Alameda County Behavioral Health

Mobile Crisis Assessment: Findings Report

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Introduction

In late 2023, Alameda County, Disability Rights California, and the United States Department of Justice entered into a settlement agreement addressing the provision of community behavioral health services in the County. The settlement agreement includes provisions designed to assess the need for Full Service Partnership (FSP) and mobile crisis services in order to inform the County's program development and expansion efforts. Alameda County Behavioral Health Services (ACBH) contracted with the Indigo Project (Indigo) to conduct the Mobile Crisis assessment.

ACBH provides a full range of behavioral health services, ranging from crisis services through outpatient, residential, and inpatient programs to address mental health, substance use, and co-occurring disorders. Through a partnership with the Office of Homeless Care and Coordination (OHCC), ACBH also funds a range of housing options for people with behavioral health issues.

This assessment focuses on mobile crisis services, specifically on the needs and gaps in mobile crisis coverage. **The assessment is designed to determine the amount and number of mobile crisis teams needed to provide on a county-wide basis mobile crisis services** that: (1) provide timely in-person[1] response to resolve crises as appropriate; and (2) are provided with the purposes of reducing, interactions with law enforcement and 5150 and John George Psychiatric Emergency Services (PES) placement rates, to the greatest extent possible, and increasing the use of voluntary community-based services.

This assessment was informed by necessary data and information sufficient to assess the need for crisis services, as well as community and stakeholder input. The assessment results in an estimate of the amount and number of mobile crisis teams needed to provide timely, in-person mobile crisis coverage county-wide. During the assessment process, the County had already planned and began to implement mobile crisis expansion. These planned and new mobile crisis teams are not reflected in the data presented in this assessment as they were not yet operational. As a result of this mobile crisis capacity expansion, it appears that the County has already created the mobile crisis capacity that is identified in this assessment.

This assessment does not include any evaluation of existing mobile crisis programs and therefore does not assess quality and outcomes of existing mobile crisis programs. While this assessment does use local service utilization data from mobile crisis programs, other crisis services, and hospital emergency department admissions, this assessment does not include any assessment or evaluation of the capacity or quality of any other crisis programs that individuals may access—including mobile crisis programs operated by City-departments, hospitals, and other crisis services.

[1] When clinically appropriate, such services may also be provided through the use of telehealth.

Background Information

Internationally, mental health-related crises represent a large proportion of emergency service calls.[2] Providing crisis services in the community wherever they are and whenever they are needed enables people with behavioral health conditions to live and be served within their communities. The California Department of Health Care Services (DHCS) submitted an amendment to the Medicaid state plan in 2023 to add mobile crisis services as a benefit to Medi-Cal beneficiaries. The intention of the state plan amendment is to access federal funds to support the expansion of mobile crisis coverage. DHCS defined mobile crisis services as:

> *Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health or substance use-related crisis wherever they are, including at home, work, school, or in the community. Mobile crisis services are provided by a multidisciplinary team of trained behavioral health professionals. Mobile crisis services provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations and law enforcement involvement. The mobile crisis services benefit will ensure that Medi-Cal beneficiaries have access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year*.[3]

The purpose of mobile crisis services is to provide timely, in-person response to an individual or family experiencing crisis in order to reduce avoidable emergency department, psychiatric emergency department, and hospital utilization as well as increase connection to ongoing behavioral health services. Mobile crisis services are also intended to minimize law enforcement contact and time spent on crisis calls, where possible. There are multiple mobile crisis models in practice across the nation, including police-led interventions, co-responder interventions, and interventions that do not include law enforcement. Alameda County operates the following three models:

- Mobile Evaluation Teams (MET) that pair a mental health clinician with a police officer,
- Mobile Crisis Teams (MCT) with a team of two clinicians that may respond independently to a crisis or in partnership with law enforcement, and
- Crisis Assessment and Transport Teams (CATT) that pair a mental health clinician with an Emergency Medical Technician.

[2] CAMH (2020). Mental health and criminal justice policy framework. https://www.camh.ca/-/media/files/pdfs---public- policy-submissions/camh-cj-framework-2020-pdf.pdf
[3] https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0043-Approval.pdf

Additionally, many cities within Alameda County operate their own mobile crisis programs, some of which are in partnership with their local police department and some of which operate independent of their law enforcement agency.

