Programs participated in both rounds of data collection. The first survey collected data from the beginning of the SB-82 grant–funded adult/TAY programs through December 31, 2020. The second program survey — which included additional questions about staffing, peer advocates, community partners, cultural diversity, and other topics — collected data from January 1, 2021, through December 21, 2021. The UC Davis internal review board reviewed and approved the program surveys. Final program surveys 1 and 2, and the unique final surveys for City of Berkeley and Los Angeles County can be found in Attachment 1.

Pilot Phase

Prior to formal data collection, the UCLA and UC Davis evaluation teams jointly conducted a SB-82/833 data collection pilot phase. The pilot was conducted with six counties (Calaveras, Humboldt, Placer, Sacramento, Stanislaus, and Yolo) to establish a road-tested process for data collection. This process helped the evaluation teams to understand and address challenges prior to formal data collection, and to learn about counties' data infrastructure, policies, and procedures. This provided insight on what data were feasible for counties to provide which helped to inform the development of the program survey.

Collaboration with UCLA

Since the inception of the evaluation, the UC Davis and UCLA evaluation teams have worked side-by-side to develop evaluation methods and problem solve data collection challenges. This close collaboration through monthly meetings was particularly beneficial in the development of the program survey.

Survey Development and Distribution

The evaluation team developed the surveys with input from key experts on mental health treatment and crisis services from UC Davis and UC San Francisco and SB-82 grant–funded program providers. The survey questions were reviewed and revised to ensure clarity that the

requested data were well-defined and obtainable. The survey was also reviewed by the UC Davis SB-82 Community Advisory Board. Once feedback was incorporated, the survey underwent a second round of review by the groups listed above as well as the Data Coordinators Working Group —a workgroup consisting of grant recipient representatives across all three SB-82/833 grant–funded initiatives (adult/TAY, child, school-county programs), UCLA evaluation team members, and UC Davis evaluation team members — who met regularly to inform and improve data collection efforts. The surveys were generated using Qualtrics, a web-based survey software, and were distributed by email to an identified primary program contact. Only one response was collected from each grant recipient during each round of data collection.

Survey 1 was disseminated to 13 grant recipients in April 2021. Two grant recipients did not receive the program survey during round 1: Los Angeles County and City of Berkeley. Due to substantial differences in these two programs and delays in implementation in Los Angeles County, unique surveys were developed for Los Angeles County and City of Berkeley during round 2 of data collection.

The updated version of the program survey for round 2 of data collection was sent to 13 grant recipients in February 2022 and separate, unique surveys were sent to the City of Berkeley and Los Angeles County in March 2022.

Program Survey Data Analysis

The evaluation team checked that grant recipient responses were reasonable and consistent with the type and format of data requested. If this manual check generated questions, the evaluation team contacted the staff member responsible for the survey seeking clarification. Survey responses from round 1 from the Qualtrics survey online platform were imported into Stata/MP 17 (henceforth referred to as "Stata"). Survey responses from round 2 from the Qualtrics survey online platform were imported into Microsoft Excel. Data were coded to allow the analysis of categorized numerical data. Tabulation of survey data was performed for client counts, client demographics, referrals to and from SB-82 grant–funded programs, and service utilization data by quarter from every participating grant recipient. Means, summations, and standard deviations were calculated; and tables and graphics were generated to display the data.
When available, grant recipients reported unduplicated client counts by demographics, service type received, referral sources, and setting client was referred to for every quarter the program was active. The distinction between "clients" and "encounters," as described in the results, is

that "clients" refer to measures in which each client was counted once. "Encounters" refer to measures in which the same client might be counted more than once (e.g., annual encounters were calculated as the sum of quarterly data).

Other Sources of Data

Other key sources of data were obtained to inform the formative design, including questions asked in the qualitative interviews and incorporated into the program survey.
Other key sources of data were obtained to inform the formative design, including questions asked in the qualitative interviews and incorporated into the program survey. These data sources included:

- Program memoranda of understanding (MOUs),
- County demographic data,
- Community-centered data,
- Webinars,
- Quarterly MHSOAC meetings, and
- Ride-alongs.

Data Accuracy

To ensure data accuracy, the SB-82 adult/TAY evaluation team:

- Reviewed original grant proposals from all 15 SB-82 adult/TAY grant recipients and summarized each grant recipient's existing triage services, goals, proposed services and staffing, outcomes, location, and potential data sources.
- Modified program summaries based on updated proposals submitted to the MHSOAC in response to the budget cuts.
- Conducted follow-up interviews with each program's team manager or appointed representative to confirm the structure of the program delivered.
- Conducted regular quantitative data meetings jointly with the UCLA evaluation staff and with staff from all grant recipients in the Data Coordinators Working Group meetings to obtain and verify methodological feedback.
- Conducted a data collection pilot program from April 2020 to August 2020. Met at least twice with six SB-82 grant recipients to gain knowledge of grant recipient data system, including available data, sources of data, and data system capabilities. This concluded with the collection of pilot data from grant recipients.

- The UC Davis evaluation team attended weekly joint meetings with the UCLA evaluation team to brainstorm, discuss, and coordinate data collection and evaluation design issues and methodology. These meetings were used to discuss evaluation objectives, identify threats to the evaluation design, and methodological strategies to address potential threats.
- Met with six SB-82 grant recipients individually between January 2021 and March 2021 to get input on survey design and questions. Grant recipient staff were provided copies of the draft survey at least one week prior to meetings. Meetings were used to discuss grant recipient feedback on survey questions and design. The team sought county input to ensure program survey questions were appropriate and tailored as necessary to capture reliable data.
- Sent the revised and final version of the program survey to grant recipients for a final round of review and feedback prior to program survey 1 distribution in April 2021.
- Compared grant recipient responses from program survey 1 to program survey 2 to ensure they were consistent with the type and format of data requested.
- Met with 14 of the 15 grant recipients over Zoom (specifically the individuals responsible for completing the program surveys) to confirm unduplicated counts of total clients served by each program and to seek clarification on program descriptions and any missing or inconsistent data. The evaluation team requested missing or corrected data when necessary. Communication with Ventura County was conducted over email.
- Conducted additional follow-up with 10 of 15 grant recipients to discuss inconsistencies in the types of services offered by their programs as reported in program survey 1 compared to program survey 2 and updated records for all 10 grant recipients for accuracy. The evaluation team learned inconsistencies between round 1 and round 2 of data collection — specifically related to service types reported — were explained by changes in services provided by the programs over the course of the grant cycle, staff turnover, or differences in knowledge of the personnel pulling data if it was not the same person (e.g., Alameda County started including their mobile crisis team in SB-82 grant–funded services partway through the grant cycle).

Appendix 5. Hiring Reports

The evaluation team obtained quarterly hiring reports submitted to the MHSOAC by requesting the reports for all grant recipients and receiving them via email. After a thorough analysis, the evaluation team discovered notable limitations to the hiring reports including missing and inconsistent data; missing quarterly reports; absence of unique identifiers (e.g., names and position title); and inconsistent position titles, dates hired, and dates vacated. For example, a staff member may fill various roles across reports or the date of hire/vacated may slightly differ between reports. Additional limitations arose due to the inclusion of unfilled positions, backup coverage, and staff transfers and promotions being marked as newly hired or vacated positions. These limitations and the lack of unique staff identifiers resulted in duplicated counts of program staff hired. For example, Merced's hiring reports included a duplicate count of 37 new hired and 15 vacated staff due to the inclusion of unfilled positions, staff providing backup coverage for other positions, and staff promotion and transfers.

Several approaches were used to address these challenges. The evaluation team used subsequent reports to calculate the total staff hired and vacated when missing quarterly reports were identified. In the absence of unique identifiers, names and position title were used in calculations. However, when names or unique identifiers were not available, the evaluation team was not able to confirm hiring or vacated positions. The evaluation team emailed multiple grant recipients to discuss questions from missing or inconsistent data, unveiling that many programs interpreted the reporting of hiring changes differently. Since identifiers of staff hired and vacating positions were not consistently available in the reports, turnover could not be estimated. Due to these challenges, lack of reliable data, and after much internal discussion, the evaluation team decided to remove the hiring report data from the main findings in the final report, and instead include the summary below. These limitations should be considered in reviewing the summary and table below.

Using available hiring reports, annual total staff hired and vacated were calculated in Microsoft Excel, as shown in **Table A1**. Many grant recipients began hiring staff in the first quarter of their program, while seven grant recipients hired program staff a quarter and two quarters before their program start dates, respectively. Across all programs, a total of 256 staff were hired, and 84 staff vacated. Merced hired the most staff with 37 hires, while Yolo and Berkeley hired the least at three employees each. Berkeley, Los Angeles, and San Francisco retained the same number of staff across their programs' active periods. Finally, the average number of total staff hired and vacated across all grant recipients over their program start date to December 2022 was 17.07 and 5.6, respectively.

Table A1. Reported Annual Total Staff Hired and Vacated

Grant Recipient	Funding Start Date	Funding End Date	Reported Annual Total Staff Hired						Reported Annual Total Staff Vacated					
			2018	*2019*	*2020*	*2021*	*2022*	Total	*2018*	*2019*	*2020*	*2021*	*2022*	Total
2018 Funding Start Date														
Yolo	10/1/2018	12/1/2020	3	0	0	0	0	3	0	0	1	0	0	1
Sonoma	12/12/2018	11/30/2022	6	3	4	3	0	16	0	4	1	5	0	10
Tuolumne	12/12/2018	11/30/2021	1	4	2	0	0	7	0	1	0	0	0	1
Humboldt	12/14/2018	11/30/2021	4	4	1	1	0	10	0	3	2	1	0	6
2019 Funding Start Date														
Ventura	1/2/2019	11/30/2021	11	12	0	1	0	24	0	2	0	2	0	4
Calaveras	1/4/2019	1/31/2022	0	6	0	1	0	7	0	1	1	0	0	2
Merced	1/22/2019	11/30/2021	0	25	3	9	0	37	0	6	3	6	0	15
Butte	3/1/2019	6/30/2023	2	15	9	2	2	30	0	4	3	1	3	11
Placer	4/15/2019	11/30/2022	0	6	1	1	0	8	0	1	0	1	0	2
San Francisco	6/15/2019	11/30/2022	0	10	2	3	1	16	0	0	0	0	0	0
Berkeley	6/21/2019	11/30/2021	0	3	0	0	0	3	0	0	0	0	0	0
Sacramento	7/1/2019	11/30/2022	0	16	7	11	1	35	0	3	5	11	2	21
Stanislaus	7/22/2019	11/30/2021	0	8	1	1	0	10	0	1	2	2	0	5
Alameda	12/1/2019	6/30/2024	0	5	7	3	0	15	0	0	3	3	0	6
2020 Funding Start Date														
Los Angeles	12/1/2020	6/30/2023	0	0	35	0	0	35	0	0	0	0	0	0
Total								256						84

Source: Hiring reports from SB-82 grant–funded adult/transitional age youth (TAY) programs. Totals are evaluation team's tabulations of grant recipient–level data.

Note: Staff hired may include existing employees assigned new roles or promoted. All grant recipients were offered a 1-year no cost extension from November 2021 to November 2022.

Key: TAY = transitional age youth.

Appendix 6. Supplemental Tables

Table A2. Service Types Provided by Grant Recipient

Grant Recipient	Assessment	Case Management/ Brokerage	Plan Development	Rehab	Outreach/ Engagement	Gathering Collateral Information	Crisis Intervention	Individual Therapy	Family Therapy	Group Session/ Therapy	Medication Support
Alameda	X	X			X	X	X				
Butte	X	X	X	X	X	X	X	X	X	X	X
Calaveras		X	X	X		X	X				
Humboldt	X	X	X	X		X	X	X			
Los Angeles	X	X	X	X	X	X	X	X	X		X
Merced	X	X	X	X		X	X			X	X
Placer	X	X	X		X	X	X				X
Sacramento		X	X	X	X		X				
San Francisco	X	X	X	X	X	X	X	X	X		
Sonoma	X				X	X	X				
Stanislaus	X	X		X	X	X	X				
Tuolumne		X		X	X	X	X				
Ventura	X	X		X	X	X	X				
Yolo	X	X	X	X		X	X	X			X

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: The grant-funded adult/TAY program in the City of Berkeley was a telephone hotline only and was not asked this question.
Key: TAY = transitional age youth.

Table A3. Interventions During Client Encounters

Grant Recipient	Psych-Ed/ Resources	Peer Support	Motivational Interviewing	Coping Skills	De-escalation	Safety Plans	Remove Mean of Self-Harm	Emergency Medication	Admin of Narcan	Work w/ Support System	Coordinate Care w/ Providers	Arrange Inpatient Admission	Other
Alameda	X	X		X	X	X			X	X	X		
Butte	X	X	X	X	X	X	X		X	X	X	X	
Calaveras	X	X	X	X	X	X	X	X		X	X	X	
Humboldt	X	X	X	X	X	X	X			X	X	X	
Merced	X	X	X	X	X	X	X	X		X	X	X	
Placer	X	X	X	X	X	X	X			X	X	X	Medical assessment/clearance (tox screen, medical first aid, vitals, etc.)
Sacramento	X	X	X	X	X	X	X			X	X	X	
San Francisco	X	X	X	X	X	X	X	X	X	X	X	X	CBT, CBT for Psychosis, Mindfulness, attending/maintaining client appointments, narrative therapy, Trauma-informed therapy
Sonoma	X	X	X	X	X	X	X			X	X		
Stanislaus	X	X	X	X	X	X				X	X	X	Connection to Community Resources and Basic Needs
Tuolumne	X	X	X	X	X	X				X	X	X	Assist client access services and community resources
Ventura	X	X	X	X	X	X				X	X	X	Housing linkage, and linkage to other resources that may be needed.
Yolo	X	X	X	X	X	X	X	X		X	X	X	

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Key: CBT = cognitive behavioral therapy; TAY = transitional age youth.

Table A4. Community Partnerships with SB-82 Grant–Funded Programs

Grant Recipient	Law Enforce-ment	EDs	Homeless Shelters	Domestic Violence/ Sexual Assault Services	Schools/ Colleges	Community-Based Mental Health Services	Social-Service Groups	Religious Orgs	Mental Health Urgent Care Clinics	Acute Short-Term Crisis Facilities	Inpatient Psych Facilities	Crisis Residential Programs	Long-Term Housing	Substance Use Services
Alameda	X	X	X		X	X	X		X	X	X	X	X	X
City of Berkeley	X	X	X	X		X	X		X	X	X	X		X
Butte	X	X	X	X	X	X			X	X	X	X		X
Calaveras	X													
Humboldt	X	X	X	X	X	X	X	X	X	X	X			X
Los Angeles	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Merced	X	X	X			X	X		X		X	X		X
Placer	X	X	X	X	X	X	X	X		X		X	X	X
Sacramento			X	X	X	X	X	X	X	X	X	X	X	X
San Francisco		X				X			X	X	X	X		
Sonoma	X	X	X		X	X				X		X		
Stanislaus	X	X	X			X	X		X	X	X	X	X	X
Tuolumne	X	X			X									
Ventura	X	X	X	X	X	X	X	X		X	X	X	X	X

Source: Surveys 1 & 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis).
Note: The grant–funded adult/TAY program in Yolo County ended in 2020, therefore Yolo was not surveyed for 2021.
Key: EDs = emergency departments; Key: TAY = transitional age youth.

Table A5. Census of Worker Roles as of January 1, 2021, by Grant Recipients

	Manger/ Supervisor		Case Manager		Clinician		Counselor		Peer Coach/ Advocate		Outreach		Office Assistant		All Roles	
Grant Recipient	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**
Alameda	1	1	0	0	1	1	0	0	2	1	2	1	0	0	6	4
Berkeley*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Butte	1	1	0	0	0	0	2	2	4	2	0	0	0	0	7	5
Calaveras	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1
Humboldt	0	0	1	1	1	1	0	0	1	1	0	0	0	0	3	3
Los Angeles*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Merced	2	1	3	3	5	5	0	0	0	0	0	0	1	1	11	9
Placer	0	0	0	0	1	1	0	0	1	1	0	0	0	0	2	2
Sacramento	3	1	3	2	1	1	1	1	9	9	1	1	1	1	19	16
San Francisco	2	1	1	1	2	2	0	0	0	0	0	0	1	0	6	4
Sonoma	0	0	0	0	2	2	0	0	0	0	0	0	0	0	2	2
Stanislaus	1	1	0	0	2	2	0	0	2	2	0	0	0	0	5	5
Tuolumne	1	0	1	1	0	0	0	0	2	1	0	0	0	0	4	2
Ventura	1	1	3	3	1	1	0	0	2	2	3	3	0	0	9	9
Yolo	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	12	6	13	12	16	16	3	3	23	19	6	5	3	1	75	61

Source: Surveys 1 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis). Totals are evaluation team's tabulations of grant recipient–level data.
**Grant recipient not surveyed during survey round 1.*
Key: FTE = full-time-equivalent.

Table A6. Census of Workers as of January 1, 2022, by Grant Recipient

	Manger/ Supervisor		Case Manager		Clinician		Counselor		Peer Coach/Advocate		Outreach		Office Assistant		All Roles	
Grant Recipient	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**	**N**	**FTE**
Alameda	2	2	0	0	3	3	0	0	0	0	1	1	0	0	6	6
Berkeley	2	2	0	0	1	1	2	2	0	0	0	0	1	1	6	6
Butte	1	1	0	0	0	0	2	2	7	0	0	0	0	0	10	3
Calaveras	1	0.25	1	0.5	0	0	0	0	0	0	0	0	0	0	2	0.75
Humboldt	1	1	1	1	2	2	0	0	2	2	0	0	0	0	6	6
Los Angeles	20	8.6	22	11.75	30	16	0	0	26	15.25	0	0	15	3	113	54.6
Merced	2	0.7	2	1.5	5	5	0	0	0	0	0	0	1	1	10	8.2
Placer	0	0	0	0	1	1	0	0	1	1	0	0	0	0	2	2
Sacramento	2	1.17	0	0	1	1	0	0	14	13.5	1	1	1	0.92	19	17.59
San Francisco	1	1	1	1	1	1	0	0	0	0	0	0	1	0.4	4	3.4
Sonoma	1	0.25	0	0	2	0.25	0	0	1	0.25	0	0	1	0.25	5	1
Stanislaus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tuolumne	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ventura	1	1	5	5	1	1	0	0	2	2	5	5	1	1	15	15
Yolo*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	34	18.97	32	20.75	47	31.25	4	4	53	34	7	7	21	7.57	198	123.54

Source: Survey 2 of SB-82 grant–funded adult/transitional age youth (TAY) programs (UC Davis). Totals are evaluation team's tabulations of grant recipient–level data.
**Grant recipient not surveyed during survey round 2.*
Key: FTE = full-time-equivalent.

