NOTICE OF PUBLIC MEETING – County of Santa Cruz
IDEAL CRISIS SYSTEM (ICS) COMMITTEE of the
MENTAL HEALTH ADVISORY BOARD
FRIDAY, MAY 13, 2022 ♦ 3:30 PM-4:30 PM
HEALTH SERVICES AGENCY
1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060
THE PUBLIC MAY JOIN THE MEETING BY CALLING (831) 454-2222, CONFERENCE ID 298 041 202#

ICS COMMITTEE MEMBERS:
Jeffrey Arlt, 5th District | Jennifer Wells-Kaupp, 5th District
Laura Chatham, 1st District | Serg Kagno, 4th District

IMPORTANT INFORMATON REGARDING PARTICIPATION IN THE
MENTAL HEALTH ADVISORY BOARD MEETING

The public may attend the meeting at the Health Services Agency, 1400 Emeline Avenue, Room 207, Santa Cruz. All individuals attending the meeting at the Health Services Agency will be required to use face coverings regardless of vaccination status. Individuals interested in joining virtually may click on this link: Click here to join the meeting or may participate by telephone by calling (831) 454-2222, Conference ID 298 041 202#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

Si usted es una persona con una discapacidad o necesita servicios de interpretación (inglés/español o Lenguaje de señas), por favor llame al (831) 454-4611 (Personas con Discapacidad Auditiva TDD/TTY: 711) con 72 horas de anticipación a la junta para hacer arreglos. Personas con discapacidades pueden pedir una copia de la agenda en una forma alternativa.

AGENDA

I. Roll Call
II. Public Comment
(No action or discussion will be undertaken *today* on any item raised during this Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each)
III. Vote on Committee Chair
IV. Discuss Roadmap updated executive summary
V. Discuss and decide on three goals for the committee – ICS Goals Sheet
VI. Review ICS Service Providers Sheet
VII. Adjournment

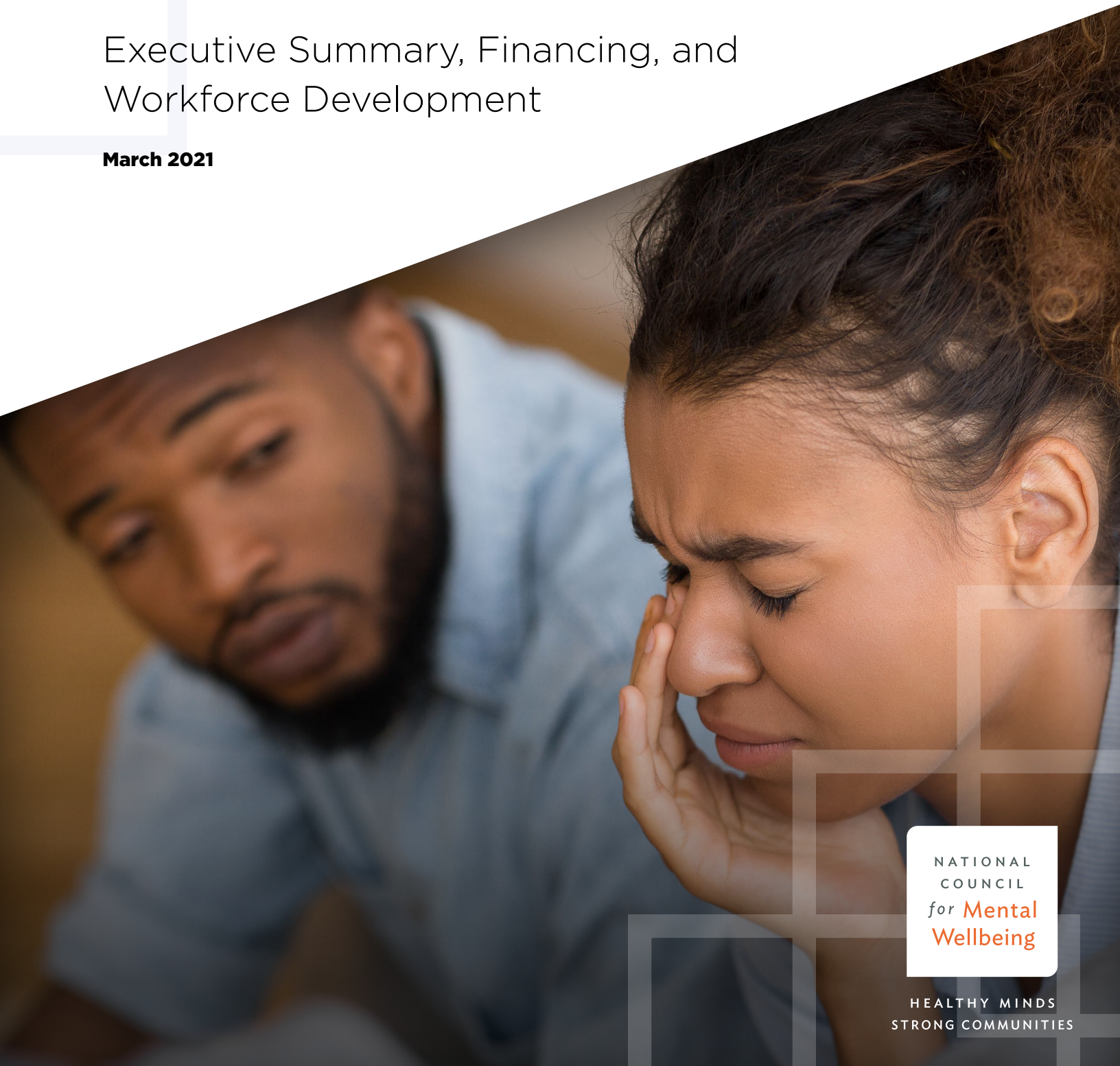
NEXT ICS COMMITTEE MEETING IS ON:
JUNE 10, 2022 ♦ 3:30 PM – 4:30 PM
HEALTH SERVICES AGENCY
1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060
TELEPHONE CALL-IN NUMBER (831) 454-2222; CONFERENCE ID # - TO BE ANNOUNCED

GROUP for the ADVANCEMENT of PSYCHIATRY

ROADMAP TO THE IDEAL CRISIS SYSTEM

Executive Summary, Financing, and Workforce Development

March 2021



NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

ROADMAP TO THE IDEAL CRISIS SYSTEM:

Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response

March 2021

Authored by Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry
Published by National Council for Mental Wellbeing

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EXECUTIVE SUMMARY

THE CHALLENGE

There is broad recognition that behavioral health crises have reached epidemic proportion, with drug overdoses and suicides having overtaken traffic accidents as the two leading causes of death among young Americans ages 25-44. The COVID-19 pandemic has further underscored the dramatic need for behavioral health services, including crisis services. Yet very few communities in the United States have a behavioral health crisis system that would be considered excellent, let alone ideal.

In most American communities today, the behavioral health crisis system isn't really a system at all, but a combination of services provided by law enforcement and hospital emergency rooms that are typically not designed to meet the needs of individuals in the midst of behavioral health crises. Often the only treatment options for individuals in behavioral health crises are in settings that do not adequately meet their needs despite being extremely costly, such as emergency rooms and inpatient psychiatric units. Further, lack of appropriate and accessible behavioral health crisis response too frequently results in law enforcement being the only available first responders, which may lead to an increase in unnecessary arrest and incarceration for people with acute behavioral health needs.

Thankfully, this situation is changing, as there is growing recognition that behavioral crisis needs special attention to ensure appropriate response for everyone, on par with that provided for medical crises, disaster response, fire response and public safety. Table 1 lists a series of reports over the past decade that describe various components of state-of-the-art behavioral health crisis services. Among the most recent is a toolkit from the Substance Abuse and Mental Health Services Administration (SAMHSA) that proposes national guidelines for crisis services (SAMHSA, 2020). Another important driver has emerged from work on reducing inappropriate criminal justice involvement, recognizing the need for focus on "Intercept 0" (an effective community crisis system) in the Sequential Intercept Mapping process (Bonfine, 2019) so that law enforcement involvement in behavioral health crises is minimized. Even more important, federal legislation (National Suicide Prevention Hotline Improvement Act) has led to the initiation of implementation of a national suicide prevention and behavioral health crisis line number – 988 – that is intended to go live nationally by 2022. This major initiative provides an opportunity for the creation of high-quality community crisis response systems that approximate the level of response that we have grown to expect from medical, fire and public safety emergency response since the implementation of 911 several decades ago.

For communities to respond to the need for effective behavioral health crisis response and to implement successful 988 response systems, significant guidance will be needed. Existing reports, such as the SAMHSA guidelines, provide helpful direction for making progress but do not address all the essential elements of a behavioral health crisis system or measurable standards and implementational strategies for communities. Consequently, communities (as well as counties and states) have inadequate guidance regarding the development, implementation and maintenance of behavioral health crisis systems that effectively meet their specific population needs.

The purpose of this report is to fill that gap. This report provides a detailed guide for communities to use to create a vision and direction for their behavioral health crisis systems, to evaluate their current behavioral health crisis capacities and to operationalize a strategy for implementing structures, services and processes that move toward an ideal crisis system.