Within the myriad mobile crisis models that exist nationally and in Alameda County, there is tremendous variability in terms of structure, staffing, and approach. As a result, there is minimal evidence about which model may be the most effective, although collectively, evidence suggests that mobile crisis interventions are generally effective at reducing unnecessary emergency and psychiatric emergency services and hospitalization as well as increasing connection to care during the mobile crisis intervention.[4]

The outcomes following a mobile crisis intervention have also been explored. Mobile crisis services are associated with reduced post-crisis hospitalization, meaning that people who receive community-based mobile crisis services are less likely to be hospitalized in the 30 days following a crisis than their peers who received a hospital-based crisis intervention.[5] Mobile crisis services are also associated with increased service engagement post-crisis. Specifically, consumers who receive mobile crisis services are 17% more likely to participate in community-based behavioral health services in the 90 days following a crisis event. Among individuals with no prior mental health service use, mobile crisis intervention consumers are almost 50% more likely to participate in community-based behavioral health services than those who receive a hospital-based intervention.[6]

Mobile crisis teams are an important component to providing community-based mental health services for individuals who may otherwise be at risk of hospitalization and/or incarceration as a result of their behavioral health issues. They function as a part of a larger behavioral health service system as well as a larger emergency response system that includes dispatch, fire, emergency medical, and law enforcement.

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[4] Center for Police Research and Policy. (2021). Assessing the Impact of Mobile Crisis Teams: A Review of Research. University of Cincinnati. Retrieved May 10, 2024, from https://www.informedpoliceresponses.com/_files/ugd/313296_8d01cdc7187a489893197f2d07300ee6.pdf

[5] Guo, Shenyang & Biegel, David & Johnsen, Jeffrey & Dyches, Hayne. (2001). Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. Psychiatric services (Washington, D.C.). 52. 223-228. Retrieved May 10, 2024, from https://pubmed.ncbi.nlm.nih.gov/11157123/.

[6] Dyches, H., Biegel, D. E., Johnsen, J. A., Guo, S., & Min, M. O. (2002). The Impact of Mobile Crisis Services on the Use of Community-Based Mental Health Services. Research on Social Work Practice, 12(6), 731-751.Retrevied May 10, 2024, from https://doi.org/10.1177/104973102237470.

Assessment Methodology

The primary question that guided this assessment was:

> What is the amount and number of mobile crisis teams needed to provide on a county-wide basis mobile crisis services that (1) provide timely and effective in-person[7] responses to resolve crises as appropriate; and (2) are provided with the purposes of reducing interactions with law enforcement and 5150 and John George Psychiatric Emergency Services (PES) placement rates, to the greatest extent possible, and increasing the use of voluntary community-based services?

To further guide the assessment process and analysis, Indigo developed more targeted research questions. Table 1 outlines the research questions that were addressed through quantitative and qualitative methods.

The assessment includes a mixed methods analysis that leverages: 1) demographic and service data about individuals who receive mobile crisis and other crisis services, 2) program information about the existing mobile crisis programs in the County, and 3) community and stakeholder input. The assessment culminates in an estimate of the number of mobile crisis teams needed as well as guidance about where and when coverage may be needed in order to provide 24/7 mobile crisis coverage that ensures all people living in Alameda County have access to timely mobile crisis services. Greater detail is provided in the following sections about the specific methods and data gathered to address the research questions.

[7] When clinically appropriate, such services may also be provided through the use of telehealth.

Table 1. Mobile Crisis Assessment Research Questions

Research Question	Sub-Questions to be answered with Qualitative & Quantitative Methods	Data Sources
What is the current state of mobile crisis response in Alameda County?	• **What mobile crisis teams are operating in Alameda County?** • **What and how many calls are mobile crisis teams responding to?**	• FY21-24 ACBH Mobile Crisis Response Data • FY23-24 City Mobile Crisis Response Data • FY21-24 ACBH Crisis Program Data • FY23-24 Hospital Emergency Department Data via ACBH Data Warehouse • FY22-23 Crisis Line Data from Crisis Support Services of Alameda County (CSS) • Interviews with ACBH Mobile Crisis & CATT Leadership • Interviews with City Mobile Crisis Team Program Managers & Staff • Interview with Crisis Support Services of Alameda County Leadership • Discussion with Subject Matter Expert Stakeholder Group
What is the need for mobile crisis services in Alameda County?	• **What is the total number of known crisis interventions in Alameda County?** • **What proportion of known crisis interventions were responded to by mobile crisis teams?** • **How many additional mobile crisis teams are needed to meet mobile crisis needs in Alameda County?**	

How can Alameda County meet the mobile crisis need?	• **Where are there gaps in mobile crisis coverage and utilization?**
	  ○ **What time of day are mobile crisis services needed?**
	  ○ **Where in the County are mobile crisis teams needed?**
	  ○ **Who is not receiving mobile crisis services?**	

Assessment Analytic Approach

The figure below summarizes the analytic approach and process to address the assessment question and determine the County's mobile crisis needs. More detailed information about each phase of the assessment is provided below.

Figure 1. Mobile Crisis Assessment Analytic Approach

Describe Current State of Mobile Crisis: In order to describe the current mobile crisis program, the assessment team gathered data from the ACBH Crisis System of Care and City-operated mobile crisis teams about the current mobile crisis programs. This includes service utilization data about mobile crisis services such as the time of day of encounters, locations of service, and service dispositions—including placement of psychiatric holds and transportation to other crisis receiving centers. We also conducted interviews with leadership and staff from mobile crisis programs to gather information about programs models, types of calls teams respond to, call duration, staffing, and hours of service.