Appendix 7. Individual Program Summary Data

SB-82 grant–funded adult/TAY individual program demographics and service utilization are detailed below.

Alameda County

The Alameda County SB-82 adult/TAY triage grant supported three programs. The Post Crisis Follow Up/Crisis Connect team provided follow-up services to clients who were recently in crisis. The Community Connections team provided outreach in the field, linking clients with serious mental illnesses to on-going mental health services. While the Familiar Faces team conducted services for clients in the field who are considered high utilizers, including follow-up visits, care coordination, and linkage to ongoing care or resources. The programs served 3,972 unique clients over 4,039 encounters since they began on December 1, 2019, through the end of 2021. For encounters for which Alameda provided demographic data, 75% of total encounters involved adults aged 26 to 59, 15% TAY aged 16 to 25, 9% adults 60 years or older, and 2% children under 16 years. Sixty-one percent of total encounters involved clients who identified as male. Fifty percent of total encounters involved clients who identified as Black, 24% White, and 6% Asian. Seven percent of the programs' encounters involved clients who identified as Hispanic or Latinx. The demographic counts for client encounters by Alameda County's SB-82 grant–funded adult/TAY programs are summarized in **Table A7** below.

Table A7. Encounter Demographics by Alameda County's SB-82 Grant–Funded Adult/TAY Programs

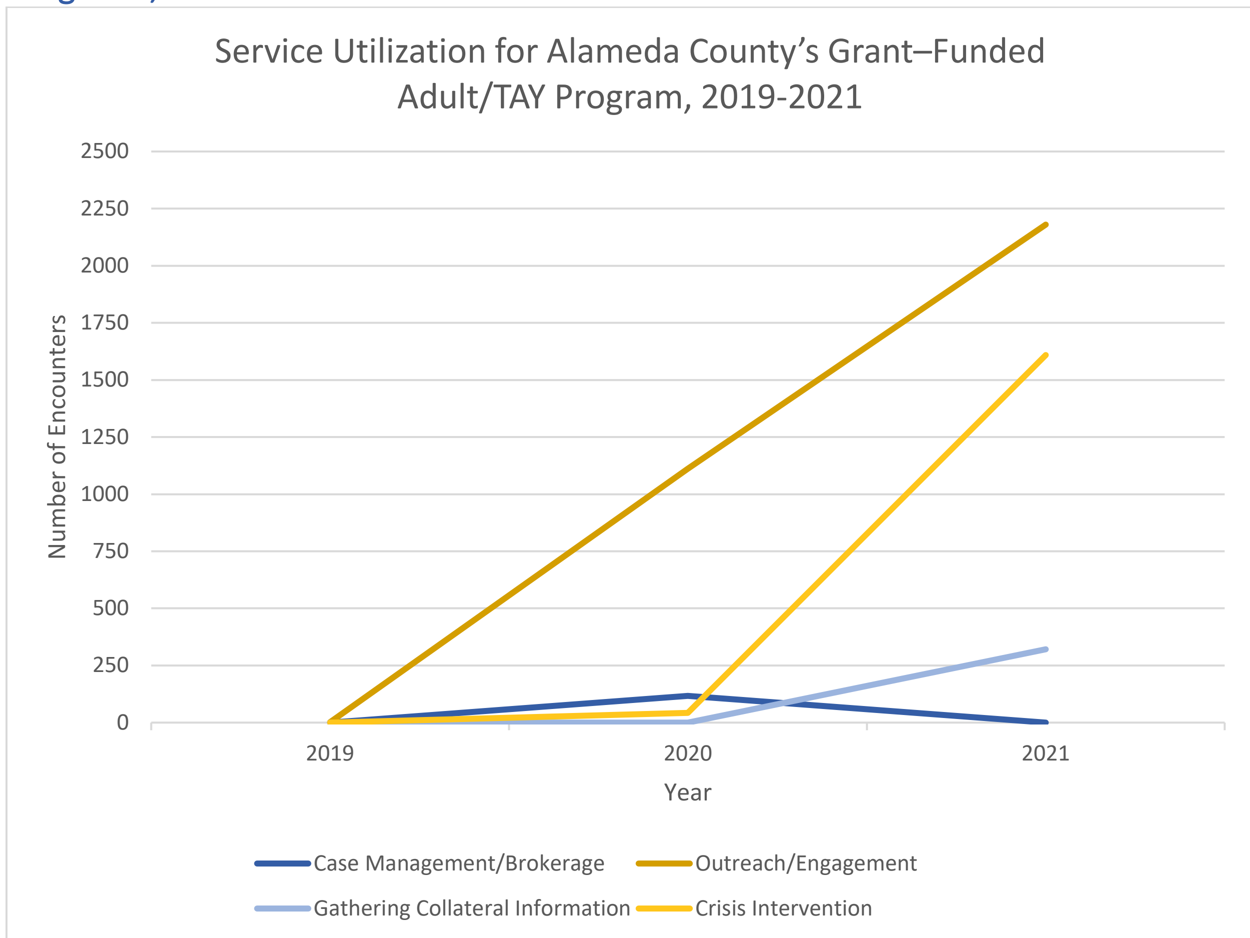
	2019*	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	3	71	74	2%	
TAY (16-25)	0	207	380	587	15%	
Adult (26-59)	2	1,060	1,914	2,976	75%	
Older Adult (60+)	0	138	205	343	9%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	0	430	1,046	1,476	37%	50.7%
Male	2	937	1,517	2,456	61%	49.3%
Other Gender	0	7	7	14	0%	
Unknown/Not Reported	0	34	59	93	2%	
Ethnicity						
Hispanic/Latinx	0	117	174	291	7%	22.3%
Not Hispanic/Latinx	2	1,038	2,400	3,440	85%	77.7%
Unknown/Not Reported	0	253	75	328	8%	
Race						
American Indian or Alaska Native	0	12	10	22	1%	0.8%
Asian	0	57	154	211	6%	31.1%
Black	1	660	1,134	1,795	49%	10.7%
Hawaiian Native or Pacific Islander	0	8	47	55	1%	0.8%
Multiple	0	0	0	0	0%	6.3%
Other	0	15	317	332	9%	11.4%
Unknown/Not Reported	0	253	133	386	10%	
White	1	286	611	898	24%	38.8%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Alameda County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
**Note: 2019 totals include data from one quarter when the program started December 1, 2019.*
Key: TAY = transitional age youth.

Alameda County's three SB-82 grant–funded programs — Familiar Faces, Post Crisis Follow-up, and Community Connections Team — each focused on different populations and provided different services. This report combined data for all three programs. Sixty-one percent of the services provided by the programs from 2019 to 2021 involved outreach and engagement, 31% involved crisis intervention services, which the grant recipient reported also included assessments. Six percent of total services involved gathering collateral information, and 2%

were case management, which ended in 2020. Thirty-five percent of total encounters with clients were referred to the program by hospitals (EDs or other), 16% by crisis stabilization unit, 12% by law enforcement, 11% by other, 8% by family referral, 7% by community bystander or other mobile outreach, 4% by full-service partnership, 3% by crisis call center or hotline, 2% by homeless shelter, and 1% by self-referral. Forty-nine percent of the programs' encounters resulted in clients referred to emergency departments, 25% to outpatient clinic/services, 12% to outreach/engagement, 4% to other mental health services, 2% to crisis stabilization unit, 2% to private insurance or current provider, 2% to housing services or shelters, and 2% to other. See **Figure A3** for more details regarding Alameda County's service utilization.

Figure A3. Service Utilization for Alameda County's Grant-Funded Adult/TAY Programs, 2019-2021



Note: Alameda County's data for crisis intervention services also includes assessments. 2019 totals include data from one quarter when the program started December 1, 2019.
Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

City of Berkeley

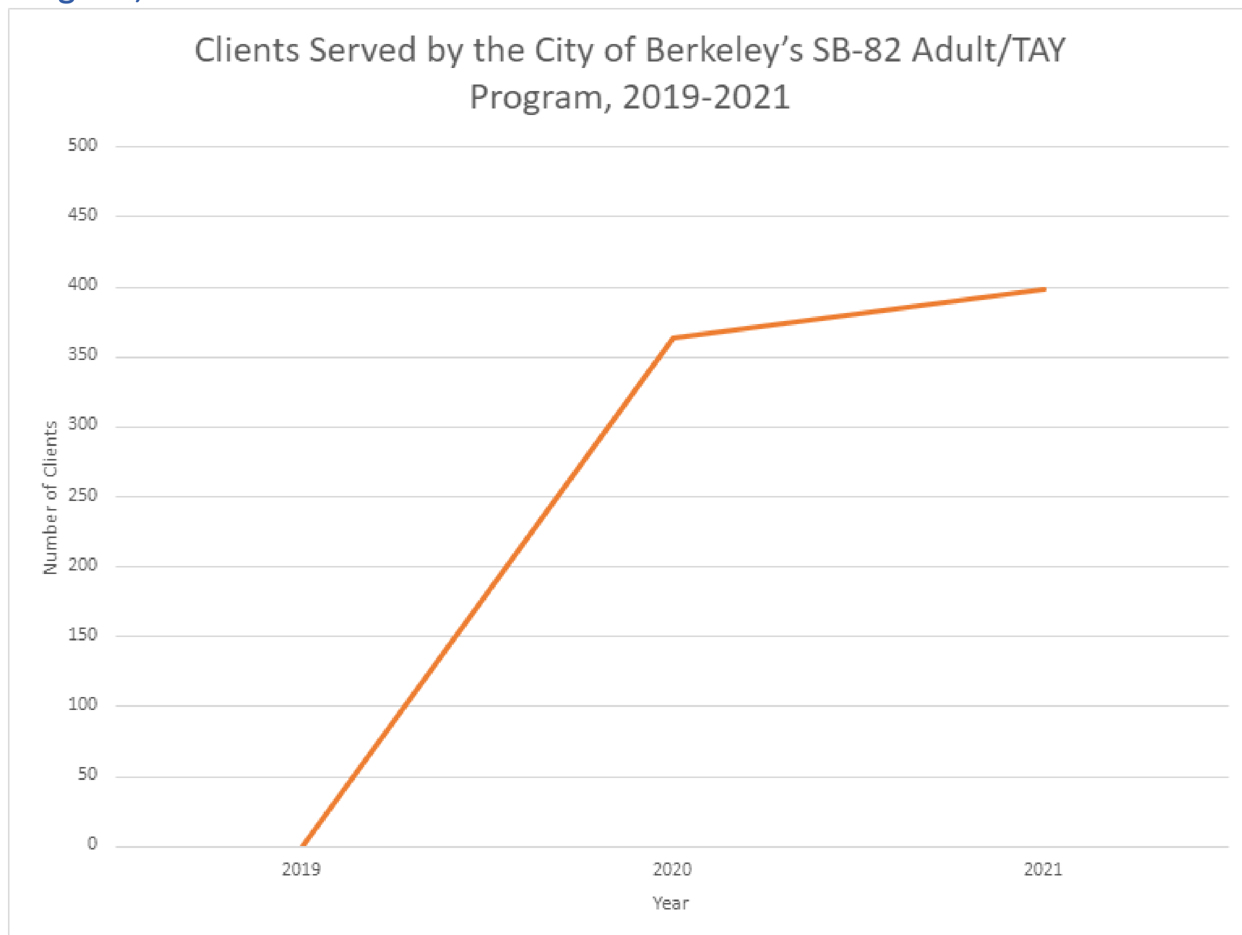
The SB-82 adult/TAY triage grant helped the City of Berkeley staff and operate the Crisis, Assessment, and Triage (CAT) Line to provide clinical, non–law enforcement support to individuals. The City of Berkeley reported 762 encounters (or calls) with clients via the CAT line from 2019 to 2021. According to the grant recipient, all 762 calls involved staff providing crisis intervention services (e.g., de-escalation, linkage to services). The grant recipient tracked information related to all calls in a database. Due to the unique structure of their program and methods for data tracking, the City of Berkeley was unable to provide confirmation of unduplicated data. Therefore, the counts reported in this section may include duplicate clients. Since the City of Berkeley is located in Alameda County, it is important to note Berkeley residents also had access to the services in Alameda County.

Berkeley provided services during 364 calls in 2020 and 398 calls in 2021, as shown in **Figure A4** below. In 2021, 256 calls involved individuals who requested mental health services and 163 calls were labeled as moderate/severe. This designation relates to an individual's moderate or severe mental health diagnosis and/or the functional impairments they experience as related to their mental health diagnosis. The staff are allowed to provide ongoing services to clients who meet this criterion and will connect these individuals to the case management team through their clinic.

Berkeley also tracked calls by clients' insurance type. Of the 518 calls with insurance type logged for 2021 more than half involved clients with AlaMediCal (57%), then unknown insurance (21%), other public insurance (11%), private insurance (7%), and no insurance (4%).

From 2019 to 2021 the CAT line received 1,430 calls for noncrisis, nonurgent reasons. Some of the common reasons for these calls included individuals seeking services from the clinic or linkage to other community providers or services or calls from other community providers trying to link people to services.

Figure A4. Clients Served by the City of Berkeley's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Butte County

The South County Mobile Crisis Team in Butte County, a partnership between mental health professionals and law enforcement, provided rapid response to individuals in crisis. The mobile team conducted needs assessments and coordinated necessary placements into Crisis Services. The program served 327 unique clients over 521 encounters since it began on March 1, 2019, through the end of 2021. For encounters for which Butte provided demographic data, 53% of total encounters involved adults aged 26 to 59, 17% involved adults aged 60 years or older, 15% involved children under 16 years, and 15% involved TAY aged 16 to 25. Fifty percent of total encounters involved clients who identified as male. Seventy-three percent of total encounters involved clients who identified as White, 5% American Indian or Alaska Native, 3% Black, and 1% Asian. Thirteen percent of the program's encounters involved clients who identified as

Hispanic or Latinx. The demographic counts for client encounters by Butte County's SB-82 grant–funded adult/TAY program are summarized in **Table A8** below.

Table A8. Encounter Demographics for Butte County's SB-82 Grant-Funded Adult/TAY Program

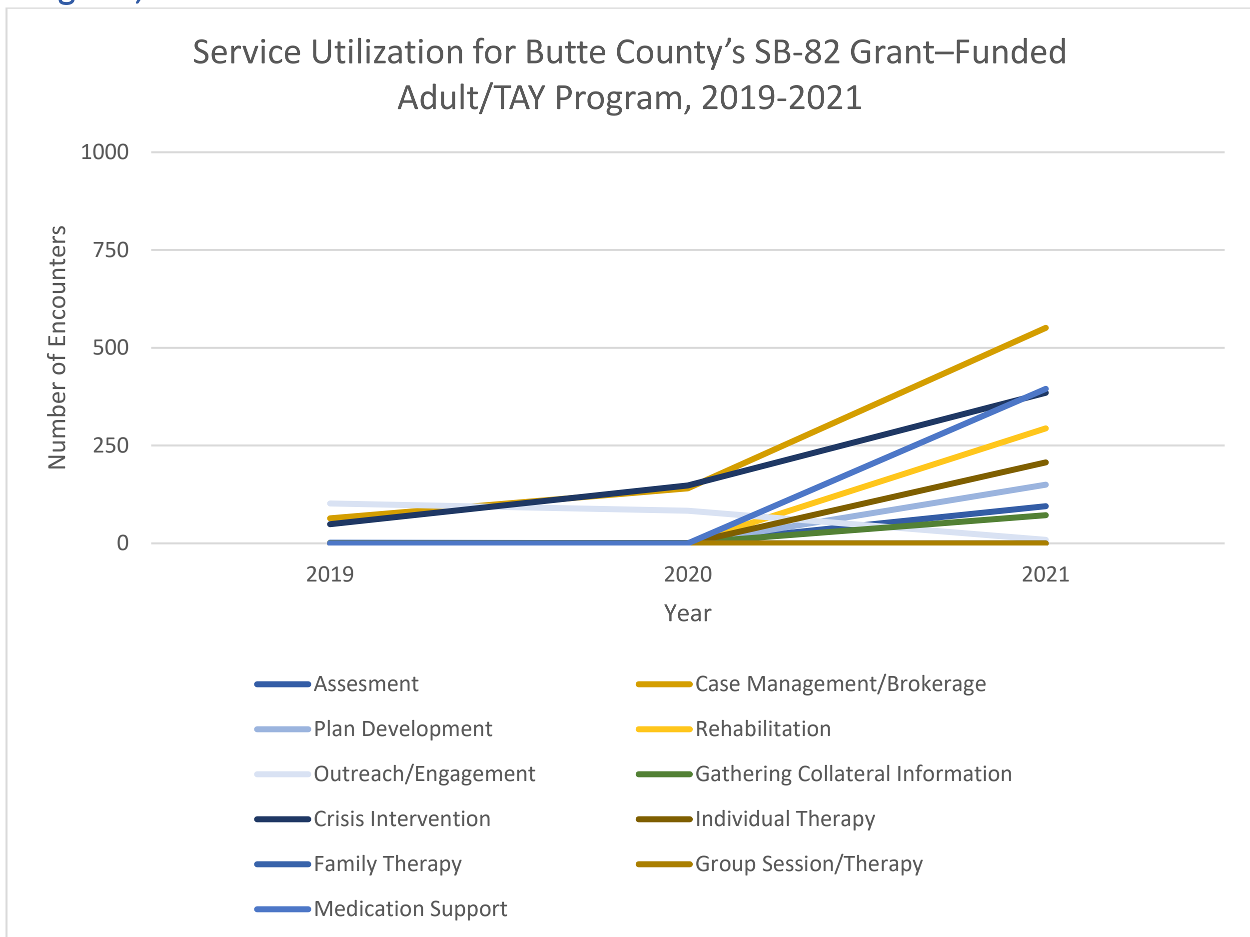
	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	26	25	25	76	15%	
TAY (16-25)	27	30	23	80	15%	
Adult (26-59)	70	112	91	273	53%	
Older Adult (60+)	34	38	17	89	17%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	71	107	83	261	50%	50.5%
Male	86	98	76	260	50%	49.5%
Other gender	0	0	0	0	0%	
Unknown/Not Reported	0	0	0	0	0%	
Ethnicity						
Hispanic/Latinx	29	22	17	68	13%	17.2%
Not Hispanic/Latinx	106	142	115	363	70%	82.8%
Unknown/Not Reported	22	41	28	91	17%	
Race						
American Indian or Alaska Native	8	9	10	27	5%	1.1%
Asian	3	1	3	7	1%	4.7%
Black	6	8	4	18	3%	1.8%
Hawaiian Native or Pacific Islander	0	2	0	2	0%	0.4%
Multiple	0	0	0	0	0%	6.2%
Other	10	5	11	26	5%	5.6%
Unknown/Not Reported	17	26	16	59	11%	
White	113	154	115	382	73%	80.2%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Butte County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Twenty-eight percent of the services provided by the program from 2019 to 2021 involved case management and 21% involved crisis intervention. Unlike many programs, 14% of the services provided by the program were medication support, all of which the program provided in 2021. The breakdown for the remainder of services included 11% rehabilitation, 8% individual

therapy, 7% outreach/engagement, 6% plan development, 3% assessment, and 3% gathering collateral information. Services provided by service type from 2019 to 2021 can be seen in **Figure A5** below. Seventy-two percent of total encounters with clients were referred to the program law enforcement, 17% by community bystander or other mobile outreach, 8% crisis call center or hotline, and 2% by self-referral. Thirty-three percent of the program's encounters resulted in clients referred to outpatient clinic/services, 31% to other mental health services, 29% to outreach/engagement, and 6% to emergency departments.