Table 1. Recent Reports on Behavioral Health Crisis Services and Systems: (Full citations in the bibliography)
• SAMHSA (2009). Practice guidelines – Core elements in responding to MH Crises.
• SAMHSA (2014). Crisis services – effectiveness, cost-effectiveness, and funding strategies.
• National Suicide Prevention Lifeline (2014). Lifeline best practices for helping callers.
• Suicide Prevention Resource Center (2015). Zero suicide toolkit.
• National Action Alliance for Suicide Prevention (2016) Crisis now: Transforming services is within our reach.
• Meadows Mental Health Policy Institute (2016, December). Behavioral health crisis services: A component of the continuum of care.
• National Association of State Mental Health Program Directors (NASMHPD) and Treatment Advocacy Center (2017, October). Beyond beds: The vital role of a full continuum of psychiatric care.
• NASMHPD (2018, August). A comprehensive crisis system: Ending unnecessary emergency room admissions and jail bookings associated with mental illness. (Assessment Paper No. 5).
• NASMHPD (2018 August). Making the case for a comprehensive children's crisis continuum of care. (Assessment Paper No. 8). TBD Solutions (2018). Crisis residential services best practices handbook.
• U.S. Department of Veterans Affairs (2018). National strategy for preventing veteran suicide: 2018-2028.
• National Suicide Prevention Lifeline.org (February 7, 2019). National suicide hotline improvement act: The SAMHSA report to the Federal Communication Commission.
• Policy Research Inc. and National League of Cities (2020, January). Responding to individuals in behavioral health crisis via co-responder models: The roles of cities, counties, law enforcement, and providers.
• SAMHSA (2020). National guidelines for behavioral health crisis care – a best practice toolkit.
• NASMHPD (2020). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies

RESPONDING TO THE CHALLENGE

The Committee on Psychiatry and the Community for Group for Advancement of Psychiatry (GAP) accepted the challenge by Judge Steven Leifman (a member of our Committee) to define understandable, achievable and measurable expectations for ideal behavioral health crisis system performance, so any community can know what its crisis system should be and take steps over time to achieve that goal. The National Council for Mental Wellbeing has partnered with GAP to publish and distribute this important material, both for the benefit of its member organizations, many of whom are assuming leadership roles in developing community behavioral health crisis systems, as well as for the benefit of the many stakeholders nationwide who are committed to improving behavioral health services.

This report is based on the available literature on best practices for behavioral health crisis services as well as on the experiences of the authors and other informants who are currently operating effective behavioral health crisis services and designing innovative behavioral health crisis services and systems.

However, an ideal crisis system cannot be designed solely from the perspective of psychiatrists. Multiple perspectives informed this report through provision of direct feedback and input, including individuals who have experienced behavioral health crisis services, often in very traumatic ways: family members of people in need, law enforcement, behavioral health crisis providers, other human service providers; county and state leaders, community advocates and public and private funders. This continuum of input is needed to identify what an ideal behavioral health system consists of and to establish a consensus for action that will result in every community in the US having such a system to meet the needs of its population. The Committee is particularly grateful for the contribution of Keris Myrick, formerly director of the Office of Consumer Affairs for SAMHSA, and discipline chief for peer services in the Los Angeles County Department of Mental Health, who served as a consultant to the Committee.

DEFINITIONS

Establishing Acceptable Definitions: What Constitutes An Ideal Behavioral Health Crisis System?

This report endeavors to describe an ideal crisis system, not just a minimally adequate crisis system. But does it make sense to define an ideal crisis system when many states and counties do not have the additional resources even to create minimal crisis services in every community? Not only does it make sense, it is also imperative.

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Historically, the problems of people with mental illnesses, substance use disorders and cognitive disabilities (e.g., acquired brain injury) were not the responsibility of the community. Those were things that happened to "other people." "Someone else" funds these services. Fortunately, as noted above, society is beginning to recognize that behavioral health crises are common and can happen to anyone – to any individual or family – just like crime, fire, flood and emergency medical events. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social and economic cost, resulting in incarceration, devastation, homelessness and death. As a society, therefore, our collective perspective is changing about how behavioral health crisis services should be prioritized.

To describe a vision for an ideal behavioral health crisis system, it is first necessary to define terms.

What is Behavioral Health?

As used in this report, behavioral health is a term of convenience that refers to both mental illnesses and mental health needs (e.g., trauma) and substance use/addictive disorders and substance use needs and issues, as well as to the overlap of those behavioral health issues into primary health, cognitive disabilities, criminal justice, child welfare, schools, housing and employment, and to prevention, early intervention, treatment and recovery.

Behavioral health also includes attention to personal behaviors and skills that impact general health and medical wellness as well as prevent or reduce the incidence and impact of chronic medical conditions and social determinants of health. We are aware that many stakeholders appropriately take issue with the term behavioral health because of its implication that the problem is that people are behaving badly rather than that they are suffering from a combination of medical conditions, trauma and other social and environmental challenges. Nonetheless, with that caveat in mind, for the sake of convenience and for want of better terminology, we will utilize that term throughout this report.

What is a Behavioral Health Crisis?

Behavioral health crisis refers to any event or situation associated with real or potential disruption of stability and safety as a result of behavioral health issues or conditions. Crisis, as used here, does not only refer to situations that require calling 911 or 988. A crisis may begin at the moment things begin to fall apart (e.g., a person runs out of psychotropic medication and cannot obtain more, or is overwhelmed by urges to use substances they are trying to avoid) and may continue until the person is safely re-stabilized and connected or re-connected to ongoing supports and services. Crisis requests may be initiated by an individual, a caregiver or a service provider, as well as by any concerned person observing someone in need. Crisis systems and services should ideally be positioned to respond to any type of crisis request as soon as possible to prevent deterioration and for as long as necessary to help people in need stay safe and keep making progress, just like other community services.

What is a Behavioral Health Crisis System?

A behavioral health crisis system is more than a single crisis program, such as a mobile crisis team, a psychiatric emergency service or a crisis residential unit, and more even than just a few of those distinct elements. The term refers to an organized set of structures, processes and services that are in place to meet all the urgent and emergent behavioral health crisis needs of a defined population in a community, as soon as possible and for as long as necessary. In short, a crisis system involves an array or continuum of components, processes and services managed collaboratively and interlinked. The target population for the system of services is ideally defined geographically, as a state, county, multi-county region or city, although other mechanisms (e.g., covered lives) may be used at times. Successful systems require multiple layers of organization and partnership based on ongoing collaborations within the community to address the behavioral health crisis needs of the population of the community.

The concept of a crisis system in this report is intended to be distinguished from the routine system of short-term or ongoing care, although the two must necessarily interact seamlessly for service users and providers alike. Even an ideal crisis system cannot succeed without adequate access to good quality routine care to hand people off to once their crisis is resolved and to meet the behavioral health needs of the majority of the community before they fall into crisis.

What is an Ideal Behavioral Health Crisis System? THE GOAL!

In an ideal behavioral health system, every individual and family with behavioral health issues can receive services that are helpful and effective quickly and easily for as long and as intensively as needed to achieve the best possible results for a successful and meaningful life. “Ideal” as used here does not mean perfect, nor does it assume unlimited resources. It refers to a set of recommendations or criteria any community can use to determine how to invest resources to achieve the best overall outcomes and to incorporate the known best practice processes, programs and practices that would contribute to the achieving the best possible results, as effectively, efficiently and flexibly as possible.

These definitions lead to the aspirational vision for this report.

THE VISION

An excellent behavioral health crisis system is an essential community service, just like police, fire and EMS. Every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects for other essential community services.

A behavioral health crisis system is more than a single crisis program. It is an organized set of structures, processes and services that are in place to meet all types of urgent and emergent behavioral health crisis needs in a defined population or community, effectively and efficiently.

While no system will ever likely reach the ideal, the aspirational goal is, "Every person receives the right service in the right place, every time."

ACHIEVING THE VISION

For communities across the US to transition from minimal behavioral health crisis services toward an ideal system, there must be a blueprint that contains all aspects of an ideal crisis system along with measurable performance criteria that communities can use for ongoing assessment of their progress through a continuous quality improvement process. The blueprint can provide a framework for community leaders (e.g., county executives, behavioral health system administrators, health system leaders, judges), funders (e.g., state agencies, Medicaid, commercial insurers, managed care organizations, accountable care organizations, counties, cities, community foundations) and other stakeholders (e.g., behavioral health providers, other human service providers, emergency responders, law enforcement, people and families receiving services) to come together to develop a shared vision of an excellent crisis system for their community, a set of shared values and action steps for making progress.

This report describes the criteria of an ideal behavioral health crisis system as a blueprint for any community to follow to establish community crisis services for individuals and families with mental health and substance use needs that are on par with other essential community services that respond to other types of crises.

WHO SHOULD READ THIS REPORT?

- Those who plan, administer, fund and regulate systems of care.
- Behavioral health and human service providers, service recipients and advocates for whom quality care is paramount.
- All stakeholders, including legislators, state and county administrators, health systems, judges, law enforcement and other first responders.
- Anyone who is interested in thoughtful and reasonable opportunities to support the transformation of community responses to behavioral health crises from unprepared chaos to best practice.