Estimate Need for Mobile Crisis: The assessment then estimated the total need for mobile crisis services. In order to capture unmet need for mobile crisis services, the assessment first quantified the total number of crises known to the County, regardless of whether there was a mobile crisis intervention. This includes the sum of all known admissions to crisis receiving centers—including Psychiatric Emergency Services, Crisis Stabilization Units, Sobering Center, Medical Emergency Departments for a mental health-related episode—as well as telephone interventions provided by Crisis Support Services of Alameda County.

According to the Recovery International Crisis Now Calculator, 32% of mental health crises are appropriate for mobile crisis intervention.[8] This proportion based on the mobile crisis interventions in jurisdictions nationwide. To estimate unmet need for mobile crisis services, Indigo calculated the proportion of known crisis interventions in Alameda County that were responded to by all mobile crisis response teams and compared this to the national average (32%). We then determined if and how many additional mobile crisis teams would be needed to meet the expected

[8] Crisis Now: Transforming Crisis Services. Crisis Now Crisis System Calculator. Retrieved May 10, 2024, from https://crisisnow.com/tools/

mobile crisis intervention benchmark (i.e., 32% of all crisis events responded to with mobile crisis intervention).

Determine Gaps in Mobile Crisis Coverage: To explore how ACBH may address the mobile crisis need, we explored patterns of crisis events and utilization that would identify gaps in current mobile crisis coverage, including identifying geographic and temporal gaps in coverage by comparing and triangulating operating hours of existing mobile crisis teams, geographic reach of mobile crisis teams, and time and location of known mobile crisis episodes compared to crisis receiving center admissions and/or crisis hotline calls. The assessment also explored differences in demographic characteristics of individuals who receive mobile crisis services compared to individuals who access other crisis services.

Feedback from Subject Matter Experts: The preliminary results of the assessment were shared with a group of subject matter experts (SME), including mobile crisis and other crisis service providers, first responders, and people with lived experience of mental health crisis and mobile crisis services. The discussion with the SMEs served to refine estimates for mobile crisis services and provide additional context and feedback about assessment findings.

Data Sources & Data Elements

Crisis Now Model: Crisis Resource Calculator

In 2017, Recovery International developed a Crisis Need Calculator to help jurisdictions plan and develop their crisis systems. The Crisis Need Calculator is a nationally recognized tool that is used to help estimate:

1. Optimal allocation of crisis system resources,
2. Associated healthcare costs, and
3. Shifts in costs and benefits based on incorporating specific Crisis Now elements such as high-tech crisis call centers, 24/7 mobile crisis response, and crisis stabilization programs.

This Crisis Resource Need Calculator suggests that nationally, on average, mobile crisis should respond to 32% of all known crisis episodes in a county. [9]

[9] Crisis Now: Transforming Crisis Services. Crisis Now Crisis System Calculator. Retrieved May 10, 2024, from https://crisisnow.com/tools/

Quantitative Data

The quantitative data sources and specific data elements obtained for the assessment are summarized below.

FY21-24 ACBH Mobile Crisis Data: Indigo worked with the ACBH Data Services Team to obtain aggregate data regarding ACBH and CATT mobile crisis services from the ACBH electronic health record system and ACBH Mobile Crisis Contact Tracking Log. For all ACBH-operated/contracted mobile crisis teams, we obtained data regarding call volume, placement of psychiatric holds (i.e., 5150 or 5585 psychiatric hold), and demographic characteristics of individuals receiving mobile crisis services—including age (adults ages 18+ and minors younger than 18), gender, race/ethnicity, language, and region of residence. For CATT, additional information about crisis episodes was obtained via the Alameda County Emergency Medical Services electronic health record system—including call time of day, location of calls, and transport destination. To the extent possible, we examined data over the last three fiscal years (FY21-24) in order to assess changes and trends in crisis service utilization over time.

FY23-24 City Mobile Crisis Team Data: Indigo worked with each City mobile crisis team to obtain aggregate data regarding volume of mobile crisis calls and placement of psychiatric hold. Data were requested only for FY23-24 as several City-operated programs began operations fairly recently (within the last one to two years).

FY21-24 Crisis Receiving Center Data: Indigo worked with the ACBH Data Services Team to obtain aggregate data regarding admissions to crisis receiving centers in Alameda County, including—John George Psychiatric Emergency Services (PES), Amber House Crisis Stabilization Unit (CSU), Telecare Adolescent CSU, Willow Rock Psychiatric Health Facility (PHF), and Cherry Hill Sobering Center. Available data included number of admissions and demographic characteristics of individuals. To the extent possible, we examined data over the last three fiscal years (FY21-24) in order to assess changes and trends in crisis admissions over time.