Figure A5. Service Utilization for Butte County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Calaveras County

Calaveras' Behavioral Health Crisis and Outreach Unit program provided crisis intervention, stabilization services, and linkages to services in crisis situations. The unit first began serving clients on January 4, 2019, but only provided data for 2020-2021. The Calaveras Behavioral Health Crisis and Outreach Unit served 251 unique clients over 326 encounters. Forty-one percent of the encounters involved clients who were adults aged 26 to 59, 9% TAY aged 16 to 25, 9% adults aged 60 years or older, and 1% children under 16 years. However, age was unknown or not reported for 40% of client encounters. Sixty-two percent of the program's encounters involved clients who identified as male. The program served clients who identified as White in 77% of the total client encounters and 2% of total encounters involved clients who identified as Black. Four percent of the encounters involved clients who identified as Hispanic or Latinx. The demographic counts for clients served by Calaveras County's SB-82 grant–funded adult/TAY program are summarized in **Table A9** below.

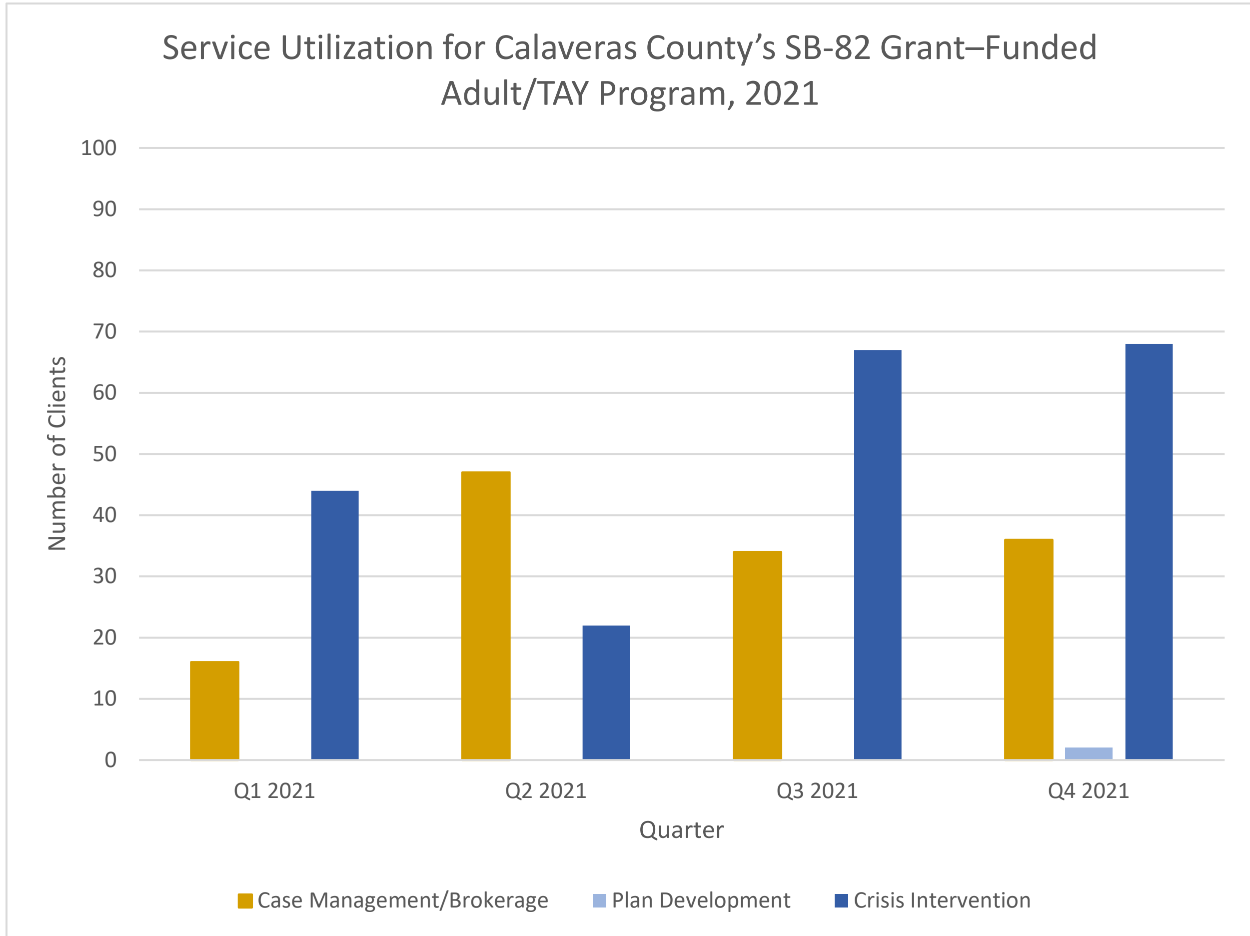
Table A9. Encounter Demographics for Calaveras County's SB-82 Grant–Funded Adult/TAY Program

	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age					
Children (0-15)	0	3	3	1%	
TAY (16-25)	0	29	29	9%	
Adult (26-59)	0	135	135	41%	
Older Adult (60+)	0	29	29	9%	
Unknown/Not Reported	130	0	130	40%	
Gender					
Female	28	71	99	30%	50.2%
Male	76	125	201	62%	49.8%
Other Gender	0	0	0	0%	
Unknown/Not Reported	26	0	26	8%	
Ethnicity					
Hispanic/Latinx	7	5	12	4%	12.1%
Not Hispanic/Latinx	95	141	236	72%	87.9%
Unknown/Not Reported	28	50	78	24%	
Race					
American Indian or Alaska Native	0	7	7	2%	0.8%
Asian	0	0	0	0%	1.5%
Black	4	2	6	2%	0.7%
Hawaiian Native or Pacific Islander	0	0	0	0%	0%
Multiple	0	4	4	1%	5.2%
Other	6	2	8	2%	1.3%
Unknown/Not Reported	26	25	51	16%	
White	94	156	250	77%	90.5%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Calaveras County population data obtained from the ACS Demographics and Housing Estimates table of the 2015-2019 5-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Calaveras only provided data for clients by referral source and service type received for 2021. As expected, due to the grant recipient's partnership with law enforcement, most of the clients served by the program were referred from law enforcement (47%) or AB-109 programs (35%) and received either crisis intervention services (60%) or case management/brokerage (40%), as seen in **Figure A6**. Two encounters with clients involved plan development services. Additionally, Calaveras County was unable to provide data on where clients were referred to in their response to the adult/TAY program survey.

Figure A6. Service Utilization for Calaveras County's SB-82 Grant–Funded Adult/TAY Program, 2021



Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Humboldt County

Humboldt County's Mobile Response Team was designed to serve individuals at all phases of the crisis continuum, from pre-crisis to postcrisis follow-up. The SB-82 grant–funded program began on December 14, 2018, and served 1,352 unique clients during 1,690 encounters over the life of the program. The program primarily served adult clients aged 25 to 59 at 62% of encounters, while 18% of encounters involved TAY aged 16 to 25, and 16% seniors aged 60 or older. About 52% encounters involved males. Humboldt County was unable to provide gender, race, and ethnicity data for encounters with clients in 2021 in their response to the adult/TAY program survey. The program's encounters with clients involved 74% of clients who identified as White, 8% as American Indian or Alaska Native, 2% as Black, 1% as Asian, and 7% as Hispanic

or Latinx. The demographic counts for client encounters by Humboldt County's SB-82 grant–funded adult/TAY program are summarized in **Table A10** below.

Table A10. Encounter Demographics for Humboldt County's SB-82 Grant–Funded Adult/TAY Program

	2018*	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age							
Children (0-15)	0	5	23	22	50	3%	
TAY (16-25)	7	54	127	121	309	18%	
Adult (26-59)	15	201	372	465	1,053	62%	
Older Adult (60+)	4	68	90	112	274	16%	
Unknown/Not Reported	1	2	0	1	4	0%	
Gender							
Female	17	168	277	-	462	48%	51%
Male	9	157	335	-	501	52%	49%
Other gender	0	0	0	-	0	0%	
Unknown/Not Reported	1	5	0	-	6	1%	
Ethnicity							
Hispanic/Latinx	0	12	52	-	64	7%	12.1%
Not Hispanic/Latinx	20	237	454	-	711	73%	87.9%
Unknown/Not Reported	7	81	106	-	194	20%	
Race							
American Indian or Alaska Native	1	30	51	-	82	8%	5.2%
Asian	0	3	5	-	8	1%	2.6%
Black	0	10	12	-	22	2%	1.5%
Hawaiian Native or Pacific Islander	0	2	5	-	7	1%	0.4%
Multiple	0	0	0	-	0	0%	7.9%
Other	0	11	10	-	21	2%	3.6%
Unknown/Not Reported	7	41	61	-	109	11%	
White	19	233	468	-	720	74%	78.7%

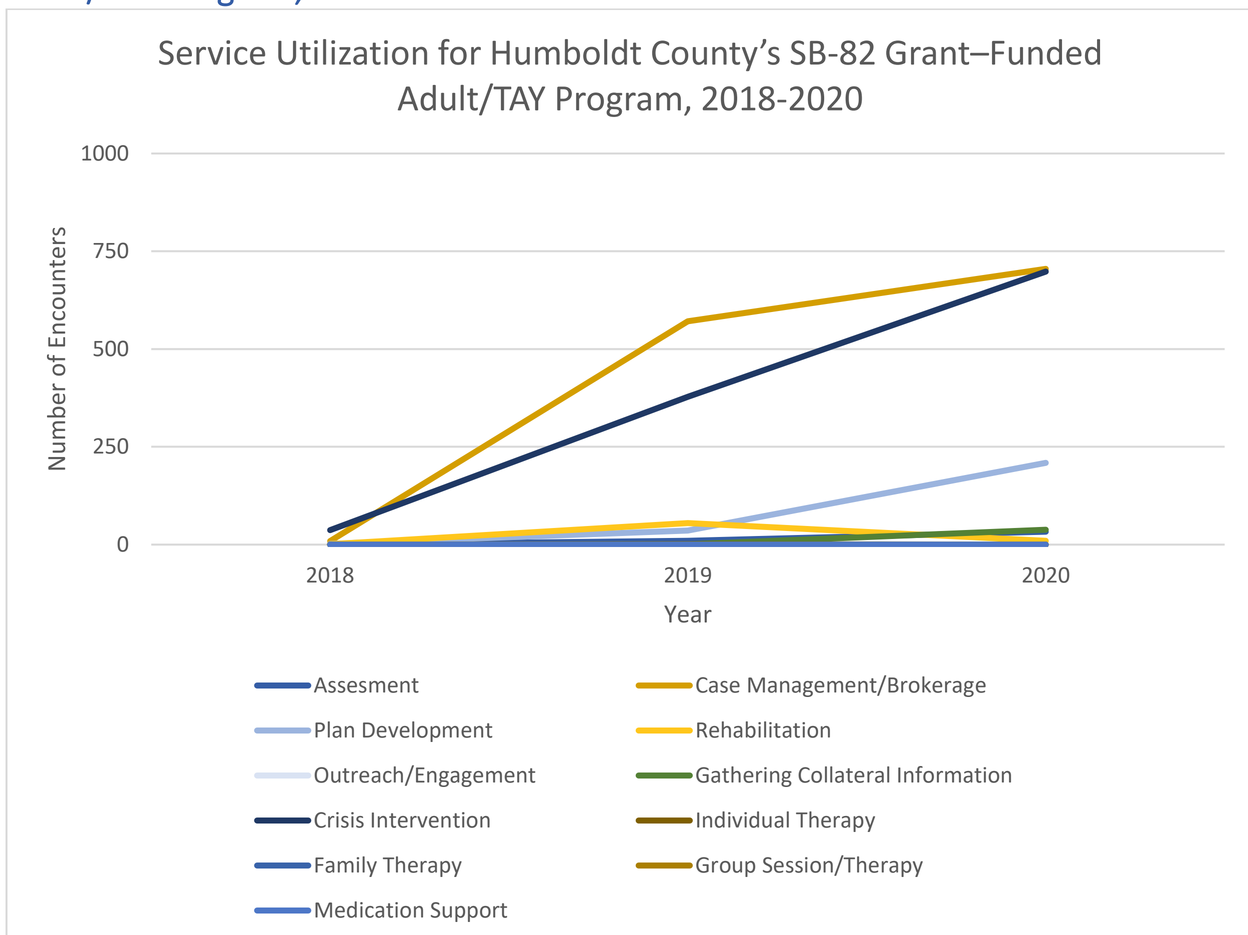
Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Humboldt County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.

**Note: Data for 2018 includes one quarter.*

Key: TAY = transitional age youth.

The grant recipient was also unable to provide service utilization data for 2021. However, 46% of encounters provided case management services, while 40% provided crisis intervention services during 2018-2020, shown in **Figure A7**. The program also provided plan development (9%) and assessment (2%), rehabilitation (2%). Lastly, few encounters provided gathering collateral information (1%) and two individuals received individual therapy. Humboldt reported that most of their encounters (99%) in 2021 involved clients referred to the program through hospitals (EDs or other). Encounters by Humboldt County's Mobile Response Team primarily resulted in clients' linkages to the county's crisis stabilization unit, outpatient clinics or services, a local ED or psych hospital, or other community mental health services.

Figure A7. Service Utilization for Humboldt County's SB-82 Grant-Funded Adult/TAY Program, 2018-2020



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded *adult/transitional age youth (TAY) programs.*
Note: Data for 2018 includes one quarter.
Key: TAY = transitional age youth.

Los Angeles County

To reduce involuntary hospitalization, the Los Angeles County's Outreach and Triage Teams provided immediate intervention and connected TAY and adults to needed services. Los Angeles County made 2,062 unique encounters with individuals since the program began on December 1, 2020, through the end of 2021. Sixty-four percent of encounters were with adults aged 26 to 59, while 19% and 12% of encounters were TAY aged 16 to 25, and seniors aged 60 and older, respectively. More than half (57%) of program encounters involved clients who identified as male. Twenty-seven percent of total encounters involved clients who identified as Black, 24% Unknown/Not reported, 22% White, and 21% Asian. Thirty-seven percent identified as Hispanic or Latinx. The demographic counts for client encounters by Los Angeles County's SB-82 grant–funded adult/TAY program are summarized in **Table A11** below.

Table A11. Encounter Demographics for Los Angeles County's SB-82 Grant–Funded Adult/TAY Program

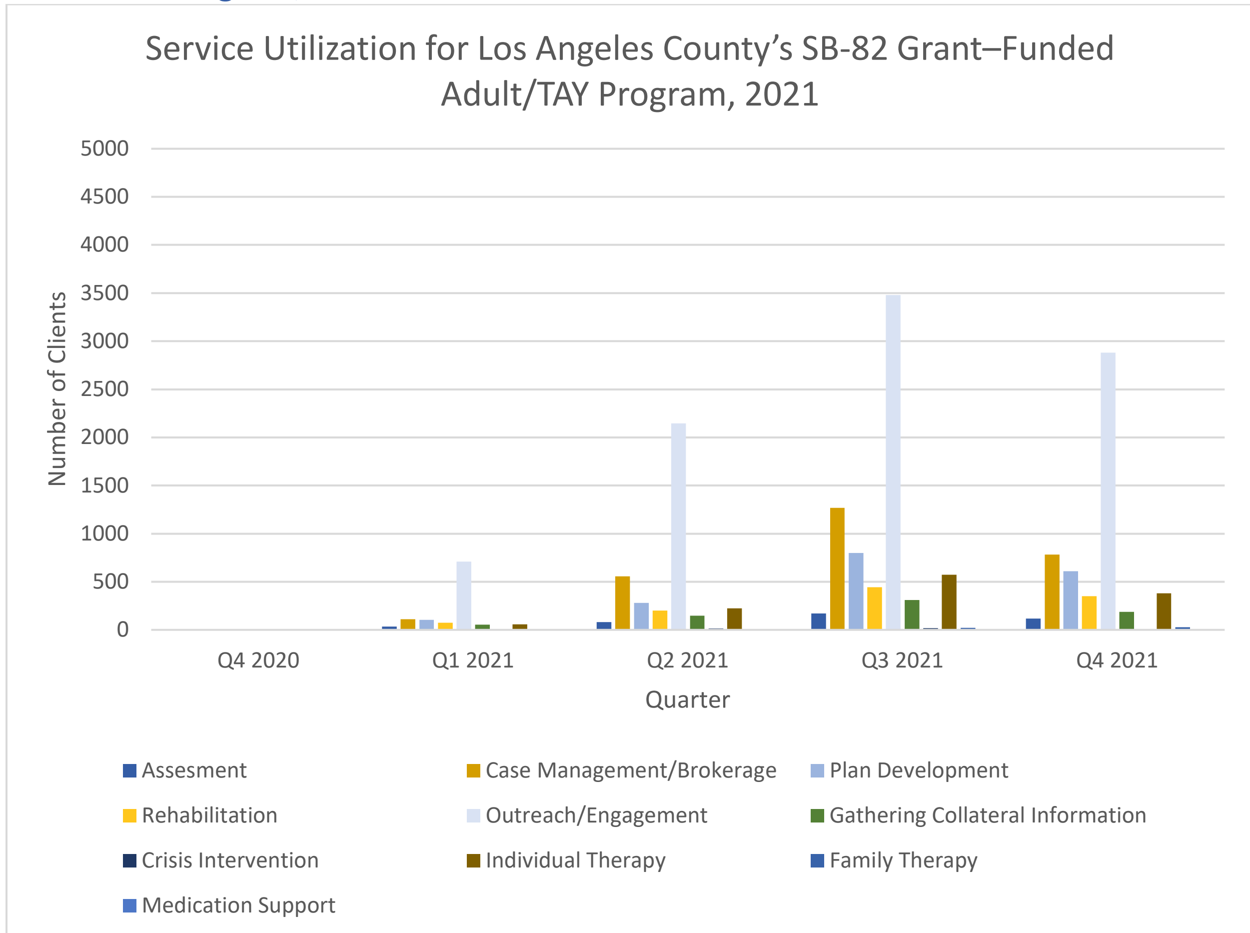
	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age					
Children (0-15)	0	79	79	4%	
TAY (16-25)	0	373	373	19%	
Adult (26-59)	1	1,264	1,265	64%	
Older Adult (60+)	0	244	244	12%	
Unknown/Not Reported	0	1	1	0%	
Gender					
Female	0	873	873	42%	50.7%
Male	1	1,181	1,182	57%	49.3%
Other gender	0	0	0	0%	
Unknown/Not Reported	0	7	7	0%	
Ethnicity					
Hispanic/Latinx	0	746	746	37%	48.6%
Not Hispanic/Latinx	0	931	931	46%	51.4%
Unknown/Not Reported	1	357	358	18%	
Race					
American Indian or Alaska Native	0	5	5	0%	0.8%
Asian	0	325	325	21%	14.7%
Black	0	408	408	27%	8.1%
Hawaiian Native or Pacific Islander	0	16	16	1%	0.3%
Multiple		0	0	0%	4.1%
Other	0	72	72	5%	19.9%
Unknown/Not Reported	1	357	358	24%	
White	0	338	338	22%	52.1%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Los Angeles County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Of all Los Angeles County's Outreach and Triage Teams' encounters, 53% of program services involved outreach and engagement, 16% were case management/brokerage, and 10% were plan development. Additional services provided to clients are shown in **Figure A8**. Most clients (85% of referrals) were referred to the program through a crisis call center/hotline, followed by law enforcement with about 14% of referrals. Additionally, 1% of clients learned of the program through the School Threat Assessment Response Team (START), individual clinics, or UCLA. Forty-one percent of Los Angeles County's encounters with clients resulted in linkages to

outpatient clinics or service, followed by linkages to housing services/shelter (21%), detox/sobering or SUD treatment (12%), full-service partnerships (4%), and private insurance or current provider (3%).