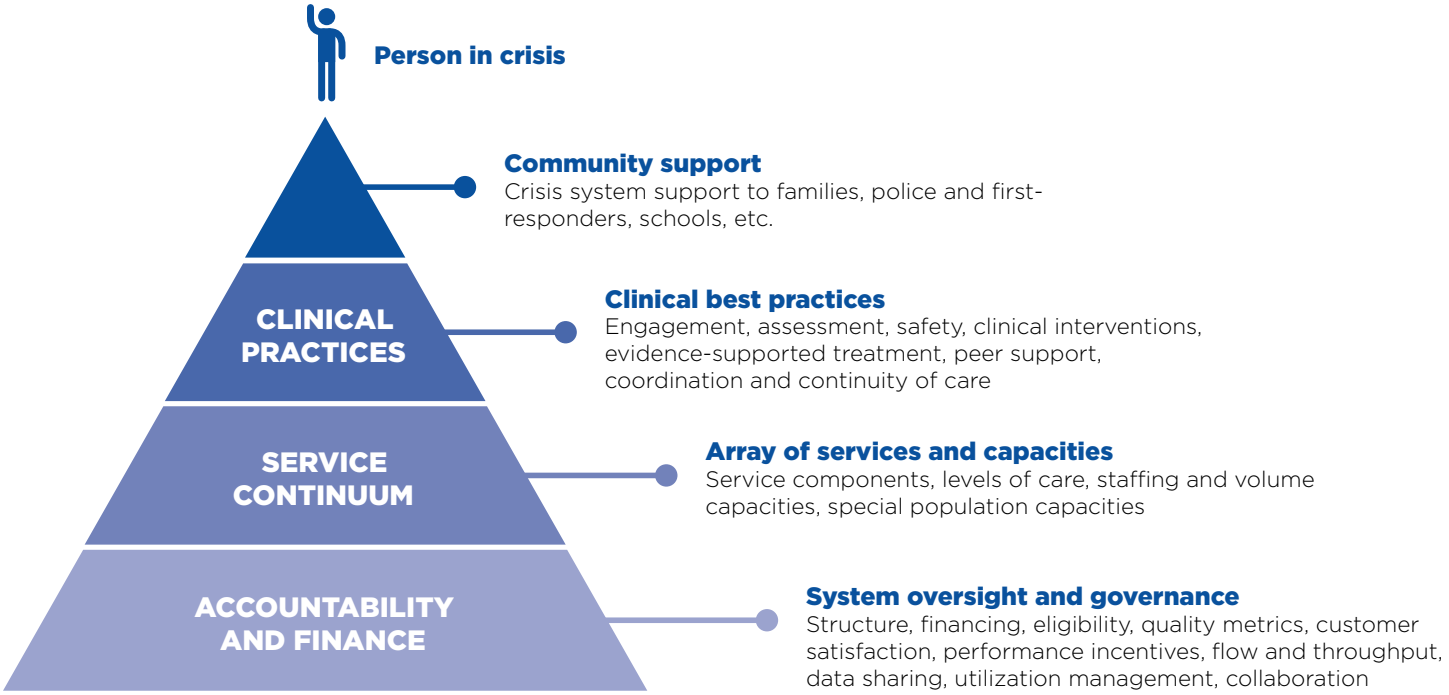
READING THE REPORT

The report begins with an organizing framework that describes how to build an ideal crisis system that is "person-centered" and "customer-oriented", inclusive of a foundational set of values and operational principles. (Link to Framework, Values, and Principles Chapter).

The report delineates how implementation of successful systems requires three interacting design elements, along with measurable indicators for the components of each. These three interacting design elements provide the structure for the three major sections of this report.

- Section I: Accountability and Finance
- Section II: Crisis Continuum: Basic Array of Capacities and Services
- Section III: Basic Clinical Practice

The following provides a brief introduction to these three sections, along with key takeaways from each.



Section I: Accountability And Finance

An ideal behavioral health crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum.

This continuum of services is responsible for and responsive to a designated community or catchment area (depending on the nature of the area's geography), and each state, county or community will have a mechanism for allocating responsibility and accountability. This section defines the concept of an accountable entity, which is a structure that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.

FINANCING

FLOW AND THROUGHPUT

ELIGIBILITY (ALL-PAYER)

COMPREHENSIVE CLIENT TRACKING DATA SYSTEM

GEOGRAPHIC ACCESS AND NETWORK ADEQUACY

FORMAL ASSESSMENT OF CUSTOMER SATISFACTION

QUALITY METRICS

STANDARDIZED UTILIZATION MANAGEMENT AND LEVEL OF CARE DETERMINATION

PERFORMANCE INCENTIVES

RELATIONSHIP TO THE REST OF THE SERVICE SYSTEM

Section I: Key Takeaways

- **There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.**
- **There is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems and service recipients.**
- **There is a stated goal that each person and family will receive an effective, satisfactory response every time.**
- **Geographic access is commensurate with that for EMS.**
- **Multiple payers collaborate so that there is universal eligibility and access.**
- **There are multiple strategies for successfully financing community behavioral health crisis systems.**
- **Service capacity of all components is commensurate to population need.**
- **Individual services rates and overall funding are adequate to cover the cost of the services.**
- **There is a mechanism for tracking customers, customer experience and performance.**
- **There are shared data for performance improvement.**
- **Quality standards are identified, formalized, measured and continuously monitored.**

Section II: Crisis Continuum: Basic Array Of Capacities And Services

An ideal behavioral health crisis system has comprehensive array of service capacities, a continuum of service components and adequate multi-disciplinary staffing to meet the needs of all segments of the population.

OVERALL DESIGN ELEMENTS

ELEMENTS OF THE CONTINUUM
(see inset below)

POPULATION CAPACITIES

STAFFING CAPACITY

SERVICE COMPONENTS

Elements Of The Continuum			
	Crisis Center or Crisis Hub		Intensive Community-based Continuing Crisis Intervention
	Call Centers and Crisis Lines		23-hour Evaluation and Extended Observation
	Deployed Crisis-trained Police and First Responders		Residential Crisis Program Continuum
	Medical Triage and Screening		Role of Hospitals in Crisis Services
	Mobile Crisis		Transportation and Transport
	Behavioral Health Urgent Care		

Section II: Key Takeaways
• **The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.**
• **Family members and other natural supports, first responders and community service providers are priority customers and partners.**
• **Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.**
• **There is capacity for sharing information, managing flow and keeping track of people through the continuum.**
• **There is a service continuum for all ages and people of all cultural backgrounds.**
• **All services respond to the expectation of comorbidity and complexity.**
• **Welcome all individuals with active substance use in all settings in the continuum.**
• **Medical screening is widely available and is not burdensome.**
• **There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.**
• **Telehealth is provided for needed services not available in the local community.**
• **Program components are adequately staffed by multidisciplinary teams, including peer support providers.**
• **There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.**

Section III: Basic Clinical Practice

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.

CORE COMPETENCIES FOR ENGAGEMENT, ASSESSMENT AND INTERVENTION

POPULATION-SPECIFIC CLINICAL BEST PRACTICES

SCREENING AND INTERVENTION TO PROMOTE SAFETY

COLLABORATION, COORDINATION AND CONTINUITY OF CARE

PRACTICE GUIDELINES FOR INTERVENTION AND TREATMENT

Section III: Key Takeaways

- **The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.**
- **Engagement and information sharing with collaterals is an essential competency.**
- **Staff must know how to develop and utilize advance directives and crisis plans.**
- **Essential competencies include formal suicide and violence risk screening and intervention.**
- **"No force first" is a required standard of practice.**
- **Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.**
- **Utilizing peer support in all crisis settings is a priority.**
- **Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.**
- **Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.**
- **Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.**

WORKING EXAMPLES

Throughout this report, we have inserted textboxes highlighting working examples of progress at multiple levels. The Appendix contains more detailed examples of system level progress.

Examples include:

- Communities that have organized to develop excellent behavioral health crisis systems: Pima County (Tucson), Arizona.
- Statewide legislation to define a crisis system vision: Iowa's crisis access standards.
- Statewide efforts to establish best practices: Michigan's guidelines for medical screening.
- National efforts to expand resources and expectations for community crisis systems: Certified Community Behavioral Health Clinics (CCBHCs).

USING THIS REPORT TO IMPROVE COMMUNITY CRISIS SYSTEMS: 10 STEPS FOR COMMUNITIES; 10 STEPS FOR SYSTEM LEADERS AND ADVOCATES

The intent of this report is to provide guidance for action both at the community level and at the system leadership and advocacy level.

It includes specific recommendations for action steps that can be taken to advance the development of ideal behavioral health crisis systems at the state and local level: 10 Steps for Communities and 10 Steps for System Leaders and Advocates. In addition, the Behavioral Health Crisis System Report Card incorporates the essential elements and measurable indicators in this report into a self-assessment scorecard which can be used to evaluate the current baseline in any community and measure progress over time.

How to proceed. This document deals with complex systems of care and is designed for stakeholders who desire radical change yet understand the need to proceed in small steps. Those who utilize the criteria incorporated in this report can delve into each section in as much detail as may be relevant to their own system. The baseline crisis system status, the level of change desired and the degree of community collaboration that has been developed will inform the level of detail with which each reader or community will use each recommendation and the approach to measuring its successful attainment.

All stakeholders can and should be engaged in participating in crisis system design and development: legislators, payers, state and local policymakers, service providers, researchers, service recipients, family members, judges, advocates and community members. We hope that by defining the ideal crisis system, we can stimulate activity at many levels to help every community identify next steps of progress toward that ideal system and to have the impetus and inspiration to keep going until its behavioral health crisis system is as close to the ideal as possible.

No matter what your community's level of progress in developing a behavioral health crisis system, this document will help you and your community make progress. As you read this report, you and your community partners can assess your current baseline and use this document as a roadmap for what you eventually want your behavioral health crisis system to become and to identify the next achievable steps on your journey. Each time your community makes a little progress, give yourselves a round of applause, then go back to the document and identify your next steps…AND KEEP GOING. Our goal is that communities and systems all over the U.S. use this document to guide their progress to achieve the vision described at the beginning of this chapter.

This is a process of progress TOWARD perfection. Do not be discouraged if your community has a long way to go. We recommend further that communities and systems do not hesitate to ask for help (e.g., consultation, technical assistance) at any step, in order to facilitate progress by contacting Consulting@TheNationalCouncil.org. The journey toward developing ideal crisis systems will be a new venture for most communities and outside facilitation may be needed to help the community or state come to consensus on the best path to reach their goals.

No matter where you are in the continuum of crisis system development, our hope is that you can use this document to assess your level of progress and find your next steps forward in the spirit of continuous improvement.