FY23-24 Hospital Emergency Department (ED) Data: Indigo worked with the ACBH Data Services Team to obtain aggregate data via the ACBH Data Warehouse regarding admissions to EDs for mental health-related crises—including number of admissions, time of day of admissions, and demographic characteristics of individuals admitted to the ED. ED data were unavailable for some EDs—including Children's Hospital and Alta Bates Herrick Campus. Additionally, all ED data unavailable prior to FY23-24.

FY22-23 Crisis Support Services of Alameda County Crisis Call Data: Indigo worked with Crisis Support Services of Alameda County to obtain de-identified crisis hotline call log data—including time of the call, type of call, suicide risk level, and referrals and emergency procedures. We examined FY22-23 call data as the FY23-24 data were not yet available at the time of data collection.

Qualitative Data

During the assessment, the Indigo team conducted 9 interviews with the County and City mobile crisis team leadership and staff, including:

- ACBH Director of Crisis Services;
- ACBH Mobile Crisis Program Manager;
- CATT Program Managers from Alameda County Emergency Medical Services, Bonita House, and Falck
- Program Managers and/or Staff from City Mobile Crisis Teams including—Alameda, Berkeley, Fremont, Livermore, Oakland, and Pleasanton

During these interviews, we discussed the mobile response team models, including hours of operation, staffing and response models, the types and quantity of calls they respond to, call duration, and how they coordinate with other mobile crisis teams and/or crisis services. As part of these conversations, we also discussed quantitative data availability regarding mobile crisis service utilization.

We also conducted an interview with leadership from Crisis Support Services of Alameda County, including the Executive Director, Crisis Services Director, and Crisis Line Program Manager. During this interview we discussed the volume and types of crisis calls they are receiving and through what hotlines, what their crisis intervention entails, what types of calls would be appropriate for mobile crisis intervention, and the extent to which calls are forwarded for mobile crisis or other emergency intervention. We also discussed quantitative data availability and potential limitations.

Subject Matter Expert Group

Indigo convened a diverse group of local subject matter experts to provide feedback on the analytic decisions used to determine mobile crisis need as well as validate and refine assessment findings. The subject matter expert group included one or more representatives from the following groups:

- ACBH Crisis Services & Mobile Crisis Teams
- Alameda County Emergency Medical Services
- Berkeley Mental Health – Crisis Services
- Mobile Assistance Community Responders of Oakland (MACRO)
- Bay Area Community Services – Crisis Programs
- John George Psychiatric Hospital & Psychiatric Emergency Services
- Washington Hospital
- Cherry Hill Sobering Center and Detox
- Crisis Support Services of Alameda County
- Oakland Police Department
- ACBH Office of Peer Support Services
- ACBH Office of Health Equity

Data Limitations and Methodology Adjustments

During the assessment process, Indigo encountered some data limitations and also made minor methodology adjustments in response to emerging data trends and data availability. Key data limitations are described below. Data limitations are also noted throughout the report where relevant.

Notably, some quantitative data was not available or had quality concerns. For most crisis teams, data were unavailable about the time of day, response time, service duration, call location, and transport destinations. In some cases, these data are not tracked in a standardized way, or there were data accuracy issues as staff do not always enter these data elements in real-time. However, data for the CATT program was more complete as CATT is requested through the Alameda County Regional Emergency Communications Center which tracks more call information. CATT data was therefore used a proxy to describe ACBH mobile crisis calls when other ACBH mobile crisis data was unavailable. To help address gaps in mobile crisis data availability, Indigo also conducted interviews with mobile crisis teams to qualitatively assess information such as the time of day, locations, and duration of calls.

Additionally, City mobile crisis teams utilize different data systems from the County and from one another, resulting in inconsistencies across data elements and data format. City mobile crisis data is also outside of the purview of ACBH, making it more difficult to obtain to some data elements. We initially requested information about the volume of mobile crisis encounters, time of day, encounter dispositions, and demographic information; however, this information was not available across all programs. In order to standardize data elements across City mobile crisis teams, we therefore only assessed the volume of mobile crisis calls and the number of calls resulting in a 5150 or 5585 psychiatric hold.

Some requested data were also unavailable for crisis receiving center admissions and crisis hotline calls. Most crisis receiving center admission data included only the admission date, and not time of day. Emergency departments were the exception and included information about the admission time of a day. However, emergency department data was not available for all hospitals in the County—including Children's Hospital and Alta Bates – Herrick campus. As a result, emergency department data is likely underreported. Crisis hotline data was available for a different time period than mobile crisis and crisis receiving center data. At the time of the assessment, crisis hotline crisis hotline data was not yet available for FY23-24 so we examined FY22-23 crisis hotline data. Demographic information was also largely unreported for crisis hotline calls.