Figure A8. Service Utilization for Los Angeles County's SB-82 Grant–Funded Adult/TAY Program, 2021



Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Merced County

Merced County's Mobile Triage Team provided crisis intervention and evaluations for individuals experiencing mental health crises. The program served about 3,302 unique clients over 4,726 encounters since first beginning operations in January 2019. The program served a diverse range of clients, with 51% of encounters involving adults aged 26 to 59, 26% TAY aged 16 to 25, 16% children under 16 years, and 7% seniors aged 60 years or older. Furthermore, 52% of encounters involved clients who identified as female. The demographic breakdown of

client encounters was 48% White, 30% Other, 10% Black, 3% Asian, 2% American Indian or Alaska Native, and 47% Hispanic or Latinx. The demographic counts for client encounters by Merced County's SB-82 grant–funded adult/TAY program are summarized in **Table A12** below.

Table A12. Encounter Demographics for Merced County's SB-82 Grant–Funded Adult/TAY Program

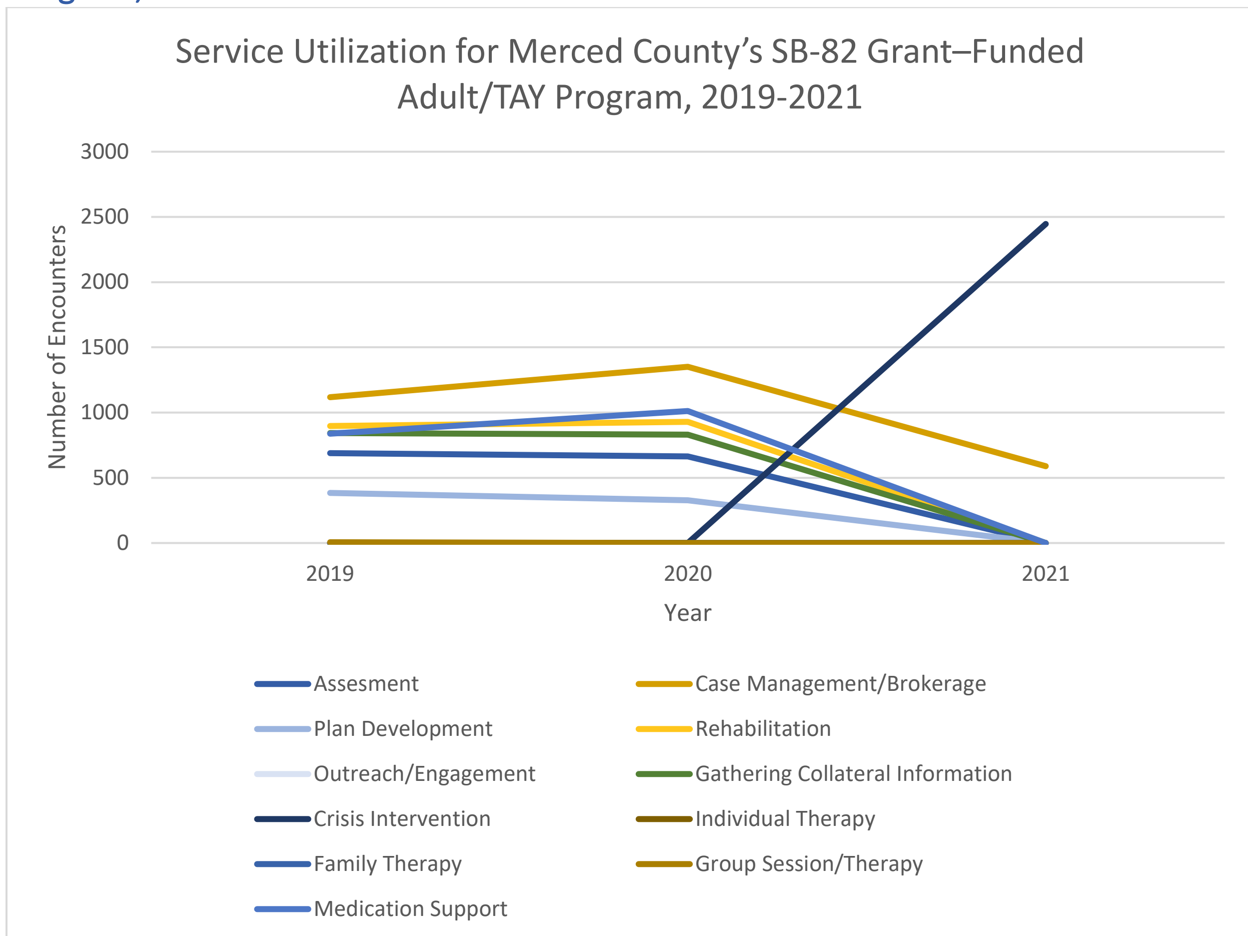
	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	241	220	283	744	16%	
TAY (16-25)	410	383	429	1,222	26%	
Adult (26-59)	717	832	870	2,419	51%	
Older Adult (60+)	87	117	140	344	7%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	827	802	858	2,487	52%	49.5%
Male	700	739	857	2,296	48%	50.5%
Other gender	9	10	5	24	0%	
Unknown/Not Reported	0	0	2	2	0%	
Ethnicity						
Hispanic/Latinx	676	729	829	2,234	47%	61%
Not Hispanic/Latinx	730	762	818	2,310	49%	39%
Unknown/Not Reported	48	61	75	184	4%	
Race						
American Indian or Alaska Native	33	26	25	84	2%	1%
Asian	45	48	58	151	3%	7.4%
Black	152	156	179	487	10%	3.4%
Hawaiian Native or Pacific Islander	5	12	6	23	0%	0%
Multiple	23	18	21	62	1%	3.1%
Other	403	461	547	1,411	30%	34.3%
Unknown/Not Reported	71	64	81	216	5%	
White	712	760	804	2,276	48%	50.8%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Merced County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Merced County's Mobile Triage Team served a wide variety of clients and with a wide range of services. Twenty-four percent of encounters provided case management/brokerage services, followed by crisis intervention (19%), medication support services (14%), rehabilitation services

(14%), gathering collateral information (13%), and assessment services (10%), as seen in **Figure A9**. Most referrals came from hospitals (71%), with a small number of referrals from other sources, mainly self-referral (8%) or from a bystander, community, or other mobile outreach (6%). The grant recipient did not provide data on clients' referrals.

Figure A9. Service Utilization for Merced County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Placer County

The Placer County Physical and Behavioral Health Mobile Crisis Triage Team (P/B MCT) program provides both mental and physical care and links services to clients in mental crisis. The program served 231 unique individuals over 225 encounters since it began serving clients on April 15, 2019. The P/B MCT client encounters were 66% adults aged 25 to 59 years, 21% TAY aged 16 to 25, and 13% adults aged 60 years or older. Fifty-four percent of encounters involved

clients who identified as female. Sixty-nine percent of the program's encounters were clients identifying as While, 4% as Black, and 3% as Asian. Additionally, 9% of clients identified as Hispanic or Latinx. The demographic counts for client encounters are summarized in **Table A13** below.

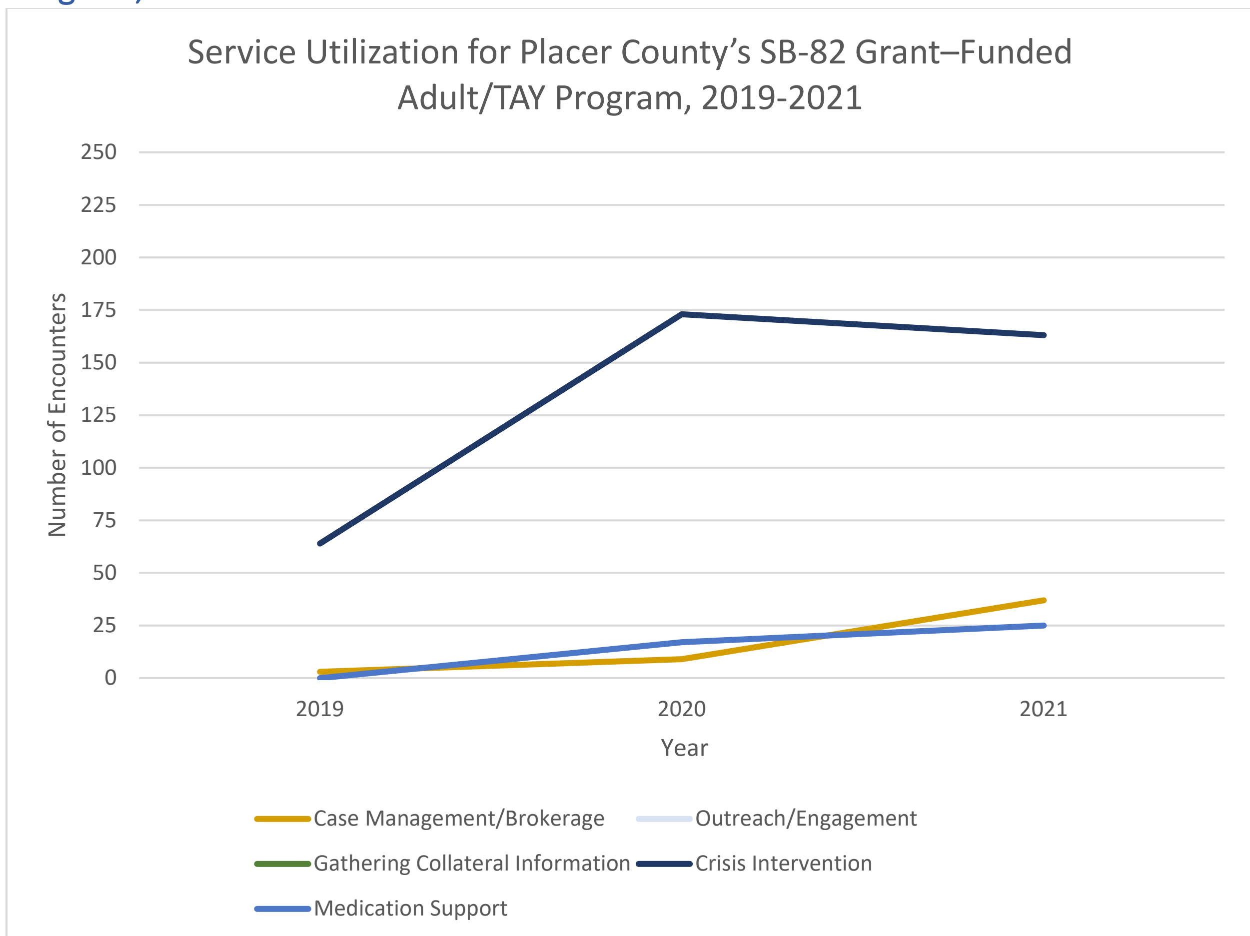
Table A13. Encounter Demographics for Placer County's SB-82 Grant–Funded Adult/TAY Program

	2019*	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	0	0	0	0%	
TAY (16-25)	9	18	20	47	21%	
Adult (26-59)	32	63	53	148	66%	
Older Adult (60+)	6	12	12	30	13%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	29	46	46	121	54%	51.1%
Male	18	47	39	104	46%	48.9%
Other gender	0	0	0	0	0%	
Unknown/Not Reported	0	0	0	0	0%	
Ethnicity						
Hispanic/Latinx	6	4	11	21	9%	14.4%
Not Hispanic/Latinx	35	72	52	159	71%	85.6%
Unknown/Not Reported	6	17	22	45	20%	
Race						
American Indian or Alaska Native	0	1	1	2	1%	0.6%
Asian	2	4	1	7	3%	8.2%
Black	1	6	3	10	4%	2%
Hawaiian Native or Pacific Islander	0	0	2	2	1%	0.2%
Multiple	0	0	0	0	0%	5%
Other	4	9	11	24	11%	1.4%
Unknown/Not Reported	2	10	12	24	11%	
White	38	63	55	156	69%	82.8%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Placer County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
**Note: Data for 2019 includes three quarters.*
Key: TAY = transitional age youth.

Most of the mental health services provided by this program were classified as crisis intervention services (79%), followed by case management services (10%), and medication support (8.4%). Some clients also received outreach and engagement (0.4%) and gathering collateral information (1.4%). Of the 201 encounters for which the program provided data, 67% of encounters were referred by law enforcement, 14% by bystanders, 12% by a family member, 3% by full-service partnership, and 1% by self-referrals. Thirty-six percent of encounters resulted in referrals to EDs, followed by referrals to private insurance of client's current provider (12%), outpatient clinic or services (11%), other mental health services (10%), other services such as VA and senior services (10%), SUD treatment (9%), outreach and engagement (6%), and housing services (4%). Service utilization is shown in **Figure A10**.

Figure A10. Service Utilization for Placer County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Sacramento County

Sacramento County's SB-82 grant–funded adult/TAY program, Youth Help Network (YHN), focused on improving outreach and crisis services in TAY-populated areas that typically have limited access to mental health services. Sacramento's YHN began on July 1, 2019, and served a total of 699 unique clients over 1,275 encounters through the end of 2021. All clients served by YHN were TAY aged 16 to 25 years. Fifty-six percent of encounters involved clients who identified as female. Thirty-two percent of encounters involved clients who identified as Black, 25% as White, 25% Unknown/Not reported, 9% as other, 5% as multiple races, 2% as American Indian or Alaska Native, 1% as Asian, and 1% as Hawaiian or Pacific Islander. Twenty percent of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for clients served by Sacramento County's SB-82 grant–funded adult/TAY program are summarized in **Table A14** below.