10 STEPS FOR COMMUNITIES

In order to make this information optimally accessible and useful for communities that wish to improve their behavioral health crisis system, the following 10 steps are a recommended approach:

1. **Identify and convene community partners:** Identify community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within your community and develop a voluntary ad-hoc group for initial discussions. Remember to engage stakeholders and funding partners that represent the whole community, not just those who are indigent or funded by Medicaid. Behavioral health crisis systems are an essential community service for everyone.
2. **Read and process relevant sections of the report:** Share this report with those stakeholders and ask them to read the Executive Summary and the Introduction. Have the stakeholders identify aspects of the report most relevant to them over a few sessions and have them present sections of the report to the group as a whole.
3. **Develop a local vision:** Have the stakeholders develop an initial vision for an ideal behavioral health crisis system in your community. Do not be discouraged if you are far from that goal right now. Every community with an improved behavioral health crisis system had to start at the beginning and make progress over time.
4. **Disseminate the vision:** Write down this vision with some initial action steps and actively share it with others.
5. **Accountable entity:** Identify one or more entities that may serve as the accountable entity within your community. It could be county leadership, city leadership, a managed care organization or an existing community collaborative addressing jail diversion or suicide prevention.
6. **Planning and implementation team:** Identify a team of people to meet regularly on an ongoing basis to begin to plan the ideal behavioral health crisis system. This could be a new group under the accountable entity or a component of an existing collaboration. Do not hesitate to seek consultation or outside facilitation if needed at this step or any point along the way.
7. **Baseline self-assessment:** Using the measurable criteria in the report, rating each item from 1-5, have the planning team rate the current status of your behavioral health crisis system. No matter what you find, give yourselves a round of applause. See the Report Card to help organize this step. Use the Report Card as well to track your progress over time.
8. **Early wins:** Identify three to five improvement opportunities that the team can address early on, within available capacity and resources. Develop and implement a collaborative plan to begin to make progress in small steps on each item. Give yourselves another round of applause for making progress.
9. **Data and financing:** At the same time, members of the planning team begin to gather clinical and cost data on current system performance and identify potential local, state and federal funding opportunities. Do not worry that your initial data are not perfect or if you do not find all the funding you will eventually need. Every community makes progress in steps with slow improvement in data using initial seed funds to attract further funding as the vision of the crisis system takes shape.
10. **Comprehensive plan:** Keep meeting and working together. Over a period of time, using the data you have gathered, with consultation if needed, use this report for guidance to develop a comprehensive, collaborative plan for the design of an ideal behavioral health crisis system for your community. Identify a step-by-step approach so multiple partners can begin to work together to make progress over a period of years.

10 STEPS FOR SYSTEM LEADERS AND ADVOCATES

What can system leaders at the state and regional/county level do to facilitate development of ideal community behavioral health crisis systems? What can advocacy organizations do to encourage state leaders, legislators, funders and policymakers to support progress at all levels? This report provides detailed guidance for how to address these issues at many levels. Here are 10 steps that can help to focus and prioritize these efforts:

1. **Establish, articulate and communicate a systemwide vision of ideal behavioral health crisis systems for all:** The core of this vision is that behavioral health crisis systems are an essential community service that should be at least on par with the responsiveness of emergency and urgent medical care - every person gets the right response every time. Incorporate core values in the vision: welcoming, hopeful, trauma-informed, recovery-oriented, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.
2. **Develop an implementation plan:** As part of the vision, articulate a 10-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress. Remember that implementing universal 911 response systems took a decade or more.
3. **Disseminate this report as a guiding document:** Highlight the essential elements of the system and encourage development of a system-wide conversation to adopt the vision. Essential elements that might be highlighted for purposes of conversation include local accountability (accountable entities), all-payer financing, system performance metrics, crisis continuum (e.g., call center, mobile crisis, urgent care, crisis center, various types of crisis residential programs, intensive community crisis intervention), response to all ages and population groups, clinical/medical leadership, peer support and best practices for crisis intervention.
4. **Perform baseline self-assessment:** Encourage communities to come together to perform a systemwide baseline assessment of the current behavioral health crisis system, using the Report Card to track progress across the system over the course of the 10-year plan.
5. **Identify performance metrics:** Using this report, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.
6. **Award planning and implementation grants:** Develop a process to award community crisis collaboratives grants (possibly matching grants) for planning and implementation. This can begin with a few pilot communities, then slowly disseminated to the whole system. Continually measure progress in all communities across the system, rewarding small steps forward over time.
7. **Create a framework for identifying and empowering accountable entities:** Identify mechanisms for regional and local accountability for crisis system performance. These could be based on regional intermediary system structures and/or on existing templates for delineating community accountability for EMS.
8. **Require all-funder participation:** Require all private and public behavioral health funders to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.
9. **Require coverage of and adequate rates for all elements of the crisis continuum:** Identify clear definitions of the various components and services in the behavioral health crisis continuum and require that Medicaid and other funders reimburse for those services (e.g. urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention) at rates that at least cover costs. Medical urgent care and emergency services do not operate at a loss; neither should commensurate behavioral health crisis services.
10. **Incorporate best practice standards into system regulations:** This report provides guidance for regulations that address items such as no force first, advance directives, medical screening, integrated response to individuals with co-occurring mental health/substance use disorder and behavioral health/intellectual and developmental disabilities and so on.

FINANCING

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community in the same way that police, fire, EMS and emergent/urgent medical care are essential community services. For this reason, there must be adequate financing for that continuum of services to achieve appropriate community response, just as is the case for other safety-net services. Aligning multiple funding streams to support a single crisis system, rather than each funder developing its own system is likely to be more efficient, effective and accessible to customers.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for providing direct services and/or coordination of all service elements that has the following approach to financing:

- **The accountable entity is responsible for producing a global budget for the ideal crisis continuum.** This budget is initially based on historical utilization data of all components and all payers of community behavioral health crisis response and has projections for future utilization based on movement toward an ideal system. For example, projections of inpatient utilization are modified by the addition of increased diversion and step-down capacity. Projections of ER visit utilization are modified by addition of non-ER-based crisis programs.
- **Shared resource contribution:** The behavioral health crisis system is a shared system capacity like an electronic health record (EHR) system or ambulance district. All funders of health coverage whose beneficiaries could potentially utilize the behavioral health crisis continuum are accountable over time to contribute resources to core capacity. This includes federal resources (Medicare, Veterans Administration, Department of Defense), state resources (including Medicaid), local (e.g., county, city), public funding (in lieu of inappropriate use of law enforcement or jails), managed care organizations and commercial insurers of all kinds and accountable public and private health systems (e.g., accountable care organizations or other large payers receiving value-based payment, hospitals accountable for preventable readmissions, ER visits). Funding for a "global" crisis financing budget is defined in each community as a collaboration between public payers (states, counties, cities/towns), public and private insurers and accountable health systems. Proportional contribution is based on historical utilization and potential value added.
- **Delegated financing authority:** The accountable entity must have either direct or delegated governmental authority at the state and/or local level to require participation of funders, assure adequate rate-setting, determine funder and provider participation requirements, determine standard of care and quality performance metrics and award and enforce service contracts.
- **Financing supports capacity, not just utilization:** For example, no community would establish a fire department that is paid only when it responds to a fire. Financing is a necessary community expenditure, like EMS, not something that will ultimately always pay for itself through savings. Financing methodology must balance assuring availability of the service with incentive to provide service. Each component of the crisis system has a base payment to maintain capacity to provide the service, and a second reimbursement based on utilization, fee-for-service. There are various reimbursement models for how this can be done.
- **Adequate reimbursement rates:** Both payments for reimbursement for crisis services must be commensurate with the complexity and comprehensiveness of service provided. This includes contacting collaterals, phone calls, home-based outreach, travel time for mobile response and complex disposition planning. Rate- setting must be based on the actual cost of providing the service as determined by provider cost reports.

- **Incentive payments:** A financial incentive for performance and penalties for non- performance on critical indicators should be included as a third component of the overall payment methodology. Any incentive payment should not be based solely on meeting cost saving or utilization reduction targets but should also include quality of care measures. Incentive payment methodology should be initiated with bonus payments for good performance. Negative incentives with reduced payment for poor performance should not be initiated until organizations have at least two years of experience with positive incentive value-based payments. Negative incentive penalties or payment reductions based on performance should not exceed 5% of the actual cost of service provision.

- **Payment for full continuum of crisis services:** Reimbursement for crisis services by all payers must be designed to support the full continuum of crisis response: payment for early or pre-crisis intervention, outreach and engagement, payment for active treatment including medication during a crisis event, payment for the continuum of crisis diversion programs, and payment for crisis follow-up at necessary level of intensity for at least 14 days and up to 90 days for individuals with high levels of need who are not easily connected to routine community-based services.
- **Budget full capacity at a 95% maximum threshold:** Because crisis utilization naturally waxes and wanes, the budget is designed with the expectation that utilization for each component is over maximum capacity no more than 5% of the time, or no more than 18 days per year. Provision is then made for funding temporary overflow on those 18 days (e.g., for extra crisis workers, contracting for overflow crisis beds). Budgeting is also designed to ensure minimization of under-utilized capacity and regularly adjusted based on actual data.
- **Payment for all populations, including those with comorbidities:** Reimbursement for crisis services by all payers is designed to support interventions for youth, adults and older adults, as well as individuals with mental health, SUD and cognitive disabilities in any combination. Funding from various categorical pots (e.g., developmental disability [DD] waiver, SUD block grant) may be blended to fund the crisis continuum, but the continuum itself has clear funding instructions that support a full array of services to individuals and families with all types of comorbidity and complexity. For example, if an adult with co-occurring DD and a mental health disorder presents in crisis, there is a clear set of instructions that indicates that the behavioral health crisis team responds using its core resources, then coordinates with the DD-funded crisis respite and continuing supports system for ongoing services as indicated. The same applies to individuals like Mr. Y with co-occurring mental health and SUD conditions, as well as youth in foster care/social service custody or youth/adults in custody of the justice system. Funding instructions for each significant type of comorbidity and complexity must be delineated in all funding and provider contracts.
- **Financing for safety net:** Financing mechanisms are designed so the behavioral health crisis system can operate as a safety net for the entire delivery system. There must be no instance in which an individual or family receives no response because there is no clear allocation of funding and responsibility. In all such instances, the behavioral health crisis system must be defined as the default safety-net provider.