Another key data challenge was assessing unmet need for mobile crisis services. One method to assess unmet need for mobile crisis services would be to identify calls that the mobile crisis team did not or could not respond to—including calls that come in outside of operating hours or calls that the team did not have capacity to respond to at the time of the call. However, this data is not standardized as mobile crisis programs have different methods of dispatch, with some using dispatch call centers and others using a direct mobile crisis line or other method for dispatching teams. Most mobile crisis teams and/or dispatch centers do not have a mechanism to track calls

that would have been appropriate for a field-response, but that mobile crisis was unavailable to respond. Mental health-related calls to 911 dispatch and call centers are often coded inconsistently and in several different ways, making it difficult to identify calls way that could have been appropriate for mobile crisis response. 911 dispatch data is also highly protected data outside the purview of ACBH, making it difficult to obtain.

Mobile crisis teams also serve as a diversion from law enforcement or other emergency response, when it is safe and appropriate to do so. If and when mobile crisis teams are unavailable, law enforcement may respond to individuals experiencing mental health crises that may or may not result in incarceration. Similar to 911 dispatch data, jail booking data often has insufficient information to identify individuals who could have been safely and appropriately served by a mobile crisis and is not a reliable data source to identify unmet need for mobile crisis services.

Lastly, some individuals may benefit from mobile crisis services, but have not utilized any crisis services (i.e., mobile crisis or other crisis receiving centers). As these crisis events are “unknown”, it is not possible to account for these crisis events and the total volume of crisis events may be underestimated.

To help address these challenges and assess need for mobile crisis services, Indigo examined admissions to crisis receiving centers that did not involve mobile crisis. To identify whether a mobile crisis team was involved in the admission to a crisis receiving center, Indigo examined dispositions of mobile crisis events, including transport to a crisis receiving center and/or placement of 5150 or 5585 psychiatric hold. In the absence of transport destination data, we used placement of a 5150 or 5585 hold to estimate transports as all individuals placed on a psychiatric hold must go to a crisis receiving center for evaluation. Indigo also examined crisis hotline calls to capture crisis events that may not have resulted in admission to a crisis receiving center or mobile crisis intervention.

Assessment Findings

The following sections present the assessment findings, organized by the research questions outlined in Table 1.

What is the current state of mobile crisis response in Alameda County?

What mobile crisis teams are operating in Alameda County? What and how many calls are mobile crisis teams responding to?

There are several mobile crisis programs operating in Alameda County, including mobile crisis programs overseen by ACBH as well as programs operated by City agencies.

ACBH Mobile Crisis programs: ACBH oversees and/or operates four mobile crisis programs:

1) Community Assessment and Transport Team (CATT),
2) Mobile Crisis Team (MCT),
3) Mobile Evaluation Team (MET), and
4) Hayward Mobile Evaluation Team (HMET).

ACBH operates the MCT, MET, and HMET programs and contracts with Bonita House and Falck to operate the CATT program. The program models are summarized in Table 2 based on program operations as of June 2024.

Table 2. ACBH-Operated and Contracted Mobile Crisis Programs

Mobile Crisis Team	Hours of Operation	Staffing Model	Number of Teams	Region Served
Community Assessment & Transport Team (CATT)	Sun – Wed: 24 hours a day Thurs – Sat: 7am – 11pm	EMT (Falck) & Bonita House Clinician	9	Countywide with 5 staging posts: Oakland, San Leandro, Hayward, Livermore, Fremont
Mobile Crisis Team (MCT)	8am – 6pm Mon – Fri	2 ACBH Clinicians	3	Countywide with 1 team each serving: North County, South County, East County
Mobile Evaluation Team (MET)	8am – 3pm Mon – Thurs	Oakland Police Officer & ACBH Clinician	1	Oakland
Hayward Mobile Evaluation Team (HMET)	8am – 4pm Mon – Fri	Hayward Police Officer & ACBH Clinician	1	Hayward

Although the specific models differ across ACBH mobile crisis programs, all ACBH-operated and contracted teams have at least one mental health clinician at all times and respond to acute mental health crises including evaluation for placement of a 72-hour psychiatric hold (i.e., 5150 hold for adults ages 18 and older or 5585 holds for youth younger than 18). MET and HMET are co-responder models with a mental health clinician paired with a police officer, while CATT and MCT do not include police officers but may respond independently or in partnership with law enforcement.

CATT is the largest program with 9 teams and operates countywide, 7 days a week. CATT operates 24 hours a day Sunday to Wednesday and from 7am-11pm Thursday to Saturday.[10] The MCT, MET, and HMET programs operate on weekdays during typical business hours (from 8am to between 3-6pm). MCT also operates countywide with three teams, with one team each serving a different region—North County, South County, and East County.[11] MET and HMET each have one team and serve specific cities, with MET serving Oakland and HMET serving Hayward.