Table A14. Encounter Demographics for Sacramento County's SB-82 Grant-Funded Adult/TAY Program

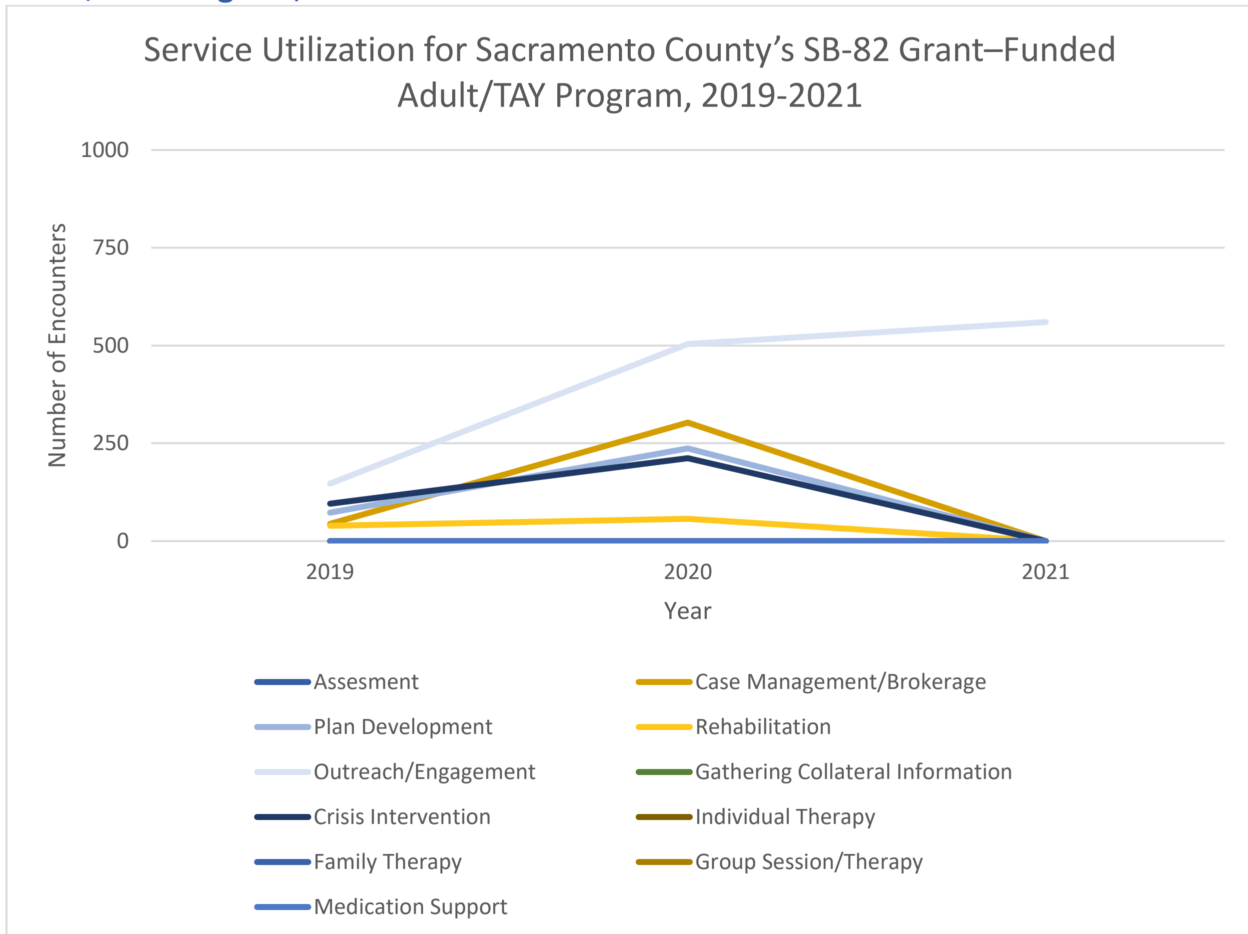
	2019*	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	0	2	2	0%	
TAY (16-25)	116	599	556	1,271	100%	
Adult (26-59)	0	0	1	1	0%	
Older Adult (60+)	0	0	0	0	0%	
Unknown/Not Reported	0	0	1	1	0%	
Gender						
Female	53	325	331	709	56%	51.1%
Male	56	240	228	524	41%	48.9%
Other gender	0	0	1	1	0%	
Unknown/Not Reported	7	34	0	41	3%	
Ethnicity						
Hispanic/Latinx	21	100	137	258	20%	23.6%
Not Hispanic/Latinx	53	240	289	582	46%	76.4%
Unknown/Not Reported	42	259	134	435	34%	
Race						
American Indian or Alaska Native	2	8	15	25	2%	0.7%%
Asian	0	0	10	10	1%	16.2%
Black	45	158	206	409	32%	9.6%
Hawaiian Native or Pacific Islander	0	0	7	7	1%	1.2%
Multiple	5	27	28	60	5%	8%
Other	10	38	68	116	9%	8.9%
Unknown/Not Reported	25	213	76	314	25%	
White	27	141	150	318	25%	55.4%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Sacramento County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
**Note: Data for 2019 includes two quarters.*
Key: TAY = transitional age youth.

Sacramento County's YHN was designed to provide mental services to TAY populations in areas of the county with few available mental health resources. As such, YHN provided many outreach and engagement services, accounting for 37% of all encounters made. Sacramento's YHN also provided case management services (21% of all encounters), plan development (18%), crisis intervention services (15%), and some rehabilitation services (8%). Most clients were

referred to the YHN by family members (73% of total encounters) while about a quarter of encounters were self-referrals (27%). Client encounters resulted in referrals to outreach and engagement (31%), other mental health services (26%), full-service partnership (17%), crisis stabilization (1%), SUD treatment (1%), and emergency departments (1%). Further details regarding service utilization are shown below in **Figure A11**.

Figure A11. Service Utilization for Sacramento County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the survey of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Note: Data for 2019 includes two quarters.
Key: TAY = transitional age youth.

San Francisco County

San Francisco's SB-82 grant–funded adult/TAY program provided crisis stabilization and linkages to follow-up mental health services for TAY clients. The program began on June 15, 2019, and served 206 unique clients during 213 encounters from 2019 to 2021. The program served

exclusively TAY clients aged 16 to 25 years. Fifty six percent of program encounters were clients who identified as male. Thirty-two percent of program encounters involved clients who identified as Black, 25% Other, 20% White, 8% multiple races, 6% Asian, 6% unknown, and 1% Hawaiian Native or Pacific Islander. Twenty-seven percent of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for clients served by San Francisco County's program are summarized in **Table A15** below.

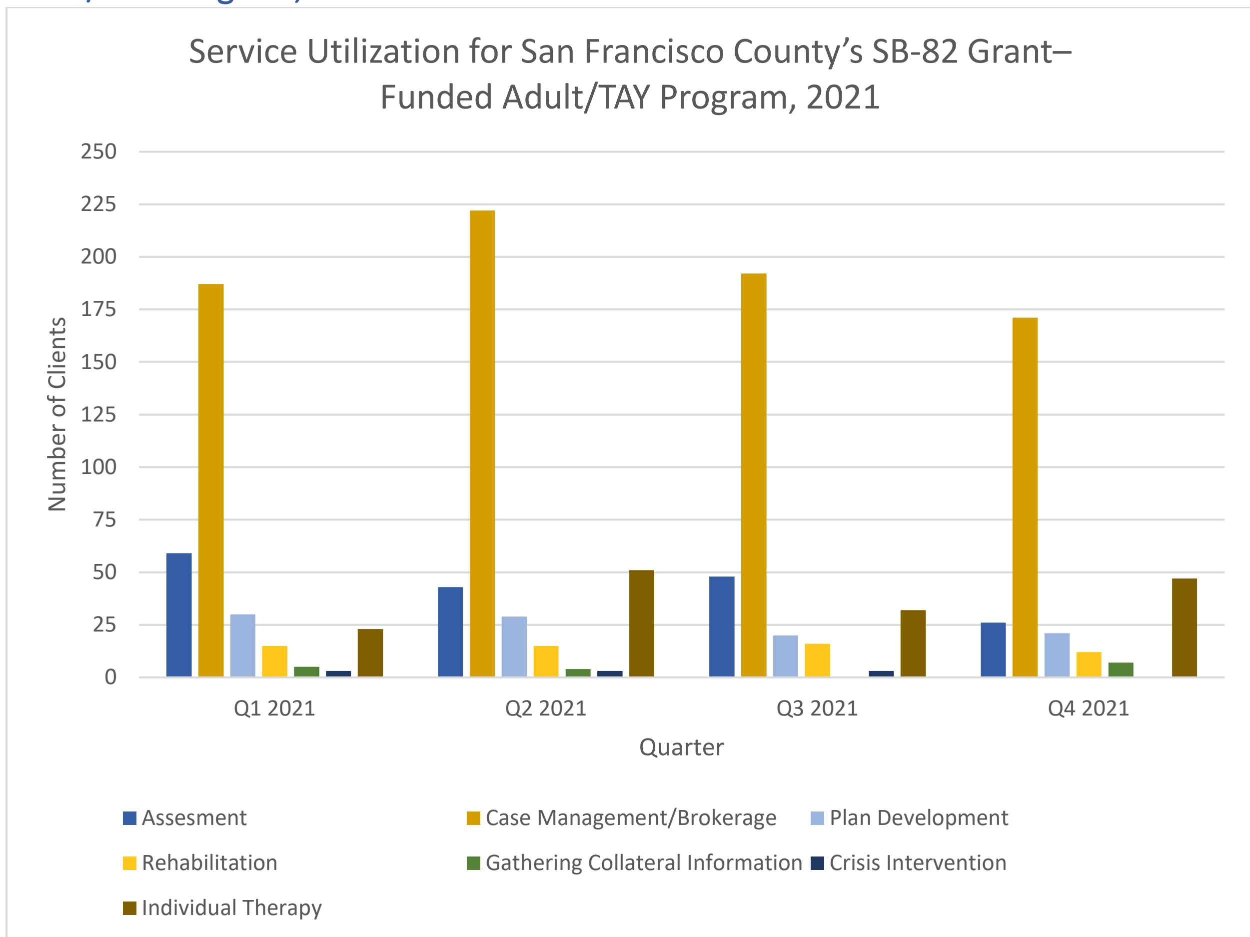
Table A15. Encounter Demographics for San Francisco County's SB-82 Grant–Funded Adult/TAY Program

	2019*	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	0	0	0	0%	
TAY (16-25)	29	84	99	212	100%	
Adult (26-59)	0	0	0	0	0%	
Older Adult (60+)	0	0	0	0	0%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	9	31	40	80	37%	49.2%
Male	18	51	53	122	56%	50.8%
Other gender	3	2	7	12	6%	
Unknown/Not Reported	0	0	3	3	1%	
Ethnicity						
Hispanic/Latinx	4	21	32	57	27%	15.2%
Not Hispanic/Latinx	17	40	49	106	50%	84.8%
Unknown/Not Reported	9	23	16	48	23%	
Race						
American Indian or Alaska Native	0	0	1	1	0%	0.4%
Asian	0	0	12	12	6%	34.9%
Black	11	21	33	65	32%	5.5%
Hawaiian Native or Pacific Islander	0	0	3	3	1%	0.4%
Multiple	2	5	9	16	8%	5.7%
Other	6	18	26	50	25%	7.9%
Unknown/Not Reported	3	7	3	13	6%	
White	5	20	16	41	20%	45.2%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. San Francisco County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
**Note: Data for 2019 includes three quarters of data.*
Key: TAY = transitional age youth.

San Francisco County only provided service utilization data for 2021, during which the program provided mostly case management/brokerage services (60%). The program received most referrals from local hospitals (97%), but also received a few from the county's crisis hotline (3%). Most client encounters resulted in referrals to either full-service partnership (35%) or outpatient clinic or services (35%). Referrals were also made to the county's crisis stabilization unit (11%), other mental health services (10%), residential rehabilitation (3%), housing services (3%), SUD treatment (1%), and outreach and engagement (1%). Further details regarding service utilization are shown in **Figure A13**.

Figure A12. Service Utilization for San Francisco County's SB-82 Grant–Funded Adult/TAY Program, 2021



Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Note: Data for 2019 includes 3 quarters of data.
Key: TAY = transitional age youth.

Sonoma County

Sonoma County's Mobile Support Team, a mobile crisis response team, began on December 12, 2018, to provide behavioral health interventions, assessments, and referrals to follow-up care to requesting law enforcement officers. The program served 130 unique clients over 159 encounters in the duration of the program. The Mobile Support Team served clients of all ages including 58% of encounters with adults aged 26 to 59, 16% TAY aged 16 to 25, 16% seniors aged 60 or older, and 8% children under 15 years. The program encountered clients who identified as female 50% of the time. Forty-two percent of the program's encounters involved clients who identified as White, 2% as Black, 1% some other race, and 1% multiracial. Race was unknown or unreported for 53% of client encounters. Most clients were of unknown or unreported ethnicity (57%). The demographic counts for clients served by Sonoma County's SB-82 grant–funded adult/TAY program are summarized in **Table A16** below.

Table A16. Encounter Demographics for Sonoma County's SB-82 Grant–Funded Adult/TAY Program

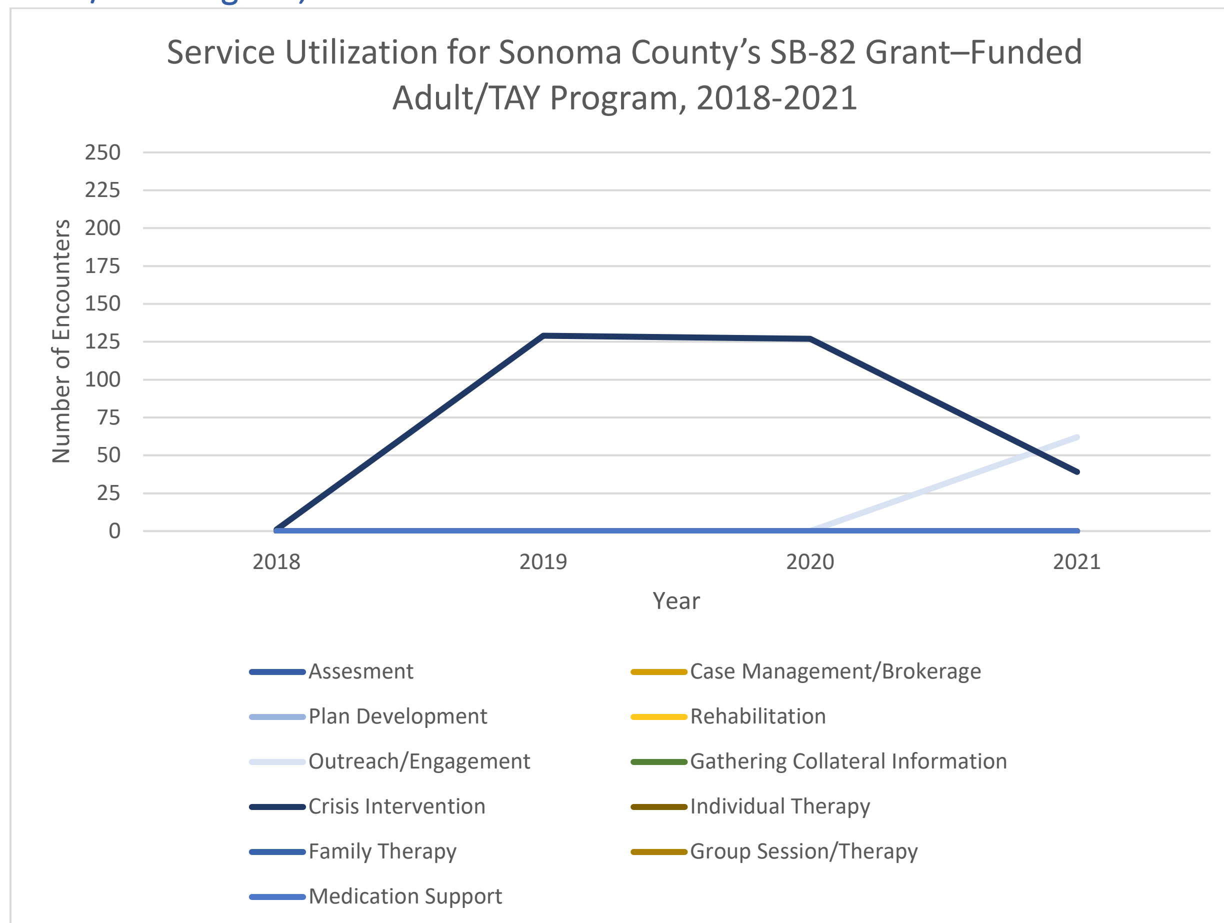
	2018	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age							
Children (0-15)	0	5	7	0	12	8%	
TAY (16-25)	0	10	6	9	25	16%	
Adult (26-59)	1	24	40	27	92	58%	
Older Adult (60+)	0	10	8	7	25	16%	
Unknown/Not Reported	0	2	3	0	5	3%	
Gender							
Female	0	28	30	21	79	50%	51.3%
Male	1	22	31	20	74	47%	48.7%
Other gender	0	0	3	2	5	3%	
Unknown/Not Reported	0	1	0	0	1	1%	
Ethnicity							
Hispanic/Latinx	0	0	5	1	6	4%	27.3%
Not Hispanic/Latinx	1	16	23	22	62	39%	72.7%
Unknown/Not Reported	0	35	36	20	91	57%	
Race							
American Indian or Alaska Native	0	0	0	0	0	0%	0.9%
Asian	0	0	0	0	0	0%	4.2%
Black	0	1	1	1	3	2%	1.5%
Hawaiian Native or Pacific Islander	0	1	0	1	2	1%	0.4%
Multiple	0	0	1	0	1	1%	5.6%
Other	0	0	2	0	2	1%	13.7%
Unknown/Not Reported	0	29	36	19	84	53%	
White	1	20	24	22	67	42%	73.8%

**Note: Data for 2018 includes one quarter.*
Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Sonoma County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Sonoma's Mobile Support Team mostly provided crisis intervention at 82% of encounters. In 2021, the team also provided outreach and engagement services, totaling 17% of encounters throughout the duration of the program. All client referrals to the Mobile Support Team came from law enforcement. Thirty eight percent of program encounters resulted in referrals to outreach and engagement services, 23% were referred to other mental health services, 15% to outpatient services, 8% to the county's crisis stabilization unit, and 8% to emergency

departments. More details regarding service utilization are shown in **Figure A13** below.

Figure A13. Service Utilization for Sonoma County's SB-82 Grant–Funded Adult/TAY Program, 2018-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Note: Data for 2018 includes one quarter.
Key: TAY = transitional age youth.

Stanislaus County

Stanislaus County's program was designed to provide triage services to mental health clients assessed for a possible involuntary hold 5150 and offers linkages to specialty mental health services to avoid a 5150 hold or other hospitalization. The program began July 22, 2019, and served 908 unique clients over 968 encounters through the end of the program in 2021. Sixty percent of encounters served adults aged 26 to 59, 27% with TAY aged 16 to 25, 10% children under 16 years, and 4% with adults aged 60 or older. Fifty percent of encounters were with individuals identifying as female. Fifty-nine percent of total encounters involved clients who identified as White, 29% as some other race, 5% as Black, 1% as Asian, 1% as Hawaiian or Pacific

Islander, and 44% of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for client encounters by Stanislaus County's program are summarized in **Table A17** below.