Certified Community Behavioral Health Clinics: Expanding Access to Care in Times of Crisis

The Certified Community Behavioral Health Clinic (CCBHC) model was established to improve access to crisis care and expand Americans' access to addiction and mental health treatment in community-based settings. CCBHCs support a robust community treatment infrastructure that includes 24/7 crisis care, mobile crisis teams and partnerships with local law enforcement and hospitals.

In contrast to the patchwork of crisis care typically available in other communities, all CCBHCs must provide a standard array of crisis services linked with ongoing outpatient treatment. CCBHC's crisis management services are available and accessible at all times, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. CCBHCs must partner with organizations that frequently come in contact with individuals in crisis – such as local emergency departments and local law enforcement agencies – to facilitate crisis intervention, care coordination, discharge and follow-up. Following a crisis, CCBHCs work with the individual on a crisis plan to prevent and de-escalate potential future crisis situations, while ensuring they are linked to comprehensive ongoing community-based treatment. CCBHCs must have an interdisciplinary care team that works together to coordinate the full range of support services needed by individuals in crisis and following a crisis. Staff must be culturally competent and have access to language services depending on the community the CCBHCs.

Results to date show substantial improvement in access to crisis care. More than half of CCBHCs added crisis services where none existed before. All engaged in new partnerships with hospitals and law enforcement to support crisis intervention and coordinate post-crisis care. (1) As a result of improved crisis intervention and ongoing community-based care, CCBHCs have produced significant reductions in hospitalizations, emergency department visits and incarcerations (2).

CCBHCs and the Crisis Now model is gaining attention and popularity as a means to improve communities' response to crisis care. The approach focuses on five core elements of crisis care including: 1) regional or statewide crisis call centers coordinating in real time; 2) centrally deployed, 24/7 mobile crisis teams; 3) short-term, "sub-acute" residential crisis stabilization programs; 4) essential crisis care principles and practices; and 5) development and implementation of protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive setting.

CCBHCs provide the opportunity to further advance the Crisis Now model, both by establishing a critical connection to ongoing community services in areas where Crisis Now has been implemented and by offering a financing model that can support many of the costs of implementing Crisis Now in areas where the model does not currently operate. Aligned with the elements of the Crisis Now model, CCBHCs provide 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. They also establish partnerships with organizations where individuals in crisis may frequently present — such as local EDs and local law enforcement agencies – to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care. Following a crisis, CCBHCs work with the individual on a crisis plan to prevent and de-escalate potential future crisis situations while ensuring access to the full range of community-based services needed to keep the individual out of crisis.

The CCBHC model improves access to crisis care by funding activities that have traditionally been difficult to implement. There are two CCBHC funding tracks: a Medicaid prospective payment rate calculated to cover CCBHCs' anticipated costs or a 2-year grant that funds CCBHC activities. Both funding streams support:

- Expanded access to crisis care through an enhanced workforce. CCBHCs' funding can support the cost of hiring new staff such as nurse care managers, training staff in required competencies such as suicide prevention and naloxone administration, and placing staff liaisons in settings like EDs or jails where individuals in crisis commonly present.
- Timely follow up and "warm hand-off" from the ED to ongoing, community-based services. CCBHCs must establish partnerships with hospitals and other providers and ensure services are available to transition patients from an ED or hospital to a community-care setting. Through quality reporting requirements, CCBHCs are held accountable for the timeliness of a patient's transition between care settings and ensuring that no patient falls through the cracks.

- Electronic exchange of health information for care coordination purposes. CCBHCs' funding can support purchasing or upgrading electronic systems for real-time electronic information exchange – along with data collection, quality reporting and population health approaches to care.
- Enhanced patient outreach, education and engagement. CCBHCs' funding supports the cost of activities that have traditionally been near-impossible to reimburse, yet play a critical role in crisis intervention, care management and coordination of services.
- Care where people live, work and play. CCBHCs' funding covers services provided outside the four walls of their clinic. For example, via mobile crisis teams, home visits, telemedicine, outreach workers and emergency- or jail-diversion programs.

CCBHC Expansion Legislation Introduced

In light of the program's success, as of January 2021, Congress has extended the original 8-state Medicaid demonstration to two additional states and allocated yearly funds for CCBHC expansion grants since 2018. Thirty-three states now have at least one CCBHC. The bipartisan Excellence in Mental Health and Addiction Treatment Act (S. 824/H.R. 1767) would renew the CCBHC Medicaid demonstration program and expand it to new states. By renewing and expanding the demonstration, Congress could expand behavioral health capacity and alleviate the pressure on our nation's jails and emergency rooms. This legislation will also ensure sustainability for CCBHC grantees beyond their 2-year grant terms by supporting more states in implementing the model as part of Medicaid.

1. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2019). Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018. Accessed July 15, 2020 at https://aspe.hhs.gov/report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018
2. National Council for Mental Wellbeing. (2020). Expanding Mental Health and Addiction Treatment: An Impact Report. Accessed July 15, 2020 at: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf?daf=375ateTbd56

ELIGIBILITY (ALL-PAYER)

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community, in the same way that police, fire, EMS and emergent/urgent medical care are essential community services.

However, unlike police, fire or EMS, in many parts of the country behavioral health crisis response is determined first by payer (or lack of payer) and in some communities, each payer (Medicaid, insurer, managed care organization [MCO]) may have a different continuum of services with different eligibility criteria. This is challenging for individuals and families trying to access help and an inefficient and duplicative use of resources.

Therefore, in an ideal community behavioral health crisis system, there is ONE crisis continuum that is responsive to ALL individuals and families. It is never necessary to establish insurance coverage before responding to behavioral health crisis; everyone is eligible for the full continuum of crisis response and all payers support the full continuum. Cross payer collaboration – not competition – is necessary for ideal community crisis response.

All-Payer Example - Kent County, Michigan

The Kent County crisis collaborative under the auspice of the population health consortium has developed a business plan for a crisis center, call center, behavioral health urgent care, and mobile crisis that includes all Medicaid Health Plans and commercial plans (including Medicare Advantage) as potential partners. The three largest health plans have been invited to the table and have agreed to participate in the funding collaboration. In Michigan, the Medicaid health plans are responsible for mild to moderate behavioral health but not crisis, even though 60% of Medicaid recipients who have behavioral health crisis are in the mild to moderate group. However, the Medicaid health plans can benefit directly from supporting ED diversion and are interested in partnering with community leaders because of the high level collaboration that has been created.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring with the following eligibility criteria:

- **Access to all:** The full continuum of crisis services is available to all members of the community, including individuals travelling through, regardless of whether they are insured or the type of insurance coverage, just as with the continuum of fire services.
- **Resource contribution by all:** See "Financing."
- **Community education on access to all:** All payers and community providers communicate to members and service recipients, first responders and other human service providers, a clear and consistent message about how to access the community's all-payer, all-eligible crisis system, 24-hours per day, seven days per week.
- **Contracts with providers include access for all:** Contracts with all crisis providers include the expectation that everyone is equally welcome for care, whether privately insured, public insured or uninsured. No one is turned away based on insurance coverage or lack of coverage.
- **Contract with public payers support the full-service array:** Contracts with all public payers doing business in the community include the expectation that the full continuum of crisis services will be supported and reimbursed for their members. This may include provision for out of network payment for certain services that may periodically be at capacity within network.
- **Contracts with private payers support the full-service array:** Contracts by businesses in the community with all private payers doing business in the community include the expectation that the full continuum of crisis services will be supported and reimbursed for their members. This may include provision for out-of-network payment for certain services (e.g., inpatient child psychiatry) that may periodically be at capacity for within network.
- **All payers involved in coordination and QI activities:** All payers are expected by contract to participate in community crisis coordination activities and quality management activities as defined by the "accountable entity."
- **Access to innovations and data:** Innovative services developed/contracted by any payer are expected to be made available to individuals served by all payers. Individual payers may retain their unique care coordination and data tracking functions for their members, but all aggregate data are accessible to the accountable entity.
- **Delegated authority:** See "Financing."

TELEMEDICINE, TELEHEALTH AND TELEPSYCHIATRY

For any system of care to work, clients need reliable access to treatment. Rural and underserved urban areas may be hard for clients to access and/or have an insufficient number of providers available. Telepsychiatry and telehealth, including audio-only interactions for those that might not have videoconferencing capability or bandwidth, can facilitate 24-hour access to medical and psychiatric staff, clinicians and other staff for crisis evaluations and on-going treatment. For younger individuals and/or persons living in unstable environments, like shelters, text/chat capability for accessing crisis services can be particularly valuable. Telepsychiatry and telehealth can greatly reduce waiting time and time to initiate treatment. Telepsychiatry can also be used for clinical supervision, clinical rounds, case conferences and team meetings.

Increasingly, telepsychiatry technology can support mobile crisis team interventions in the field by facilitating psychiatric evaluations direct to client via secure tablet platforms. Using this technology significantly improves the reach of mobile crisis services.