During the assessment process, the County planned and implemented additional mobile crisis teams, including:

- **ACBH MCT #3:** ACBH implemented an MCT East County team in March 2024. As this is a new team, the team was still ramping up services during the assessment period, and their services were not yet at full capacity. As implementation progresses, ACBH anticipates call volume will increase to full capacity.
- **CATT #9:** In partnership with ACBH, Bonita House and Falck implemented the first overnight CATT team in May 2024, operating Sunday – Wednesday from 7pm-7am. As this is a new team, the team was still ramping up services during the assessment period, and their services were not yet at full capacity. As implementation progresses, ACBH anticipates call volume will increase to full capacity.
- **CATT #10:** In partnership with ACBH, Bonita House and Falck planned to implement the second overnight CATT team in November 2024, operating Wednesday – Sunday 7pm-7am. With the addition of this team, CATT will provide overnight coverage 7 days a week.[12]
- **CATT #11:** In partnership with ACBH, Bonita House and Falck plan to implement an 11th CATT team in 2025. Based on identified mobile crisis coverage gaps, the County may wish to consider operating this team out of CATT's Oakland staging post to provide more coverage in the Oakland area and North County region.

While these teams are not reflected in the subsequent data because they were not yet fully operational, they are or will soon be part of the landscape of crisis services in Alameda County.

[10] The CATT overnight team began providing mobile crisis services in May 2024. The overnight team operates from 7pm – 7am. Prior to overnight coverage, CATT operated 7am-11pm 7 days a week.
[11] ACBH implemented the East County MCT team in March 2024.
[12] In November 2024, ACBH also began a pilot program with Crisis Support Services of Alameda County wherein CATT can be dispatched through the 988 Suicide and Crisis Lifeline on nights and weekends. Moving forward, the County expects to expand 988 dispatch to 24 hours a day, seven days a week.

In FY23-24, ACBH-operated and contracted mobile crisis programs responded to 2,501 crisis episodes (Table 3).[13] CATT responses accounted for half of the ACBH mobile crisis episodes (48%, n=1,189), reflecting the larger number of teams and longer operating hours of CATT compared to other ACBH mobile crisis programs. MCT accounted for 31% of mobile crisis episodes, and the MET and HMET programs each accounted for approximately 10% of mobile crisis episodes.

Table 3. Volume of ACBH Mobile Crisis Episodes in FY2023-24

ACBH Team	FY2023-24 ACBH Mobile Crisis Episodes	
	Episode N	% of Total
CATT	1,189	48%
ACBH MCT	758	31%
ACBH MET	260	10%
ACBH HMET	294	12%
TOTAL EPISODES	**2,501**	**100%**

Data Notes: The MCT East County Team was implemented in March 2024 and the CATT overnight team began in May 2024. Both of these teams were implemented toward the end of the assessment period and were still ramping up services. As a result, these teams responded to very few crisis episodes during the assessment period.

City-Operated Mobile Crisis programs: Many cities within Alameda County operate their own mobile crisis programs in partnership with their local police departments, fire departments, other city agencies, and/or community-based organizations. Table 4 briefly describes the known mobile crisis programs that were operated by City Agencies in Alameda County as of June 2024.

[13] ACBH mobile crisis responses are likely underreported as data were only available for incidents where the individual in crisis was located and opened to a mobile crisis service in the electronic health record. Data were unavailable for calls that were canceled or the individual referred to mobile crisis could not be located. Additionally, the CATT overnight team and MCT East County teams were implemented at the end of the assessment period and were not yet operating at full capacity.

Table 4. City-Operated Mobile Crisis Programs in Alameda County

Mobile Crisis Team	Lead Agency	Hours of Operation	Staffing Model	Region Served
Alameda CARE Team (Community Assessment, Response, and Engagement)	Alameda Fire Department (AFD) & Alameda Family Services (AFS)	24 hours a day 7 days a week	AFD Paramedic & EMT with on-call support from AFS clinician	Alameda (City)
Berkeley Mobile Crisis Team (MCT)	City of Berkeley - Mental Health Division (BMH)	11:30am-10pm Sun - Mon & Wed - Fri	Berkeley Police Officer & BMH Clinician	Berkeley
Berkeley Specialized Care Unit (SCU)	City of Berkeley & Bonita House	Sun - Tue: 24 hours Wed - Sat: 12am-4pm & 8pm-12am	Bonita House EMT, Peer Specialist, & Clinician	Berkeley
Fremont Mobile Evaluation Team (MET)	Fremont Police Department (FPD) & Fremont Human Services	Mon-Thurs: 6am-7pm Fri: 9am-7pm	FPD Sargeant, 2 FPD Officers, Community Service Officer, & Clinician	Fremont
Livermore Mobile Evaluation Team (MET)	Livermore Police Department (LPD)	9am-7pm Mon - Thurs	LPD Officer & LPD Clinician	Livermore
MACRO (Mobile Assistance Community Responders of Oakland)	Oakland Fire Department	6:30am-8:30pm 7 days a week	EMT & Community Intervention Specialist	Oakland
Pleasanton Alternative Response Unit (ARU)	Pleasanton Police Department (PPD) & Bonita House	7am-5pm Mon - Fri	PPD Police Officer & Bonita House Clinician	Pleasanton

Across City-operated programs, there is more variability in the program structure, staffing, and approach than the ACBH-operated and contracted programs. Some programs—Berkeley MCT, Berkeley SCU, Livermore MET, and Pleasanton ARU—have a full-time mental health clinician on each team and respond to higher acuity mental health crises. Berkeley MCT, Livermore MET, and Pleasanton ARU employ a co-responder model with a police officer paired with a mental health clinician.[14] The Berkeley SCU does not involve law enforcement, and each team includes a mental health clinician, EMT, and peer specialist.