Table A17. Encounter Demographics for Stanislaus County's SB-82 Grant–Funded Adult/TAY Program

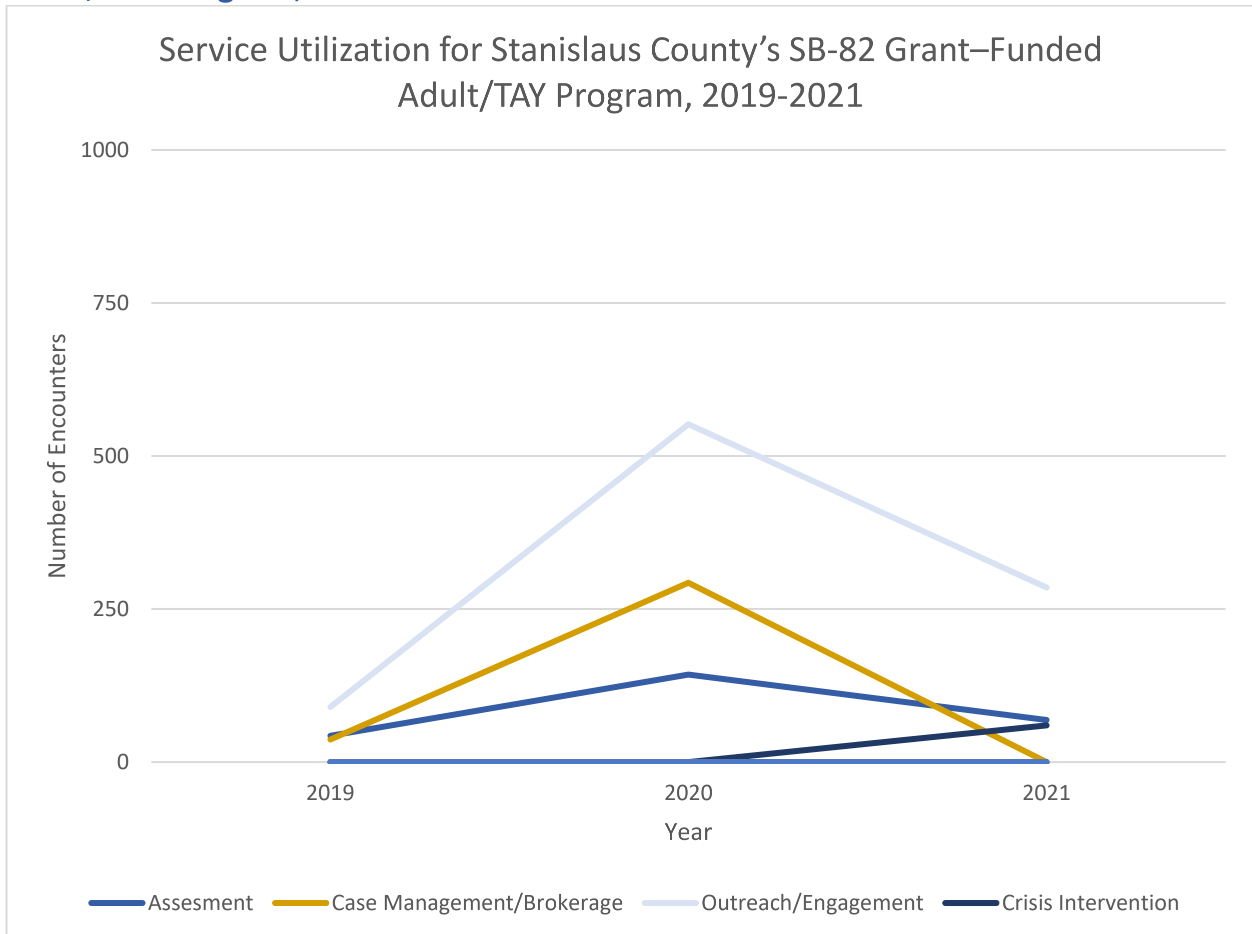
	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	0	95	95	10%	
TAY (16-25)	26	126	110	262	27%	
Adult (26-59)	77	336	165	578	60%	
Older Adult (60+)	3	20	11	34	4%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	56	224	207	487	50%	50.7%
Male	49	254	173	476	49%	49.3%
Other gender	1	3	2	6	1%	
Unknown/Not Reported	0	0	0	0	0%	
Ethnicity						
Hispanic/Latinx	44	212	167	423	44%	47.6%
Not Hispanic/Latinx	62	269	199	530	55%	52.4%
Unknown/Not Reported	0	3	15	18	2%	
Race						
American Indian or Alaska Native	0	0	3	3	0%	0.8%
Asian	0	0	6	6	1%	5.9%
Black	2	31	0	33	5%	3%
Hawaiian Native or Pacific Islander	0	0	5	5	1%	0.6%
Multiple	0	0	0	0	0%	4.1%
Other	1	2	183	186	29%	5.3%
Unknown/Not Reported	0	0	29	29	5%	
White	10	212	156	378	59%	80.4%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Stanislaus County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Note: Data for 2019 includes two quarters.
Key: TAY = transitional age youth.

Stanislaus County's SB-82 grant–funded adult/TAY program services included 59% outreach and engagement, 21% case management, 16% assessment, and 4% gathering collateral information.

Service utilization in shown in **Figure A14**. All referrals to the program came from the county's crisis hotline, 88% of encounters, or crisis stabilization unit, 12% of encounters. The program referred 41% of encounters to outreach and engagement, 27% to other services (e.g., employment services, medication services), 14% to other mental health services, 9% to the crisis stabilization unit, 8% to housing services, and 3% to SUD treatment.

Figure A14. Service Utilization for Stanislaus County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Note: Data for 2019 includes two quarters.
Key: TAY = transitional age youth.

Tuolumne County

The SB-82 grant–funded Mobile Triage Response program expanded an existing program that partners with community members and law enforcement to provide an immediate in-person response to individuals experiencing a mental health crisis. This program began on December

12, 2018, and had 983 encounters with 209 unique clients. Of these encounters, 61% involved adults aged 26 to 59, 19% TAY aged 16 to 25, 17% seniors aged 60 or older, and 2% children under 16 years. Clients identified as male during 58% of encounters. Sixty-seven percent of encounters involved clients who identified as White, 26% unknown, 3% as American Indian or Alaska Native, 2% as some other race, 1% as Asian, 1% as Hawaiian Native or Pacific Islander, and 7% of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for client encounters by Tuolumne County's SB-82 grant–funded adult/TAY program are summarized in **Table A18** below.

Table A18. Encounter Demographics for Tuolumne County's SB-82 Grant–Funded Adult/TAY Program

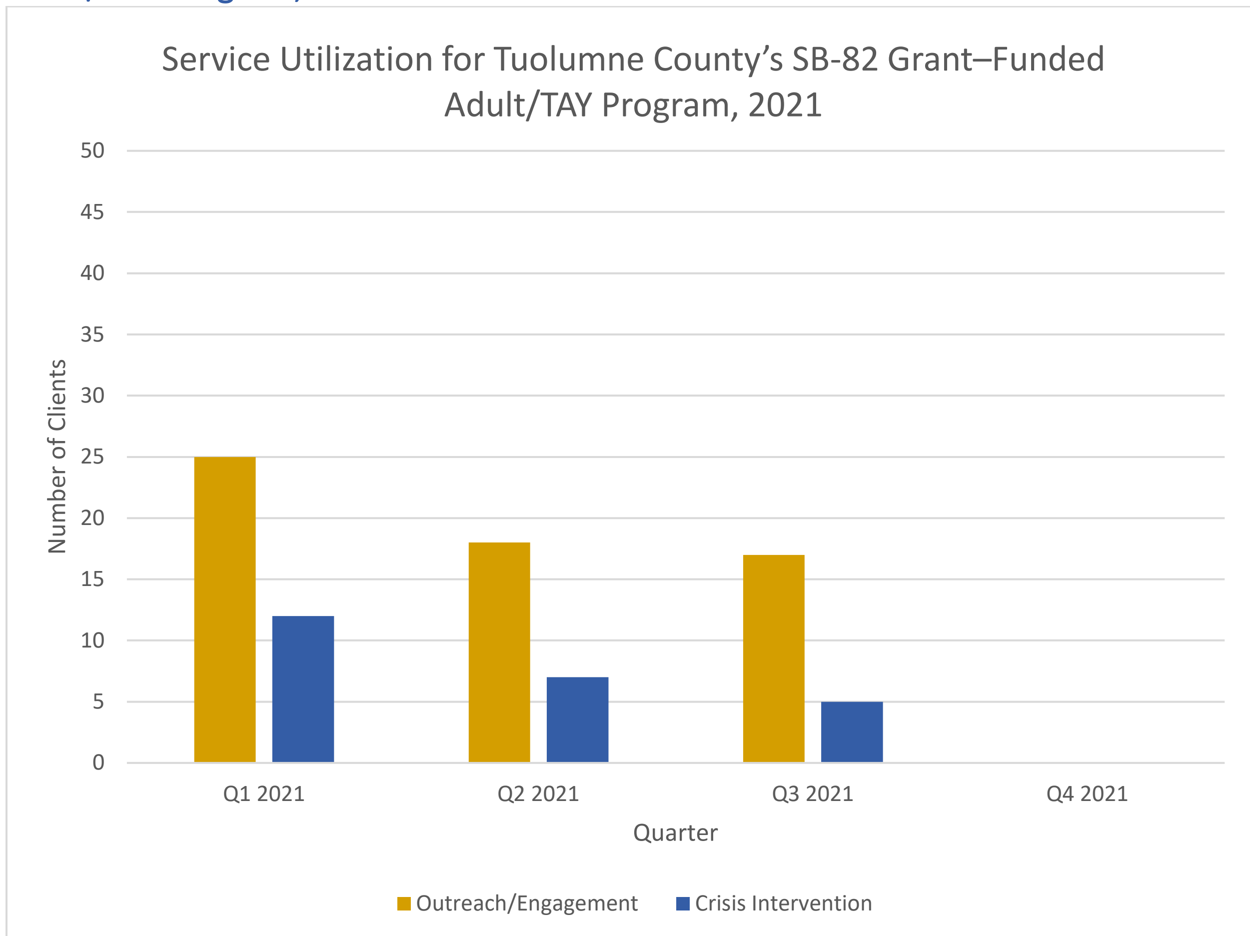
	2018*	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age							
Children (0-15)	0	5	11	5	21	2%	
TAY (16-25)	0	75	85	30	190	19%	
Adult (26-59)	0	219	266	117	602	61%	
Older Adult (60+)	0	74	64	33	171	17%	
Unknown/Not Reported	0	0	0	0	0	0%	
Gender							
Female	0	143	168	74	385	39%	48%
Male	0	226	244	102	572	58%	52%
Other gender	0	4	7	0	11	1%	
Unknown/Not Reported	0	0	6	9	15	2%	
Ethnicity							
Hispanic/Latinx	0	29	26	10	65	7%	12.2%
Not Hispanic/Latinx	0	272	314	109	695	71%	87.8%
Unknown/Not Reported	0	72	85	67	224	23%	
Race							
American Indian or Alaska Native	0	13	12	2	27	3%	1.8%
Asian	0	0	7	3	10	1%	1.4%
Black	0	3	0	0	3	0%	1.8%
Hawaiian Native or Pacific Islander	0	7	4	0	11	1%	0.2%
Multiple		0	0	2	2	0%	4.4%
Other	0	9	8	2	19	2%	2.6%
Unknown/Not Reported	0	98	106	50	254	26%	
White	0	243	288	125	656	67%	87.8%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. Tuolumne *population data obtained from the ACS Demographics and Housing Estimates table of the 2015-2019 5-year sample of the American Community Survey,*

conducted by the United States Census Bureau.
**Note: 2018 includes data from one quarter.*
Key: TAY = transitional age youth.

Service utilization data was provided for 2021 only. The program provided a total of 84 services in 2021, 71% of which were outreach and engagement services. The other 29% of services were crisis intervention services. Service utilization shown in **Figure A15**. Data on referrals to and from Tuolumne County's SB-82 grant–funded adult/TAY program were not available.

Figure A15. Service Utilization for Tuolumne County's SB-82 Grant–Funded Adult/TAY Program, 2021



Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Ventura County

The Ventura County SB-82 grant–funded adult/TAY program expanded the existing RISE program by pairing community service coordinators with police to provide field-based crisis

care and by expanding an existing TAY engagement component. Ventura County's RISE Expansion Program has capacity to provide assessment, case management, rehabilitation, outreach and engagement services, and to gather collateral information. The expansion of the RISE program in Ventura County began providing services to clients on January 2, 2019, and had 6,007 encounters with 3,626 unique clients as of December 31, 2021. Ventura County's program served clients of all ages with 56% adults aged 26 to 59, 22% TAY aged 16 to 25, 8% of encounters involved children under 16 years, and 14% seniors aged 60 or older. Fifty-two percent of encounters identified as male. The program served clients who identified as White during 48% of total encounters, 39% some other race, followed by 4% Black, 1% American Indian or Alaska Native, and 38% of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for client encounters by Ventura County's program are summarized in **Table A19** below.

Table A19. Encounter Demographics for Ventura County's SB-82 Grant–Funded Adult/TAY Program

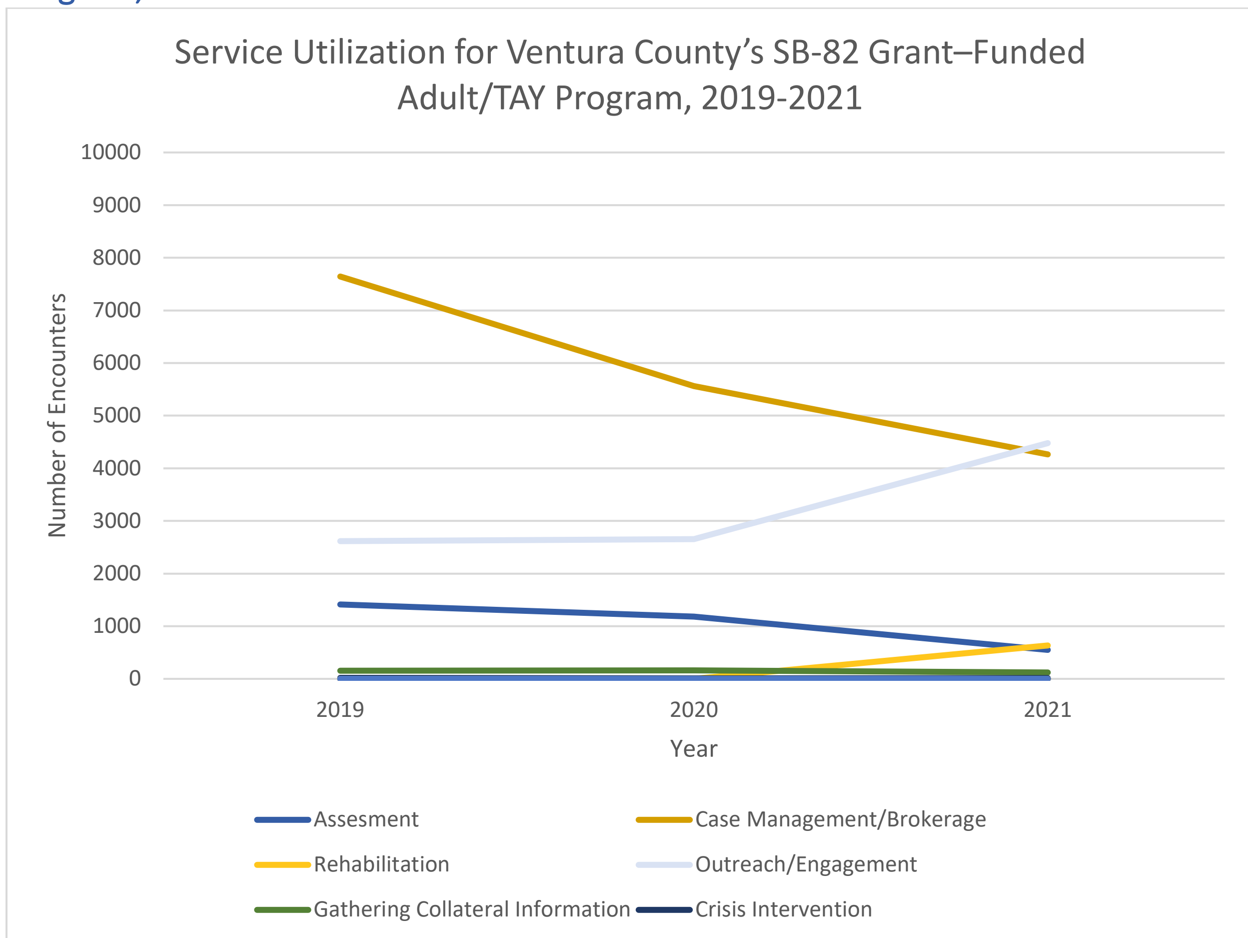
	2019	2020	2021	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	273	133	84	490	8%	
TAY (16-25)	499	523	287	1,309	22%	
Adult (26-59)	1,336	1,362	686	3,384	56%	
Older Adult (60+)	307	381	136	824	14%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	1,113	1,162	557	2,832	47%	50.6%
Male	1,294	1,227	631	3,152	52%	49.4%
Other gender	7	5	5	17	0%	
Unknown/Not Reported	1	5	0	6	0%	
Ethnicity						
Hispanic/Latinx	967	829	482	2,278	38%	43.2%
Not Hispanic/Latinx	1,025	1,064	498	2,587	43%	56.8%
Unknown/Not Reported	423	506	213	1,142	19%	
Race						
American Indian or Alaska Native	25	18	8	51	1%	0.7%
Asian	0	0	10	10	0%	7.5%
Black	84	108	50	242	4%	1.8%
Hawaiian Native or Pacific Islander	16	0	7	23	0%	0.1%
Multiple	0	0	0	0	0%	4.6%
Other	845	931	528	2,304	39%	5.1%
Unknown/Not Reported	379	65	22	466	8%	
White	1,014	1,224	571	2,809	48%	80.2%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
Key: TAY = transitional age youth.

Fifty-five percent of encounters provided case management services followed by outreach and engagement (31%) and assessment (10%). Ventura County's program received 33% of client referrals from sources not otherwise categorized (Other); 31% from the client themselves or the client's family; 12% were from bystander, community, or other mobile outreach; 9% were from the county's crisis stabilization unit; 7% were from law enforcement; 6% were from local hospitals; and 1% were from local shelters. Sixty-seven percent of encounters involved client linkages to outpatient clinics/services, 13% to local shelters (homeless, domestic violence, or

other), 10% to mental health services not otherwise categorized, and 7% to either substance abuse disorder treatment or detox/sobering services. Service utilization shown in **Figure A16**.

Figure A16. Service Utilization for Ventura County's SB-82 Grant–Funded Adult/TAY Program, 2019-2021



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Key: TAY = transitional age youth.

Yolo County

Yolo's SB-82 grant–funded adult/TAY program provided early intervention, prevention, triage, and crisis services to TAY individuals at the Yolo County Behavioral Health facility or emergency department. This program served 133 unique clients over 291 encounters from to December 31, 2020. TAY clients aged 16 to 25 received 77% of total encounters, 22% of encounters involved adults aged 26 to 59, and two encounters were clients aged 60 or older. Fifty eight percent of encounters in this program involved clients who identified as male. Fifty-three

percent of encounters involved clients who identified as White, 20% Unknown, 14% as some other race, 8% as Black, 1% as Native Hawaiian or Pacific Islander; 37% of encounters involved clients who identified as Hispanic or Latinx. The demographic counts for client encounters by Yolo County's SB-82 grant–funded adult/TAY program are summarized in **Table A20** below.