Because the rules and regulations that govern telepsychiatry vary by locality and state, the specific local requirements for licensing, billing, electronic prescribing and malpractice insurance must be considered when implementing telehealth or telepsychiatry services within the crisis continuum. However, increasingly, telehealth should be considered a standard component of crisis systems, and the general concepts and operational procedures can be set up in almost any place that has internet access, supporting clinicians and technical assistance. Use of telemedicine during the COVID-19 crisis has been well-established with considerable satisfaction noted by clients and providers. The duration of modified billing regulations by the Centers for Medicare and Medicaid Services is uncertain.

Measurable Criteria for an Ideal System

The accountable entity implements standards and creates incentives to insure:

- All crisis programs, particularly mobile crisis teams, have comprehensive telemedicine and telepsychiatry capacity, including text/chat and audio-only, that can project medical, psychiatric and crisis evaluations into multiple types of crisis intervention settings, including shelters, forensic settings and homes. Telehealth should be part of a continuum of care with capacity to reciprocally share information with other provider networks in the community, including emergency medical services, in-patient and out-patient services, criminal justice services and housing programs and support mobile crisis teams in the field, clients' homes and other locations.
- All crisis systems apply state-of-the-art telehealth technologies to maximize effectiveness of interventions in all settings.
    - » Crisis programs have appropriate space to conduct telehealth evaluations and videoconferencing consisting of a room or private area where personal information can be exchanged without violating privacy and complying with HIPAA regulations.
    - » Properly encrypted videoconferencing technology with a business associate agreement in order to remain HIPAA-compliant, including tablet-based technology that can be carried in the field by mobile crisis workers and law enforcement CIT teams.
    - » On-site technical assistance staff trained in troubleshooting the technology are available as needed to assist with client access.
- There are procedures for connecting clients evaluated through telehealth to urgent in-person medical or psychiatric evaluation when indicated.

- If a client being seen through telehealth becomes acutely distressed and in need of medical emergency services, there are other clinicians or staff available onsite to facilitate the transfer of care.
- Clinicians, ideally a registered nurse (RN) or licensed practical nurse (LPN), are available to assist in the onsite initiation of medical treatment prescribed by a telemedicine or telepsychiatry provider. The medical backup for telehealth crisis intervention can be a primary care physician, nurse practitioner, psychiatrist or other health care provider depending on state licensure and scope of practice regulations.

- Telehealth should be a routine feature of connecting crisis workers and other resources in the community and can be used by multiple participants at one time. Clinicians, family members, peers, social supports, housing and other resource or service providers can potentially conduct a team meeting with or without the client present.
  - Clinical meetings can be managed with members of the team remotely.
  - Clinical assessment can be done in the field with remote access, where first responders are linked to the crisis assessment center through telehealth.

Telepsychiatry can be a valuable tool for creating state of the art crisis systems in rural areas.

For over 10 years, Burke, the local mental health authority in Lufkin, Texas, serving a 12-county rural area in East Texas, has operated Burke's Mental Health Emergency Center (MHEC), a ground-breaking program that has significantly improved crisis mental health services in East Texas while serving as an award-winning model for other regions throughout the state.

Burke's MHEC was the nation's first rural freestanding comprehensive psychiatric emergency service and the first to depend entirely on telemedicine for psychiatric care. MHEC performs emergency psychiatric evaluations of individuals who are both voluntary and involuntary, and also offers short-term residential crisis services. Before the MHEC was established, people in mental health crisis often waited for extended periods in hospital emergency rooms - or sometimes in jails. With the MHEC, access to care is available locally with follow-up services scheduled as needed. Since it opened, MHEC has served over 11,000 people.

MHEC came about through the hard work of many stakeholders. The T.L.L. Temple Foundation donated the land and funded construction of the MHEC facility. The Stephen F. Austin School of Social Work has been an incubator of ideas. They initiated the work that became the Rural East Texas Health Network, an organization made up of county officials, judges, law enforcement, health care providers, and hospital administrators who work together in each county to coordinate and improve mental health crisis services. (from Burke website, accessed on November 18, 2020: https://myburke.org/burkes-mental-health-emergency-center-celebrates-10th-anniversary/

STAFFING CAPACITY

In an ideal crisis system, it is critical to have adequate staff capacity, in terms of numbers, credentialing, background and expertise. This section focuses on the standards for staffing capacity.

ADEQUATE INTERDISCIPLINARY MULTIDISCIPLINARY TEAM STAFFING

The staff composition of an ideal crisis continuum, and each program within the continuum, must reflect the volume of service provided and the variety of crisis needs of the community it serves. To do that, adequate numbers of staff and an interdisciplinary team of staff are required. With regard to adequate numbers of staff, precise staffing patterns will vary based on the type of program and level of service intensity provided. Discussion of exact staffing ratios for each component is beyond the scope of this paper; however, if too few staff are present, the program will not function properly and more individuals will need to be served at a higher level than might otherwise be the case.

It is helpful to discuss the importance of adequate staffing for the crisis center itself. Using the projected volume figures from the program in Phoenix, Arizona (see "How Does Your Crisis System Flow?"), crisis center staffing can be planned based on the expected crisis flow. For example, in a catchment area with 250,000 people, the expected number of crisis presentations is 500 per month (17 per day, averaging six per shift). Therefore, the capacity of front-line crisis workers needs to be able to address six crises on average with plans for routine surge capacity so the system does not get backlogged. Assuming that each individual in crisis will require three hours of intervention on average, with some requiring individual attention, it is clear that each shift needs to be planned to have no less than 24 person-hours of front-line staff availability (or at least three full-time staff members' time). Similar calculations should be applied to the whole crisis system, so that crisis response is not constantly understaffed resulting in dangerous delays for both clients and first responders.

With regard to the composition of staff teams, multiple types of expertise are required and the ability to work as an interdisciplinary team to flexibly respond to individual needs, not as parallel separate individual disciplines in separate silos. The staff must be able to collaborate easily to triage effectively; engage individuals and families who are in crisis; gather information to perform effective clinical assessment from individuals, families and other collaterals; provide urgent treatment; and assist individuals and families in crisis transition to the proper level of ongoing care. For a crisis team to work efficiently, there needs to be contribution from multiple disciplines, and all team members, regardless of discipline, must be sufficiently trained and knowledgeable to carry out their specific tasks while understanding and supporting the unique skills and knowledge of the other team members.

There should be minimal duplication of work and all team members should collaboratively provide care, treatment and education for the clients. The team should function so all team members are co-occurring competent working with people with any combination of mental health and SUD issues and cross-cover and function to support the most highly credentialed team members (e.g., physicians and nursing personnel) to help them practice to the top of their license. For example, all staff can be expected to take pulse and blood pressures, while the nurse interprets the results and makes decisions accordingly.

Measurable Criteria for an Ideal System

The accountable entity ensures that all programs in the crisis continuum have funding to support adequate staffing of an interdisciplinary team. The staffing pattern is calculated using real data for each type of program with planned surge capacity and backup plans to cover absences. Program rates are based on actual staffing cost needs to produce the desired level of service in the context of network access and adequacy and regularly reviewed as part of the system QI plan to look at instances of under- or over-staffing and continually improve. The composition of the interdisciplinary team in the crisis hub/crisis center and in other settings, as appropriate, is designed to meet the following standards:

- **Team composition:** All crisis programs are ideally comprised of an interdisciplinary team with an appropriate range of credentials and expertise. The ideal team is two or more people working cooperatively toward a common goal. Each team should have provision for an appropriately licensed or credentialed clinician (sometimes called qualified mental health professional) to be available on-site or on call to cover each shift, in accordance with the level of care provided. The higher the level of care (the greater the intensity of service provided), the higher the total number of staff per client served and the greater proportion of people with more training and experience. The essential components of a functional team include the correct mix of crisis team members with the client as team co-leader, plus engagement of collaterals such as family, friends and other non-crisis providers of care and services. The team should include capacity to incorporate all the expertise described here. The size of the team and the precise numbers of staff in each category must be commensurate with the level of need and the volume of services provided by the crisis program. The team make-up can change as the individuals' needs change. For example, if the person in crisis has housing needs, a housing specialist or housing intact person may temporarily join the team. There are, however, core team members who are consistently available for continuity, including:
  - **Crisis clinicians:** There are clinicians who are skilled in doing initial triage, crisis assessment, provisional diagnosis, crisis planning and crisis intervention. They are commonly master's level clinicians from any discipline, frequently licensed professional counselors or licensed marriage and family therapists (LMFTs), but in some settings may be bachelor's level crisis clinicians with training and supervision that qualifies them to perform crisis intervention and crisis care management. Clinicians can also begin short-term, crisis focused and motivational treatments.
  - **Psychiatric care providers:** The crisis team has psychiatric care providers available on-site or on call who can initiate medication treatment if needed. These clinicians can be MDs, doctors of osteopathy, advanced practice registered nurses, nurse practitioners (NPs) or physician assistants (PAs), depending on state licensure and regulations, and can distinguish between the need for emergency treatment, urgent treatment and ongoing care.
  - **Nursing:** Nurses are essential to oversee medical screening and evaluation, provide and monitor medications and interface with nursing personnel at referring and receiving programs. Depending on the type and intensity of services, during any shift, nursing may be on-site or on call and may involve RNs or licensed vocational nurses/LPNs. There also needs to be an individual designated as a nursing supervisor, who will be on-site or off-site depending on the number of nursing staff or extent of nursing coverage.
  - **Social worker:** Social workers, LMFTs or other clinicians trained in family engagement can gather historical information, family and social contacts and begin linkage to other services and care in the community.
  - **Substance use disorder clinician:** There are team members who are certified or licensed SUD specialists and/or individuals who have SUD experience. These team members support the ability of all team members to work with individuals with SUD/COD in crisis.
  - **Peer specialists:** Peers are essential team members who specialize in welcoming and engaging clients, helping educate clients about crisis program services and process and facilitating community transitions as community bridges.
- **Clinical and administrative team leadership:** There must be functional mechanisms to ensure successful team operation. A team administrator is also a clinical leader of any discipline (e.g., psychology, social work, psychiatric nursing) who has oversight of the internal operations of the program, including fiscal management, staffing and schedules, reporting and evaluation of services, tracking of outcomes, etc., and coordinates external relationships

with other services. Open and regular communication between team members with clear expectations and accountability is essential. Team members must be accountable for completing their tasks and there must be shared responsibility for risk and outcomes. In the ideal team, all members can Identify and value the unique roles and contributions of other team members and trust them to carry out their roles. It is also important for all team members to actively seek out collaboration with others and to actively contribute to the overall functioning of the team. The team can share essential information through face-to-face meetings, shared medical records and supervision. The team can identify measurable goals and objectives, work collaboratively and not competitively in solving problems and cross-cover to manage immediate clinical and program needs.