Other programs—such as Alameda CARE and Fremont MET—have a mental health clinician available on-call or that may respond to specific calls and requests. The Alameda CARE teams include a paramedic and an EMT who respond to non-behavioral health concerns and less acute mental health needs. However, the program also has a mental health clinician from AFS on-call

[14] At times when the mental health clinician is off-duty, Pleasanton ARU police officers respond to lower acuity mental health crises without the clinician.

24/7 to provide crisis intervention for higher acuity mental health calls and evaluations for 5150 or 5585 psychiatric holds.

The Fremont MET program is composed primarily of FPD officers with specialized training to provide crisis intervention, de-escalation, follow-up and linkage to mental health and homeless services. The team also includes a mental health clinician who provides additional mental health support and evaluation but may not be involved in all Fremont MET requests and services.

The MACRO program does not include a mental health clinician, and each team is composed of an EMT and community intervention specialist. MACRO primarily responds to calls for lower acuity mental health and non-behavioral health concerns, and also provides a high volume of street outreach and linkage to community services and resources.

In FY23-24, City-operated mobile crisis programs responded to a total of 8,816 episodes, 2,808 (32%) of which were higher acuity mental health episodes that involved a mental health clinician (Table 3). Of the 2,808 mobile crisis episodes involving a mental health clinician, Berkeley MCT accounted for the greatest portion of responses (31%, n=863).

Table 5. Volume of City Program Mobile Crisis Episodes in FY2023-24

City Mobile Crisis Team	FY2023-24 City Team Mobile Crisis Episodes	
	Episodes with Clinician	Total Episodes
Alameda CARE	224	523
Berkeley MCT	863	863
Berkeley SCU	500	500
Fremont MET*	Unavailable	1,106
Livermore MET**	650	650
Pleasanton ARU	571	1,016
MACRO	--	4,158
TOTAL EPISODES	**2,808**	**8,816**

Data Notes: *The number of Fremont MET responses for higher acuity mental health calls that involved a mental health clinician were not available. However, only 24 Fremont MET responses in FY23-2024 resulted in placement of a 5150 hold, suggesting most episodes may have been lower acuity. Additionally, as of October 2024, the Fremont MET program no longer includes a mental health clinician.
**Livermore MET began operations on January 25, 2024. As of June 30, 2024, Livermore MET responded to 271 mobile crisis episodes. To estimate the total number of episodes that Livermore MET would respond to in a year, Livermore mobile crisis episodes during the 5-month period from January 25, 2024 – June 30, 2024 were annualized to a 12-month period.

What is the need for mobile crisis services in Alameda County?

To estimate the need for mobile crisis services in Alameda County, Indigo conducted the following analysis:

1) Determined the total number of mobile crisis interventions in Alameda County to estimate the current mobile crisis response,
2) Determined the total number of known crisis interventions in Alameda County in Alameda County to estimate total crisis events,
3) Calculated the proportion of total crisis interventions that were responded to by existing mobile crisis programs and compared this to the national average, and
4) Estimated how many additional mobile crisis teams are needed to address need for mobile crisis response.

Findings for each step of the analysis are summarized in the following sections.

1. What is the total number of mobile crisis interventions in Alameda County?

5,309 TOTAL MOBILE CRISIS INTERVENTIONS:

2,501 ACBH Mobile Crisis Episodes + 2,808 City Team Mobile Crisis Episodes

Total Mobile Crisis Interventions: To estimate the current mobile crisis response in Alameda County, Indigo examined the number of mobile crisis program episodes that occurred in in Alameda County in FY23-24, including:

- Mobile crisis episodes responded to by the four ACBH-operated/contracted programs
- Mobile crisis episodes responded to by the City-operated programs that included a mental health clinician (reflecting higher acuity mental health crises)

In FY23-24, ACBH-operated and City-operated mobile crisis teams responded to 5,309 crisis episodes. ACBH-operated/contracted programs responded to 2,501 mobile crisis episodes, reflecting 47% of mobile crisis interventions. City-operated mobile crisis teams responded to 2,808 crisis episodes with a mental health clinician, reflecting 53% of mobile crisis interventions.