Table A20. Encounter Demographics for Yolo County's SB-82 Grant–Funded Adult/TAY Program

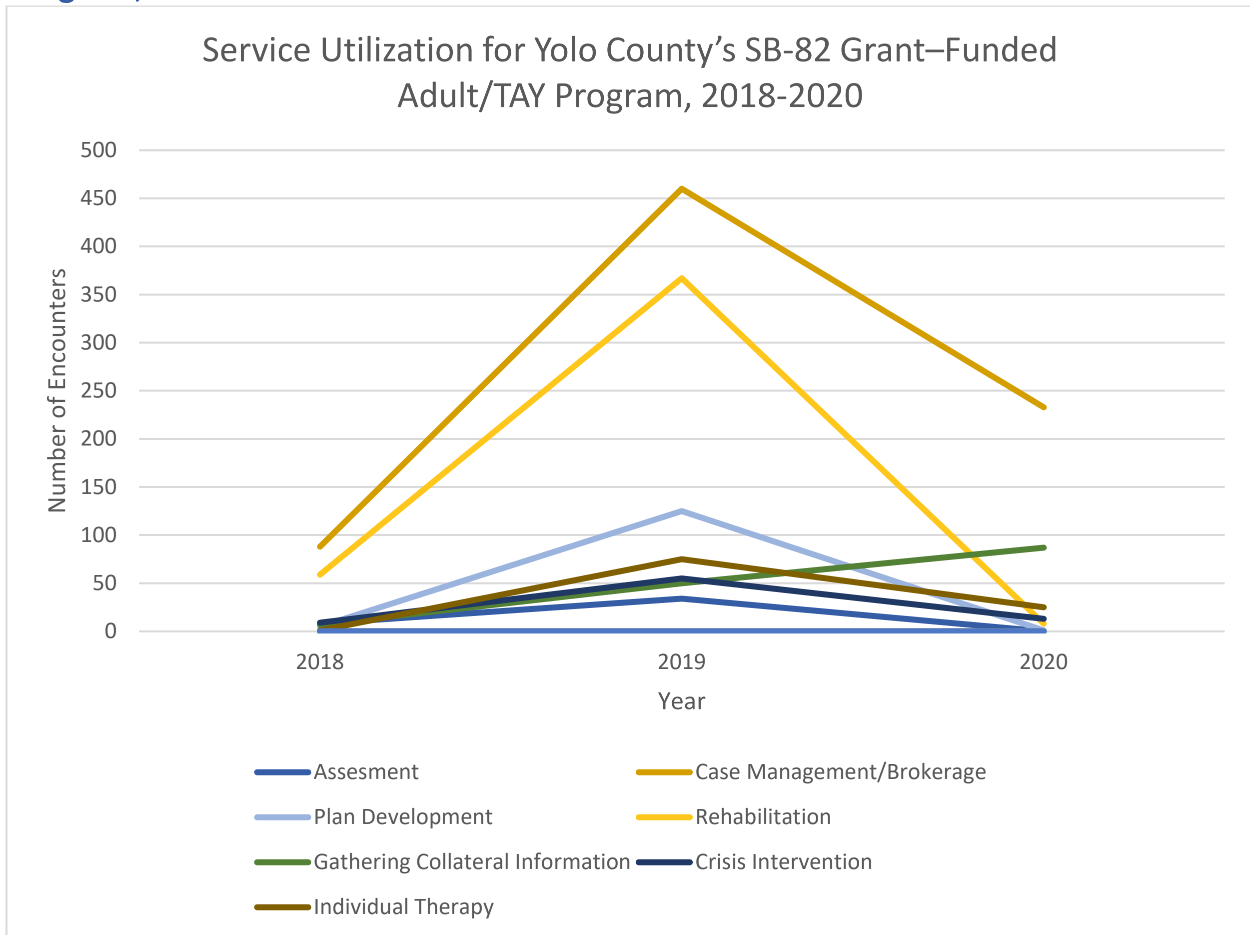
	2018*	2019	2020	Total Encounters	Percent of Total Client Encounters	County Population
Age						
Children (0-15)	0	0	0	0	0%	
TAY (16-25)	35	131	60	226	77%	
Adult (26-59)	11	49	4	64	22%	
Older Adult (60+)	0	2	0	2	1%	
Unknown/Not Reported	0	0	0	0	0%	
Gender						
Female	19	72	32	123	42%	51.5%
Male	27	109	32	168	58%	48.5%
Other gender	0	0	0	0	0%	
Unknown/Not Reported	0	0	0	0	0%	
Ethnicity						
Hispanic/Latinx	15	59	34	108	37%	31.9%
Not Hispanic/Latinx	20	85	13	118	41%	68.1%
Unknown/Not Reported	11	37	17	65	22%	
Race						
American Indian or Alaska Native	1	6	0	7	2%	1%
Asian	1	0	0	1	0%	14.6%
Black	5	13	4	22	8%	2.8%
Hawaiian Native or Pacific Islander	0	2	2	4	1%	0.5%
Multiple		0	0	0	0%	5.2%
Other	5	23	14	42	14%	4.2%
Unknown/Not Reported	11	32	16	59	20%	
White	23	104	28	155	53%	71.7%

Source: Evaluation team's tabulations of available county-reported quarterly data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs. County population data obtained from the ACS Demographics and Housing Estimates table of the 2019 1-year sample of the American Community Survey, conducted by the United States Census Bureau.
**Note: 2018 includes data from one quarter.*
Key: TAY = transitional age youth.

Up to 2019, most services provided by Yolo County were case management and rehabilitation

services, with 45% and 25% of encounters, respectively. Other encounters included gathering collateral information (8%), plan development (7%), individual therapy (6%), assessment (3%), and crisis intervention (5%). In 2020 and after the start of the pandemic, however, the program provided fewer rehabilitation and plan development services, instead mostly providing case management and gathering collateral information, while still providing some individual therapy. Data on referrals to and from Yolo County's SB-82 grant–funded adult/TAY program were not available. Service utilization shown in **Figure A17**.

Figure A17. Service Utilization for Yolo County's SB-82 Grant–Funded Adult/TAY Program, 2018-2020



Source: Evaluation team's tabulations of available county-reported annual data obtained from the surveys of SB-82 grant–funded adult/transitional age youth (TAY) programs.
Note: 2018 includes data from one quarter.
Key: TAY = transitional age youth.

Appendix 8. Definition of Service Types Used in Program Surveys

ASSESSMENT: An assessment documents the clinical evaluation of the client's current status and history of the individual's mental, emotional, or behavioral health including co-occurring substance abuse or significant medical conditions.

CASE MANAGEMENT/BROKERAGE (CMB): CMB services are activities provided by program staff to help an individual access needed medical, educational, social, prevocational, vocational, rehabilitative, or other necessary community services. The service activities may include communication, consultation, coordination, linkage and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

PLAN DEVELOPMENT: Plan development consists of development of client service plans, approval of plans, and/or monitoring of a client's progress or lack of progress.

REHABILITATION: Rehabilitation Services may be provided by licensed or unlicensed staff and include the following activities:

- Assistance in improving, maintaining, or restoring a client's or group of clients' functional skills, daily living skills, social skills, grooming and personal hygiene skills, meal preparation skills, and support resources and/or medication education;
- Counseling services related to treatment goals; and
- Training in leisure activities needed to achieve the client's goals.

COLLATERAL: A collateral service is contact with a significant support person in the life of the client with the intent of improving or maintaining the mental health status and achieving the goals of the client's service plan/goals.

CRISIS INTERVENTION: Crisis intervention is provided when a client requires an immediate response or intervention to help him/her stabilize and maintain in a community setting. This includes interventions provided by Crisis/Mobile Response Teams (C/MRTs) or other mobile response units.

INDIVIDUAL THERAPY: Individual therapy uses psychotherapeutic interventions to improve symptoms and functioning skills.

FAMILY THERAPY: Family therapy uses psychotherapeutic interventions to improve symptoms and functioning skills in a family setting.

GROUP SESSION: Rehabilitative or skill building groups provided by staff. The following are examples of group session activities:

- Assistance in restoring or maintaining a client's functional skills, daily living skills.
- Social skills, grooming and personal hygiene skills, meal preparation skills.
- Counseling of the client.
- Training in leisure activities needed to achieve the client's goals.
- Psychiatric rehabilitation such as relapse prevention.

GROUP THERAPY: Group therapy is a clinical treatment approach targeting specific diagnoses, illnesses or behaviors with specific outcomes and lengths of treatment to a group of clients.

MEDICATION SUPPORT: Includes evaluation of the need for medication, evaluation of clinical effectiveness and side effects, reviewing and obtaining informed consent, and medication education. Also includes plan development related to delivering medication, as well as dispensing and administering of psychiatric medications.

OUTREACH: Covers activities that provide resources and information to an individual/group while honoring need for anonymity for reasons related to safety; provide an opportunity for anonymous individuals to seek support and possible linkage to outreach and/or treatment services well as services available through other Mental Health Plan providers; and assess housing stability, natural supports, cultural factors, worldview, medical issues, alcohol and other drug issues, social/leisure/recreational activities, income/need for support for benefits acquisition, and overall life satisfaction to include traditional employment/education. Does NOT include crisis intervention activities.

ENGAGEMENT: Activities the purpose of which are to learn about the individual while honoring cultural norms, values, and social etiquette in order to gain a comprehensive view of their strengths, supports, needs, and concerns.

Appendix 9. Program Summaries

Summaries of the adult/TAY programs funded by SB-82, as described in the original grant proposals are provided below. Some details may have changed throughout the implementation and operation of the program.

Alameda County

Existing Triage Services: Plan to launch crisis response team and peer respite program in 2018.

Goals: 1) Increase access to mental health crisis services; 2) Reduce inappropriate and avoidable responses to mental health crisis; 3) Increase the use of planned mental health services that are likely to promote recovery and reduce future crisis events; and 4) Increase the client satisfaction and experience of services.

Proposal: 1) Extend and expand Mobile Crisis Team, 24-hour response in North County, 7-day week in South & Mid East*; 2) Peer provider postcrisis follow-up team; 3) Education and consultation hotline for education and linkage*; and 4) Santa Rita TAY Multidisciplinary Team service for post-incarceration follow-up and linkage.

Outcomes: 1) Increase crisis service linkage and utilization*; 2) Reduce 5150s, behavioral health hospitalizations, ED visits, law enforcement interactions* 3) Increase postcrisis service utilization; 4) Increase client wellbeing; 5) Reduce future crisis events; 6) Increase client satisfaction; and 7) Increase positive interactions with BH system.

Data: Service utilization data (crisis team and BH services, including 1 year follow-up data); 5150 logs; Santa Rita behavioral health data; well-being measure 1-year postcrisis; client satisfaction tool at discharge and 1-year postcrisis; focus groups will explore experiences of providing/receiving services.

Notes: Eliminating mobile crisis teams and education consultation line due to budget cuts.

Alameda General Program Information

Name: Alameda County Behavioral Health Care Crisis Continuum of Care

County Information: Population: 1,666,753; Rural: No; Beds: 279

Locations: *Main Location:* Gail Steele Wellness and Recovery Center, 409 Jackson Street, Suite 100, Hayward, CA 94544(510) 891-5600

Secondary Location: Alameda County Behavioral Health Care Services, 2000 Embarcadero Cove, Oakland, CA 94606

Post Crisis Follow-up Team: Eastmont Town Center7200 Bancroft Ave., Suite 125, Oakland, CA 94605

TAY Multidisciplinary Team: Alameda County Behavioral Health Care Services, 2000 Embarcadero Cove Oakland, CA 94606; Santa Rita Jail, 5325 Broder Blvd, Dublin, CA 94568

Staff: *TAY Multidisciplinary Teams*: 3 FTE, including 1 Licensed Behavioral Health Clinician and 2 Client Designated Peer Providers Mental Health Specialists

City of Berkeley

Existing Triage Services: City of Berkeley's Mobile Crisis Team, provides consultation to ED personnel, community agencies, fire & police, and citizens; disaster- and trauma-related MH services.

Goals: 1) Reduce law enforcement time spent on mental health calls; 2) Reduce inappropriate and avoidable responses to mental health crisis; and 3) Increase the use of planned mental health services that are likely to promote recovery and reduce future crisis events.

Proposal: 1) Staff a crisis & triage telephone line to provide clinical, non–law enforcement support; and 2) Staff Transitional Outreach Team to provide peer support & follow-up care postcrisis.

Outcomes: 1) Reduce avoidable 911 & 5150 calls; 2) Reduce mobile crisis response that result in jail, hospitalization, ED visits; 3) Increase service connectedness; 4) Increase service engagement post mobile crisis triage intervention; 5) Increase client wellbeing; and 6) Reduce future crisis events.

Data: 5150 & 911 call logs to Berkeley Police Dept; justice/service utilization records; measure of service connectedness post triage; frequency of engagement in services; wellbeing measure 1-year postcrisis.

Notes: Reducing crisis phone line hours to 11:30am–4pm, M– F because of budget cuts.

City of Berkeley General Program Information

Name: Crisis Assessment & Triage Line

City Information: Population: 121,642**;** Rural: No

Locations: *Crisis Line Staff:* Berkeley Mental Health administrative office at 1521 University Ave., Berkeley, CA 94703

Transitional Outreach Team: Berkeley Mental Health office at 2636 Martin Luther King Jr. Way, Berkeley, CA 94704

Proposed Staff: 3 FTE, 2 clinical staff will be hired for the CAT line. One of these clinical staff will be classified as a Mental Health Clinical Supervisor to manage the CAT Line. One Peer Staff will be hired to support postcrisis follow-up service connection.

Staffing Amendment due to Budget Cuts: Total reduction of 1 FTE. One position eliminated — Behavioral Health Clinician II (BHCII), One position's classification is changed (1 FTE Social Services Specialist to 1 FTE Assistant Mental Health Clinician)

Butte County

Existing Triage Services: Crisis triage services currently offered onsite at the crisis stabilization unit, outpatient clinics, ED, limited community settings. In other settings (particularly outside Chico) law enforcement personnel are typically utilized. MCT staff provide de-escalation, crisis intervention, assessment, support services.

Goals: Not listed.

Proposal: 1) Expand MCT pilot program from 1 to 2 teams to expand location delivery and support to law enforcement beyond Chico Police Dept; and 2) Recruit peer staff to advocate/provide additional support.

Outcomes: 1) Reduce involuntary psychiatric hospitalizations; 2) Increase law enforcement knowledge about mental health (MH) and de-escalation; 3) Increase MH service engagement; 4) Decrease 911 nonemergency calls; 5) Decrease ED visits, and 6) Increase client satisfaction.

Data: Pre-post survey (6-monthly) of law enforcement knowledge/attitudes; 5150 logs; ED service utilization data; MH service utilization data; satisfaction surveys post-engagement w/peer advocate.

Notes: Planning to augment budget cuts with SB-840 grant money (award pending).

Butte General Program Information
Name: Mobile Crisis Team (MCT) Expansion
County Information: Population: 231,256; Rural: Yes; Adult Psych Beds: 49
Locations: Crisis services offices in Chico, CA, and the overall community to check in with clients.
Proposed Staff: *Mobile Crisis Team:* 4 FTE Behavioral Health Counselors, 8 part-time Peer Advocates, 0.5 FTE Behavioral Health Counselor Supervisor.
Staffing Amendment Due to Budget Cuts: No changes

Calaveras County

Existing Triage Services: Sheriff Liaison Crisis Case Manager, housed at Sheriff Dept, provides crisis intervention and stabilization support. Responds to dispatch calls with potential 5150, referrals via community agencies. Funding for role ended April 2018.

Goals: BHS will hire and train one full-time BHS Triage Case Manager as part of the new BHS Crisis and Outreach Team Unit. Services include outreach in community to provide crisis intervention and stabilization services and linkages to services, which may include Medi-Cal reimbursable targeted case management for individuals in the community with mental health illness.

Proposal: Develop new team: 1) Hire bilingual Spanish case manager to provide community outreach before crisis escalation and improve inter-agency links; and 2) Peer staff to provide support posthospitalization, and individuals who experience frequent hospitalizations.

Calaveras General Program Information

Name: Calaveras County Behavioral Health Services Triage Program

County Information: Population: 45,670; Rural: Yes; Adult Psych Beds: 0

Locations: *Primary Location:* BHS Mental Health Clinic

Secondary Location: Sheriff's Office in San Andreas

Proposed Staff: 1 fulltime Triage Case Manager

Staff Amendment Due to Budget Cuts: Triage Case Manager changed to 0.7 FTE (28 hours per week)

Interview on 06/01/19: 2 full time staff, 7 days a week 12pm–9pm

Outcomes: 1) Reduce 5150 evaluations, total and number completed at Calaveras County ER; 2) Produce MOU/agreements between justice, educational, medical partners; 3) Reduction in repeat crisis calls from individuals with BH concerns; and 4) Increase in service utilization and referrals.

Data: 5150 logs, compared each year to baseline; RIMS, sheriff dispatch data; crisis and BH service utilization records.

Humboldt County

Existing Triage Services: MRT 5 MH clinicians, available 7-days a week. 2 specialists working with minors, 2 adults. Dispatched to local Eds to evaluate those detailed on 5150s. Provide assessment, develop crisis plan, referrals/linkage.

Goals: Be fully staffed for day and evening shifts, seven days a week, allowing law enforcement officers to focus on their duties, keeping area ED beds free of individuals needing supportive, outpatient mental health services, and keeping all clients of local mental health services at the least restrictive level of care where their needs can be met. The goal of the expanded Mobile Response Team is to strengthen and expand County Mental Health Services system by augmenting County Crisis Services and creating opportunities for recovery through a community team approach to mental health clients in crisis.

Humboldt General Program Information

Name: (expanded) Mobile Response Team (MRT)

County Information: Population: 136,373**;** Rural: Yes; Adult Psych Beds: 16

Location: Same Day Services Unit in the main health campus at 720 Wood St, Eureka

Proposed Staff: 0.5 FTE Supervising Clinicians, 2 FTE Mental Health Clinicians, 2 FTE Case Managers, 2 FTE Peer Support Specialists

Staff Amendment Due to Budget Cuts: Eliminate 1 part-time position and 2 personnel (e.g., the supervising clinician and one case manager)

Proposal: 1) Expand MRT to provide 24-hour crisis number, 7-11 service. Expand coverage from ED units only to wider coverage. Can now be dispatched to community clinics, law enforcement, paramedics, waterfront recovery, clients/families; 2) Early intervention, case management, clinical care, peer support in postcrisis follow-up; and 3) Specialist crisis and postcrisis support to TAY clients, family members, and community partners.

Outcomes: 1) Decrease in unnecessary arrests and crisis stabilization unit (CSU) transfers by law enforcement; 2) Decrease in psychiatric admissions via ED; 3) Decrease in time delay from ED to CSU; 4) Decrease in CSU SV re-admittance (7-day, 30-day, annually); and 5) High client and partner satisfaction with services.