    - **Medical director:** The medical director may be on the premises or off-site depending on the type of program and oversees all medical care and consults with the other team members for individuals with complex medical or behavioral health needs. The role of medical director is a certification requirement for CCBHCs.

- **Team diversity:** The team should reflect the ethnic, cultural and linguistic composition of the community served and have access to translators for any anticipated need, including American Sign Language (ASL).

CLINICAL/MEDICAL LEADERSHIP AND SPECIALTY CONSULTATION

In an ideal crisis service system, reliance on the most resource-intensive, costly and restrictive service settings, such as ERs and acute inpatient hospitalization, is minimized. The extent a full array of high-quality clinical and psychiatric services is available within the crisis setting will directly impact the degree to which emergency and inpatient settings may be avoided. Given the importance of the quality of clinical and psychiatric evaluation and intervention in the functioning of not only a crisis center, but the entire crisis continuum, it is critical that experienced clinical leaders (e.g., clinical psychologists, social workers, psychiatric nurses) and psychiatric providers are part of the leadership team in the ongoing design, implementation and oversight of crisis services. Unfortunately, in most crisis systems clinical and psychiatric leadership is not built into the design from the beginning. For this reason, it is especially important to emphasize that this is a necessary component of an ideal behavioral health crisis system, just as medical emergency services are expected to have physician leadership.

In addition to clinical medical leadership (CML) generally, there is a clear need for access to specialty consultation, coordinated by the crisis coordinator and clinical/medical director. In an ideal crisis service system, the continuum of services will respond to diverse populations who may present with varying degrees of frequency. This may include individuals of different ages, with different disabilities (e.g., intellectual and developmental disabilities (I/DD), BI, dementia), different cultural backgrounds and different conditions (e.g., OUD, eating disorders). Because it is impractical to maintain 24/7 on-site availability of expertise in all these diverse populations in all parts of the crisis system, the system needs to have a provision for accessing specialty consultation as needed.

Measurable Criteria for Clinical and Medical Leadership in an Ideal System

The accountable entity incorporates clinical and psychiatric leadership into the design of the crisis continuum. This position may be embedded in the crisis hub, working with the program leader of the crisis center, but ideally has responsibility for the functioning of the crisis continuum, working collaboratively with the crisis coordinator. The credentials and time commitment of the clinical leadership (crisis system clinical director) and psychiatric leadership (usually called the crisis system medical director) may vary depending on the size of the crisis system and usually includes a combination of on-site (or telehealth) clinical and administrative time, plus on-call availability. In some systems, particularly in rural and frontier areas, the lead clinician on-site might be a licensed professional counselor or equivalent master's professional supported by a doctoral level psychologist or more senior master's level clinician, and the lead psychiatric care provider on-site will be a nurse practitioner or physician's assistant supported by a medical director off-site, often by telehealth. In these instances, the crisis coordinator, clinical director (who may also be the crisis coordinator), lead psychiatric care provider and medical director work collaboratively to provide clinical and administrative leadership to the crisis continuum.

In addition, CML should be present throughout the entire continuum of crisis services, as follows:

- **Administrative authority:**
  - Any agency providing behavioral health crisis services should have designated CML with a substantive role in the leadership team. This requires adequate time commitment for administrative leadership, apart from time for direct clinical service. It also requires a meaningful level of authority in the organizational hierarchy.
- **Education, qualifications, expertise and training:**
  - The clinical leader/clinical director should be a licensed mental health clinician, such as a doctoral level psychologist, master's level social worker, master's level psychiatric nurse practitioner (following state regulations regarding scope or similar level of practice) or a psychiatric PA working in a meaningful supervisor relationship with a psychiatrist. The clinical director/clinical leader must have demonstrable clinical training from a recognized and reputable educational program.
  - The clinical medical leader/director should be a psychiatric care provider, either an MD or DO, a psychiatric nurse practitioner (following state regulations regarding independence), or a psychiatric PA working in a meaningful supervisor relationship with a psychiatrist. The medical director must have demonstrable clinical training from a recognized and reputable educational program.
  - The CML should have demonstrable clinical experience with the populations to be served within the crisis setting, including those with serious mental health and substance use disorders and with working in crisis and/or emergency settings.
  - The CML should have demonstrable knowledge of community psychiatry - and systems of care generally - with the expectation of gaining a sophisticated understanding of the local systems of care.
  - The clinical and medical leadership must be appropriately licensed and credentialed in a manner similar to that which occurs in a psychiatric inpatient setting.
- **Essential functions:**
  - Clinical and medical leadership collaborate with each other, administrative leadership, nursing leadership and staff to ensure efficient and effective service delivery.
  - The clinical director oversees the work of all non-medical clinical staff and establishes standards for crisis work, oversees training and competency development and ensures adherence with practice guidelines and protocols.
  - The clinical medical director oversees the clinical work of all medical, psychiatric and nursing providers to ensure provision of highly competent psychiatric and medical practices.
    - Ensures that all clients receive appropriate evaluation, diagnosis, treatment and screening.
    - Establishes standing orders and treatment protocols for the provision of psychiatric services.
  - Both clinical and medical leadership meaningfully participate in multidisciplinary team processes to ensure quality outcomes and standards of care are met.
  - Meaningfully participate in quality assurance and improvement processes directed at key outcomes.
  - Uphold and model the mission, vision and values of the organization in all interactions.
  - Provide leadership in engaging challenging systems, families and clients.
  - Comply with all relevant regulations, policies and procedures.
    - Follow and comply with all local, state and federal regulations, laws and standards.
    - Collaborate with administrative leadership to ensure appropriate medical records are maintained as required by regulations, internal policies and procedures, etc.
    - Play a leadership role in how personal health information (PHI) is managed that is consistent with state and federal guidelines while minimizing barriers to optimal care.

» Meaningfully participate in identifying needed training and ongoing education for all licensed and unlicensed clinical, medical, psychiatric and nursing staff to meet position competency.

Measurable Standards for Specialty Consultation in an Ideal Crisis System

The accountable entity must ensure that the crisis hub provider has a clear mechanism for funding and arranging both emergent and urgent access as needed to specialty assistance with populations with unique needs that may not be met by the staff available on-site. This access to specialty assistance should be available to all crisis providers in the continuum.

At minimum, the following areas of specialization should be available:

- Child and adolescent.
- Geriatric.
- I/DD and BI.
- Cultural and linguistic minorities, immigrants/refugees.
- MAT for opium use disorder (OUD).
- Eating disorders.
- Forensic.

In many systems the full array of specialists may not be available in each local community, county or region and may only be available through a consultation network provided at the state level, sometimes with an academic partner that is accessible to each community crisis system as needed.

PEER SUPPORT

Although peer support is considered part of the composition of multidisciplinary team staffing for crisis services, it is essential to emphasize the importance of peer services. The participation of peer specialists (both certified mental health peer specialists and SUD recovery peer specialists, often called recovery coaches) across the continuum of care must include the expertise of people with lived experience in every program. Peer support services and staffing are certification requirements for CCBHCs.

Direct peer involvement in behavioral health treatment grew from the mental health civil rights movement of the 1980s. Peer participation in all aspects of behavioral health care hinges on the value of lived experience in providing care. In crisis intervention, peer providers who have "been there" offer an invaluable perspective to consumers, families and providers that can significantly enhance engagement, hope and safety. In the rapidly proliferating emergency service initiatives to engage individuals with SUD, especially in the context of opioid overdose and peer providers (and especially those with lived experience of MAT), offer direct intervention for individuals in crisis because of addiction, offering counseling and immediately linking consumers to treatment services, including facilitating agreement for immediate initiation of MAT.

There is extensive literature on peer involvement in providing behavioral health services. Peer involvement has, for example, been the standard of care on assertive community treatment teams since prior to the establishment of the Dartmouth Assertive Community Treatment Scale in 1998. Peer involvement is recommended by the Schizophrenia Patient Outcomes Research Team and SAMHSA.

Further, consumer peer input is essential to developing an ideal crisis system and system of care and peer/providers partnerships are key to the ongoing evolution of care.

In addition to providing direct services, direct peer involvement should be present on the community's crisis collaborative and peers should be active in providing advocacy, education and support.

Measurable Criteria for an Ideal System

The accountable entity should purposefully work with community stakeholders to include identification, training and employment of certified peer specialists, including recovery coaches and family partners for children in crisis, throughout the crisis continuum, including participation in the community crisis collaborative.

- **Supervision and training:** There should also be provision in the crisis continuum for supervision of peer support staff, ideally by other peer supporters with more training and experience, as well as provision of peer support training in crisis work and continuing education.
- **Roles for peers that should be included in the planning and design.** The accountable entity should seek to include peers in each of these areas and to have a metric for continuous improvement of peer involvement in all areas as part of its overall QAPI plan.

Before the crisis

- Peer involvement with community education (including sharing personal narratives), education to law enforcement and providers.
- Peer involvement in interventions designed to prevent or mitigate crisis, such as warmlines.
- Peer crisis counseling programs in settings, such as high schools and colleges.

At the time of the crisis

- Peer team members in crisis centers, mobile crisis teams and emergency departments, including in implementation of Screening, Brief Intervention and Referral to Treatment and engagement of individuals with opioid overdose or frequent visits for alcohol use.
- Peer navigators in inpatient, crisis residential settings and intensive outpatient services who can advocate for consumers and assist consumers and families in maneuvering through the system.
- Peer respite programs and Living Room programs, as described earlier.

As the crisis resolves

- Peer specialists who can bridge between inpatient/acute and outpatient settings, facilitate linkages and support engagement.
- Peer specialists as treatment providers/full members of treatment teams (e.g., peer specialists on crisis intervention teams for youth or adults who have caseloads, provide services, work with clients around creation of Wellness Recovery Action Plans [WRAP]).
- Peer-run clubhouse model programs, which can provide a social context for rapid support as a crisis is resolving.
- Peer-led recovery-based educational and support programs separate from - but working in concert with - the behavioral health system.

IN THE STORY OF MR. Y: Peer support for Mr. Y at almost any point in his behavioral health crisis would have been extremely helpful. Someone with lived experience might have been able to build trust and provide Mr. Y with reassurance and an enhanced sense of safety early in the crisis and helped him navigate the system and begin mapping his recovery plan as he progressed.

REPORT CARD

Introduction and Purpose of the Report Card

This instrument is designed to provide a process to assist communities working on enhancing their crisis system to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.

Scoring the Report Card

All items are scored on a 1 – 5 scale. The scale reflects a complete continuum ranging from non-existent/not started in our community through fully implemented and functioning well.

Anchors

These may be useful in assigning a score on individual items:

1. Not started and/or not on our radar and/or If interest does exist in moving on this, barriers seen as too overwhelming to make it worthwhile to put any energy into moving forward.
2. At least some awareness of this as a desirable goal within our system, and/or initial efforts to explore implementation, but no actual movement or specific plans yet.
3. Active steps that are beginning the process toward implementation; early stages of implementation.
4. Active steps being taken toward full implementation, but still incomplete, with intent to implement further.
5. Implemented in our system in a manner that is functioning well.

Tips on Scoring and Using This Report Card

Keep in mind this is not an exact science; Not all items will fit neatly with the specific anchors suggested above. In general, **if you find yourself between two scores (which will happen commonly) choose the lower score.** This may prompt you to set the higher score as a short or intermediate term goal.

Also remember that there is neither a "perfect score" for the instrument as a whole or a "right answer" for individual items. The goal is to ensure that stakeholders are aware of each of the specific aspects or ingredients of an ideal crisis system and have a common language and a process by which to discuss and assess where their community is at with regard to each of these. Hopefully, this can be used to assist in goal setting (short-, medium- and long-term) and prioritization.

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION I: ACCOUNTABILITY AND FINANCE			
1A	Accountable entity identified and established.		
1B	Behavioral health crisis system coordinator identified.		
1C	Community behavioral health crisis system collaborative meets.		
1D	All services are accountable for system values.		
1E	Multiple payers contribute to financing services and capacity in the continuum.		
1F	Accountable entity coordinates financing.		
1G	Financing is adequate for population need.		
1H	Everyone is eligible, regardless of insurance.		
1I	The crisis continuum meets standards for capacity and geographic access for the population.		
1J	Quality metrics are established and measured for each service and the crisis continuum as a whole.		
1K	Data is collected and used collaboratively for customer oriented continuous improvement.		
1L	Provider contracts include incentives for performance in line with values and metrics.		
1M	System metrics include attention to how clients flow through the continuum timely/successfully.		
1N	The crisis system has data and capability to keep track of client progress through the continuum.		
1O	Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved.		
1P	Consistent level of care determination and utilization management criteria throughout the system.		
1Q	All services in the crisis system function as safety-net support partners for behavioral health system programs.		
1R	Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).		
1S	Standards define how community systems work collaboratively with the behavioral health crisis system.		
	Section I Total:	/ 95 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there

4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITY AND SERVICES			
2A	Safe, welcoming, values-based services throughout the continuum.		
2B	Services address the continuum of crisis experience from pre-crisis to post-crisis.		
2C	Spaces and security practices are safe, warm, welcoming, therapeutic.		
2D	Families and collaterals are partners/customers.		
2E	First responders are priority customers		
2F	The service continuum responds to all ages		
2G	Continuum of capacity for people with co-occurring needs: mental health/substance use disorder (MH/SUD), behavioral health/ intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).		
2H	Cultural/linguistic/immigrant capacity.		
2I	Continuum of services described operationally.		
2J	Capacity for seamless flow and continuity of care.		
2K	Client information sharing thru the continuum.		
2L	Clients are kept track of through the continuum.		
2M	Family/collateral outreach and engagement.		
2N	Outreach/consultation with community providers.		
2O	Telehealth utilized effectively throughout the continuum.		
2P	Crisis hub secure access and urgent care center(s).		
2Q	Crisis call/text/chat center (911/non-911).		
2R	Crisis-trained first responders deployed.		
2S	Available, low barrier, medical screening/triage.		
2T	Mobile crisis for all ages, to homes, schools, etc.		
2U	23-hour observation.		
2V	Residential crisis services: high and low medical.		
2W	Peer respite/Living Rooms.		

2X	Detox and sobering support center capacities.		
2Y	Psychiatrically capable emergency room services.		
2Z	Psychiatric inpatient capacity: all ages, both general units and specialized units.		
2AA	Continuity of crisis intervention: home and office.		
2BB	Emergency and non-emergency transport.		
2CC	Adequately staffed multidisciplinary teams in all settings.		
2DD	Clinical, nursing, medical leadership.		
2EE	Access to specialty consultation.		
2FF	Peer support throughout the continuum.		
	Section II Total:	/ 160 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there

4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION III: BASIC CLINICAL PRACTICE			
3A	Crisis system framework for practice improvement and competency development.		
3B	Universal competencies: welcoming, hopeful, safe, trauma-informed, culturally affirming.		
3C	Engaging families and other natural supports.		
3D	Competency in information sharing.		
3E	Using crisis plans and advance directives.		
3F	Basic core competencies for call center staff and first responders.		
3G	Basic core competencies for behavioral health crisis staff.		
3H	No force first: maximizing trust and minimizing restraint.		
3I	Suicide risk screening and intervention.		
3J	Violence risk screening/threat assessment.		
3K	Medical triage and screening.		
3L	Substance use disorder triage and screening.		
3M	Application of civil commitment (inpatient/output).		
3N	Practice guidelines: multidisciplinary crisis teamwork, including role of peers.		
3O	Practice guidelines: non-medical crisis intervention.		
3P	Practice guidelines: crisis psychopharmacology.		
3Q	Practice guidelines: co-occurring substance use disorder/ medication-assisted treatment startup.		
3R	Practice guidelines: co-occurring medical illness.		
3S	Practice guidelines for youth/families/guardians.		
3T	Practice guidelines for older adults/caregivers.		
3U	Practice guidelines for cognitive disabilities.		
3V	Workflows within the crisis continuum.		
3W	Post-crisis continuity, critical time intervention.		
3X	Pre-/post-crisis planning with community providers.		
3Y	Coordination of Care with Community Systems		
	Section III Total:	/ 125 (total points possible)	
	Grand Total:	/ 380 (total points possible)	

NATIONAL COUNCIL *for* Mental Wellbeing

TheNationalCouncil.org

First Name	Last name	Goal Priority	Goal
Jeffrey	Arlt	1	Create a vision and mission statement (Roadmap Exec summary page18)
Jeffrey	Arlt	2	Develop an implementation plan
Jeffrey	Arlt	3	Disseminate this report as a guiding document

District (1-5)	Service	Name	Address	City/CDP	Zip
5	Housing	Santa Cruz County Veterans Village	Jaye's Timberlane Resort Hwy 9	Ben Lomond	95005
5	Fire	Cal Fire	6059 Hwy 9	Felton	95018
5	Fire	Felton Fire Protection District	131 Kirby St	Felton	95018
5	Fire	Boulder Creek Fire Protection District		Boulder Creek	95006
5	Ambulance	AMR - AMERICAN MEDICAL RESPONSE	10 Victor Square	Scotts Valley	95066
5	Law Enforceme	Scotts Valley Police	1 Civic Center Drive	Scotts Valley	95066
5	Law Enforceme	Boulder Creek Sheriff's Service Center	13210 Central Avenue (State Route Hwy 9)	Boulder Creek	95006
5	Law Enforceme	San Lorenzo Valley Sheriff's Service Center	6062 Graham Hill Rd., Suite A & B	Felton	95018
5	Medical	Santa Cruz Community Health	9500 Central Ave	Ben Lomond	95005
5	Counseling	Mountain Community Resources	6134 Highway 9	Felton	95018
5	Counseling	Hospice of Santa Cruz County	940 DISC DRIVE	Scotts Valley	95066
5	Counseling	Shine a Light Counseling Center	315 Los Gatos Saratoga Rd., Los Gatos, CA 95030.		
5	Housing	Santa Cruz County Homeless Persons Health Project	115-A Coral Street	Santa Cruz	95060
5	Medical	Central California Alliance for Health	1600 Green Hills Road Scotts Valley, CA	Scotts Valley	95066