Data: Survey to be completed by all stakeholders. Otherwise not explicit (presumably BH, ED, service utilization data; 5150 logs; justice data).

Los Angeles County

Existing Triage Services: Mobile Triage teams, operational since April 2015; clinicians and volunteer peer-based (paid through stipend); focus on homeless/at risk; provide field-based triage, assessment, linkage, and case management including housing-related services.

Goals: The primary goal of the program is to connect referred clients who are in crisis, but do not presently meet criteria for hospitalization, to services and supports, and averting hospitalizations. Secondary realized goals will be improved PMRT response times, and a decrease in repeat PMRT visits to clients who previously did not meet criteria. Psychiatric EDs will be decompressed. The goal of the OTT is to assist individuals with mental illness access services that can lead to a productive and healthier life.

Los Angeles General Program Information
Name: Outreach Triage Teams (OTT)
County Information: Population: 10.6 million; Rural: No; Adult Psych Beds: 1,984
Locations: Psychiatric EDs, urgent care centers, high schools, and law enforcement agencies
Proposed Staff: 96 outreach triage staff consisting of a north and south administrative OT team, and eight SA each with their own outreach triage team.
Staff Amendment Due to Budget Cuts: Removal of Mental Health Coordinator 2, MH counselor RN, Management analyst, Social Worker 1, and Peer Provider 4.

Proposal: 1) Increase TAY and adult crisis triage services; 2) Addition of services for individuals that do not meet criteria for involuntary hospital admission; and 3) Addition of peers to mobile response teams.

Outcomes: 1) Reduce number of hospitalizations/incarcerations; 2) Increase linkage to non-inpatient services and supports; 3) Improve psychiatric MRTs' response times; 4) Decrease PMRT re-visits in clients who did not previously meet criteria; and 5) Decrease in client arrests; decrease risk of self-harm and/or harm to others.

Data: Service utilization data (crisis team, BH services; justice data); assessment of patient risk (not specified where/how).

Merced County

Existing Triage Services: CARS Triage Program: triage service located in 2 emergency departments; assists first responder for crisis evaluation, and immediate dispositions for placement or psychiatric care.

Goals: 1) Intervene prior to emergency department, decrease 20% of the number of 5150 transportations by police to the ED 24/7; 2) Increase linkage and referrals to SUD/dual diagnosis persons services; and 3) Improve services to homeless population.

Proposal: Not specified.

Outcomes: 1) 20% decrease in number of 5150 transportations by police to ER; 2) Increase linkage & referrals to SUD/dual diagnosis services; and 3) Improve service to homeless population.

Data: 5150 logs, service utilization data. Comparisons to FY 17/18 levels.

Merced General Program Information

Name: Community Access to Recovery Services (CARS): Mobile Triage Team (MTT)

County Information: Population: 272,673; Rural: Yes; Adult Psych Beds: 16

Locations: *CSU:* 300 East 15th Street, Merced, CA 95341; ER: Mercy Medical Center, 333 Mercy Ave, Merced, CA 95340;

Walk in Central Intake: 480 E 13th Street for Children, 300 E 15th Street for Adults

Proposed Staff: 11 Personnel total: 5 mental health clinicians I / II, 2 Licensed Mental Health Workers, 1 Mental Health Worker, 1 Office Assistant, 1 Program Manager, 1 Division Director

Staff Amendment Due to Budget Cuts: No changes

Placer County

Existing Triage Services: MCT provides crisis intervention, assessment, follow-up services to clients 16+; supports crisis respite house for those not requiring hospitalization; pairs peer advocate with clinician; partner with law enforcement; available to clients, families, providers, community partners directly; postcrisis, 60-day follow-up (referrals, linkage, brief interventions).

Goals: 1) Reduce psychiatric hospitalization rates 30% of all of those evaluated in crisis; 2) Reduce use of emergency departments for medical clearance; 3) Reduce use of emergency departments for routine or nonemergency medical care; 4) Decrease the amount of time that 911 emergency dispatch personnel spend on mental health calls; and 5) Improve client experience.

Proposal: 1) Addition of nurse to provide physical health triage; 2) Physical health care added to postcrisis follow-up; 3) Expand peer support/advocate provision to facilitate physical and mental health treatment linkage; and 4) 24-hour crisis triage via telemedicine, transferred directly from appropriate 911 calls.*

Placer General Program Information

Name: Physical and Behavioral Health Mobile Triage Program (P/B MCT); Mental Health/911 Direct Diversion

County Information: Population: 386,166**;** Rural: No; Adult Psych Beds: 16

Locations: *Mental Health Clinic Locations:* 101 Cirby Hills Dr, Roseville, CA 95678**;** 11512 B Avenue, Auburn, CA 95603

Proposed Staff: 1 FTE Nurse, 1 FTE County Client Services Practitioner,0.2 FTE County Client Services Practitioner (Telephone Crisis Counselor), 0.5 FTE Peer Advocate,0.5 FTE Peer advocate, 0.5 FTE Direct Diversion Telephone Crisis Counselor

Staff Amendment Due to Budget Cuts: Removal of 1 county practitioner position for grant year 1 and a hired contractor staff position for grant years 2 and 3; reduction of Peer Advocate position from 1 FTE to 0.75 FTE

Outcomes: 1) Reduce psychiatric hospitalization rates to 30% of those evaluated in a crisis (currently 40-45%); 2) Reduce ED visits for those in crisis (both medical clearances and nonemergency care); 3) Decrease time 911 dispatch personnel spend on mental health calls; and 4) Improve client satisfaction.

Data: Qualitative interview; data from Avatar; justice data from local emergency departments; various law enforcement; and then Placer County Health & Human Services (pre-Phase 1 MOU in place); adult intake NCT tracker.

Notes: *Removal of Mental Health/911 Direct Diversion component of the triage program (alternate source of funding established) due to budget cuts.

Sacramento County

Existing Triage Services: Not specified.

Goals: 1) Improve timeliness to services by linking TAY to same day mental health services; 2) Help stabilize future mental health crises, prevent further mental health crisis and reduce and divert from psychiatric hospitalizations; and 3) Services will be offered in the field where TAY are known to congregate to address geographic needs.

Proposal: Focus on TAY underserved communities; street outreach and co-located at organizational TAY sites; 2 5-person teams; provide on-demand crisis intervention, linkage to County MH plan provider and "fast pass" to program admissions.

Outcomes: 1) Increase engagement with MH services (80% of those engaged in triage); 2) Increase knowledge of supports in targeted TAY population; 3) Reduce hospitalizations six-months postcrisis; and 4) Improve accessibility of crisis support for TAY.

Data: Crisis and BH service utilization data; client surveys; summary of online and geographical availability.

Sacramento General Program Information

Name: Youth Help Network (YHN)

County Information: Population: 1.531 million; Rural: No; Adult Psych Beds: 343

Locations: YHN teams' time will be split between street outreach services and site-based drop-in hours. Each YHN team's site-based locations and hours will vary and be coordinated with host organization's program hours.

Location: Local host organization services

Proposed Staff: Sr. Mental Health Counselor, Mental Health Clinician 2, 4 Sr. Mental Health Workers, Mental Health Worker, 7 Mental Health Worker (Youth Advocate), 2 Youth Advocates, 1 Intake Specialists.

Staff Amendment Due to Budget Cuts: All position titles changed and new positions added: Sr. Mental Health Clinician, Mental Health Clinician 1, Mental Health Clinician 2s, Sr. Mental Health worker, 4 Mental Health Workers, 9 FTE Youth FTE Youth Advocates, 0.2 FTE Intake Specialist

Notes: County was able to use Homeless Mentally Ill Outreach and Treatment funding to make the program whole so there were no impacts to design, collaboration, access, or staffing.

San Francisco County

Existing Triage Services: San Francisco Crisis Triage Services: 24/7 peer-run warmline; 3 mobile crisis teams: 1) Spanish bilingual, 2) for victims of violence/crime, and 3) support for families of individuals recently hospitalized (grant expiration July 2018).

San Francisco General Program Information

Name: TAY Crisis Stabilization & Resolution Team (TAY C-SART)

County Information: Population: 884,363; Rural: No; Adult Psych Beds: 237

Locations: Felton Institute

Proposed Staff: 4 Clinical Case Managers, 1 Clinical Supervisor, 1 Non-Clinical Supervisor, 1 Psychiatric Nurse Practitioner, 1 Program Manager, 1 Administrative Assistant, and 1 Overarching Program Coordinator

Staff Amendment Due to Budget Cuts: Positions Eliminated: Clinical Case Manager 3, Clinical Case Manager 4, Psychiatric Nurse Practitioner; *Positions Added:* Quality Assurance Manager, Division Director.

Goals: The primary goal of the TAY Crisis Stabilization and Resolution Team will be to improve the long-term health, well- being, and safety of transition age youth experiencing a mental health crisis in San Francisco while reducing physical and emotional risks related to mental health crises for youth, their families, community members, providers and first responders.

Proposal: Development of MDT for 480 TAY clients. 24/7 support. Provide linkage, crisis navigation and discharge planning; client stabilization and family support 90-days following referral (180 for high-risk). Four clinical case managers, 10-15 clients each, providing short term services (assessment, short-term care plan development, linkage, support, monitoring). Each team supported by clinical supervisor, nonclinical case manager, Psych Nurse, program manager, and administrative assistant; take referrals from jails, youth-serving providers, main MCT, EDs, law enforcement; homeless outreach team, psychiatric emergency services; augment existing MCT, which focuses on only most severe cases.

Outcomes: 1) Significant reduction in new psychiatric and emergency hospitalization by TAY served by the program who have frequently used such services in the past; 2) Significantly lower rates of crisis service re-utilization by TAY; 3) Increased engagement in BH services, and 4) High client satisfaction.

Data: Crisis, BH, emergency hospital service utilization data; satisfaction surveys; mixed methods.

Notes: Interview: Step down from acute crisis: Linkage and support after they've had a crisis. Need-based program, focused on stabilization until client is ready for outpatient services, and then linking to services.

Sonoma County

Existing Triage Services: MST currently operating in Windsor, Santa Rosa, Rohnert Park, Cotati, Petaluma; respond to field requests by law enforcement; provides crisis intervention, support, referrals; follow-up services provided by clients and family to link to community care/treatment; dedicated TAY team on site at 15 high schools and other community sites.

Goals: 1) Provide mobile crisis response in conjunction with law enforcement to respond to crises for 90% of the requests during hours of operation; 2) Triage staff will respond to calls from law enforcement in the designated cities, and conduct a crisis assessment on 95% of individuals encountered; 3) Triage staff will conduct a suicide and/or violence risk assessment; 4) Triage staff will create a crisis responses and referral plan for 95% of individuals assessed at the time of initial contact. All individuals who are served by MST will receive follow-up about the crisis plan; 5) Triage staff will conduct follow-up phone calls within 3 business days to 90% of individuals seen in the field to offer additional support in accessing any on-going treatment needs in the community; 6) Triage staff will offer peer support services to 90% of individuals contacted at the time of initial contact; and 7) Triage staff will offer family support services to 90% of family members contacted at the time of initial contact.

Proposal: Expand the existing triage programs into the West Country (Sebastopol, Forestville, Guerneville).

Outcomes: Target outputs included response rates, follow-up call rates, and peer support offers.

Sonoma General Program Information

Name: Mobile Support Team (MST)

County Information: Population: 504,217; Rural: No; Adult Psych Beds: 75

Locations: MST staff will be based out of county offices in Santa Rosa, Petaluma, and Guerneville.

Proposed Staff: 2 Behavioral Health Clinicians or Behavioral Health Clinician Interns, 0.33 Senior Office Assistant, 0.25 Client Care Manager, 0.5 Peer support Specialists, 0.5 Family Support Staff, 1 Post Graduate Intern.

Staff Amendment Due to Budget Cuts: Positions Eliminated or Reduced: 0.75 FTE Behavioral Health Clinician, 0.03 FTE Senior Office Assistant, 0.15 FTE Client Care Manager

Positions changed: Remaining 0.25 of reduced Behavioral Health Clinician changed to Behavioral Health Clinical Specialist

Stanislaus County

Existing Triage Services: Community Emergency Response Team (CERT): responds to 5150 calls at hospital access points throughout the county; 24-hour warm line including peer navigators to specialty MH services to avoid hospitalization.

Goals: 1) Provide a wide range of triage services to adults and TAY with mental illness or emotional disorders requiring crisis intervention in Stanislaus County, including those who are homeless or at risk of homelessness; and 2) improve services to underserved populations requiring crisis intervention (Assyrian, Hmong, Latinx, LGBTQ, and others).

Proposal: Expand service provision for those that are assessed as 5150 but do not require hospitalization.

Outcomes: 1) Reduce incidences of recidivism, 2) Improve MH of TST clients, 3) Reduce "unnecessary" crisis hospitalization, 4) Improve BH service linkage, 5) Reduce in crisis evaluations, and 6) Improve services to underserved groups

Data: Demographic and service utilization data collected by services at point of entry, and each crisis contact.

Stanislaus General Program Information

Name: Triage Support Team

County Information: Population: 547,899; Rural: No; Adult Psych Beds: 67

Locations: *Primary Location:* Stanislaus Recovery Center, 1904 Richland Ave, Ceres, CA 95307

Proposed Staff: 1 FTE Working Clinical Director, 2 FTE Mental Health Clinicians, 3 FTE Navigators (lived experience), 1 FTE Peer Support Specialist

Staff Amendment Due to Budget Cuts: The Working Program Manager/Clinician was reduced from 1FTE to 0.3 FTE, the Clinical Supervisor (Contractor) was reduced from 1FTE to 0.3 FTE, the Clinical Supervisor (Contractor) was reduced as well (unspecified amount).

Tuolumne County

Existing Triage Services: Community Crisis Response Program: 8-12, 7-day service; mobile within 30-minute radius of Sonora Regional Medical Center ED; conduct assessment, develop safety plan, phone support, linkage, follow-up on return to home.

Goals: Improve utilization and access to available behavioral and community services prior to the need for higher levels of care, such as emergency department usage and inpatient psychiatric hospitalization.

Proposal: 1) Recruit TAY peer specialist to provide follow-up, linkage to services; and 2) Co-locate BH law enforcement liaison in the Sheriff's Office where appropriate dispatch calls will be diverted to provide crisis support.

Outcomes: 1) Reduce TAY and adult 5150 emergency department visits by at least 5% by end of first year; 2) Reduce inpatient admissions by at least 5% in first year; 3) Reduce number, frequency, and time spent on 911 crisis calls; 4) Increase referrals to community supports; and 5) improve BH law enforcement collaboration.

Data: 5150 logs; 911 call logs, crisis & community partner service utilization records.

Tuolumne General Program Information

Name: Crisis Response Collaboration with Law Enforcement

County Information: Population: 54,248; Rural: Yes; Adult Psych Beds: 0

Locations: *Primary Location:* Co-located with the sheriff's department

Secondary location: Sonora Police Department

Proposed Staff: 2 FTE BH Law Enforcement Liaisons hired as Tuolumne County Behavioral Health Worker II, 2 part-time (1 FTE) Peer Specialist-Relief Workers, 0.2 FTE Behavioral Health Program Supervisor.

Staff Amendment Due to Budget Cuts: Eliminated 1 FTE Behavioral Health Worker II

Ventura County

Existing Triage Services: Rapid Integrated Support and Engagement (RISE): extensive county-wide outreach in field setting; transitional case management, linkage; focus on underserved groups; provides crisis intervention training to law enforcement.

Goals: Reduce the impact on health care and behavioral health services through outreach and engagement of at-risk persons or persons experiencing a crisis in the community setting.

Proposal: 1) Community Service Coordinators to ride along with dedicated police to provide field-based crisis care, focus on high-crisis care utilizers; and 2) Expansion of specialist TAY engagement service (two teams, East and West County), greater links to community partners, add peer recovery coaches to provide advocacy and postcrisis outreach; focus on motivational interviewing and solution-focused approaches.

Outcomes: 1) Reduce MH ER visits by 35% from baseline, 2) Reduce hospitalizations due to MH crises by 35% from baseline, 3) Decrease cost of MH hospitalizations by 20% from baseline, 4) Improve client wellness, and 5) Reduce police calls/incarcerations in clients by 20%.

Data: EMR data; fiscal records; Ventura Country Outcomes System; law enforcement records.

Ventura General Program Information

Name: Rapid Integrated Support and Engagement (RISE) expansion

County Information: Population: 854,223; Rural: Yes; Adult Psych Beds: 96

Locations: Law Enforcement Partner Teams will be deployed out of Ventura, Simi Valley, Oxnard police headquarters/administrative offices, and East County and West County teams will be deployed out of Camarillo Sheriff's office.

Secondary Location: RISE Program offices at the main VCBH facility in Oxnard.

Proposed Staff: 2 FTE BH Law Enforcement Liaisons hired as Tuolumne County Behavioral Health Worker II, 2 part time (1 FTE) Peer Specialist-Relief Workers, 0.2 FTE Behavioral Health Program Supervisor.

Staff Amendment Due to Budget Cuts: Eliminated 1 FTE Behavioral Health Worker II

Yolo County

> **Yolo General Program Information**
>
> **Name:** Transitional Age Youth – Mobile Crisis Response
>
> **County Information:** Population: 219,116**;** Rural: No; Adult Psych Beds: 31
>
> **Locations:** Yolo County MHUC
>
> **Proposed Staff:** 2 Clinician II positions
>
> *Staff Amendment Due to Budget Cuts:* 1 Clinician II position

Existing Triage Services: Community Intervention Program (CIP) provides field-based crisis intervention services following law enforcement response to MH crisis calls; provide assessment, de-escalation, develop action plan, linkage; peer navigator provides follow-up support postcrisis; training to law enforcement; and additional support provided by Mental Health Urgent Care Team for people who do not meet criteria for admission.

Goals: Stabilize TAY in moment of crisis, connect TAY in crisis to ongoing services, provide peer follow-up to ensure TAY engage in services, and provide crisis, de-escalation services to prevent avoidable usage of emergency services, hospitalization, and incarceration.

Outcomes: 1) Significantly improve TAY linkage to BH and community services; 2) Decrease emergency resource utilization (911 calls, law enforcement); and 3) Reduce avoidable hospitalizations and avoidable incarcerations.

Data: Crisis & BH service utilization data; 911 and law enforcement logs, EMR hospitalization data, justice data.

Notes: Hours will be reduced from 7 days a week, 11am–10pm, to M–F, 11am–8pm.