2. What is the total number of known crisis interventions in Alameda County?

22,994 TOTAL CRISIS INTERVENTIONS:

5,309 MOBILE CRISIS INTERVENTIONS + 17,685 NON-MOBILE CRISIS INTERVENTIONS

To estimate the total volume of crisis events that are occurring in Alameda County, we examined crisis interventions that are known to the County. The total number of crisis interventions is defined as the sum of mobile crisis interventions and non-mobile crisis interventions. Information about how non-mobile crisis interventions were defined and estimated is available below.

In FY23-24, there were 22,994 total crisis interventions, including 5,309 mobile crisis interventions and 17,685 non-mobile crisis interventions.

What is the total number of <u>non-mobile crisis interventions</u> in Alameda County?

17,685 TOTAL NON-MOBILE CRISIS INTERVENTIONS:

16,937 Crisis Receiving Center Admissions Not Involving Mobile Crisis
+
748 Crisis Hotline Calls Appropriate for Mobile Crisis Response

Total Non-Mobile Crisis Interventions: To estimate the current volume of crises that occur in Alameda County and were not responded to by mobile crisis teams, Indigo examined the following data elements:

- **Admissions to Crisis Receiving Centers in Alameda County**: Crisis receiving centers included: John George Psychiatric Emergency Services (PES), Amber House Crisis Stabilization Unit (CSU), Telecare Adolescent CSU, Willow Rock Psychiatric Health Facility (PHF), Cherry Hill Sobering Center, and Hospital Emergency Departments (EDs) in Alameda County.[15]
- **Mobile Crisis Interventions Resulting in Transport to Crisis Receiving Centers in Alameda County:** Some mobile crisis episodes that cannot be resolved in the community may result in transport to a crisis receiving center for further crisis intervention, stabilization, or evaluation—including all individuals placed on a 5150 or 5585 psychiatric hold as well as individuals who request or agree to transportation to a crisis receiving center voluntarily. In order to examine crisis receiving center admissions that likely did not include mobile crisis intervention, we subtracted the number of mobile crisis episodes that included transport to a crisis receiving center from all crisis receiving center admissions.

Crisis Receiving Center Admissions Not Involving Mobile Crisis =

Admissions to crisis receiving centers

–

Mobile crisis episodes resulting in transport to crisis receiving center and/or 5150/5585 hold

- **Crisis Hotline Calls Appropriate for Mobile Crisis Response:** Indigo also examined crisis hotline calls to capture crises that did not result in admission to a crisis receiving center but that may be appropriate for mobile crisis response. Crisis hotline calls included calls received by Crisis Support Services of Alameda County via the 988 National Suicide Prevention Lifeline and the local 24-hour Crisis Hotline. Calls assessed to have a medium-high suicide risk (rating of 3 or 4 on a scale of 0 to 5) may benefit from in-person crisis support and would likely be appropriate for mobile crisis response.

[15] Data were not available for all Hospital Emergency Departments in Alameda County, including Children's Hospital and Alta Bates – Herrick Campus.

In FY23-24, there were 18,514 admissions to crisis receiving centers in Alameda County. At least 1,577 mobile crisis episodes (30%) resulted in transport to a crisis receiving center. This equates to 16,937 crisis receiving center admissions that likely did not involve mobile crisis intervention.

In FY22-23, Crisis Support Services of Alameda County received and connected to 25,653 crisis calls through the 988 National Suicide Prevention Lifeline and local 24-hour Crisis Hotline.[16] Of these calls, 748 (3%) were assessed to have a medium-high suicide risk and may be appropriate for mobile crisis response.

Additional data is available in the *Appendix* regarding admissions to crisis receiving centers, mobile crisis interventions resulting in transport to crisis receiving centers, and crisis hotline calls.

3. What proportion of known crisis interventions were responded to by mobile crisis teams in Alameda County?

% OF KNOWN CRISIS EPISODES RESPONDED TO BY MOBILE CRISIS:

23% = 5,309 Mobile Crisis Interventions ÷ 22,994 Total Crisis Interventions

As mentioned previously, Crisis Now estimates that mobile crisis response accounts for an average of 32% of crisis interventions in jurisdictions nationwide.[17] To estimate unmet need for mobile crisis services, Indigo calculated the proportion of known crisis interventions in Alameda County that were responded to by all mobile crisis response teams and compared this to the national average (32%).

In FY23-24, 23% of all known crisis interventions in Alameda County were responded to by ACBH-operated/contracted and City-operated mobile crisis teams. **To meet the national average of 32% of crises responded to by mobile crises teams, Alameda County would need to respond to 2,050 additional crises through mobile response.**

4. How many additional mobile crisis teams are needed to address mobile crisis needs in Alameda County?

ACBH needs a minimum of 2.5 – 5 <u>additional</u> full-time Mobile Crisis Teams to meet the estimated mobile crisis need.

In order to estimate the number of additional mobile crisis teams that would be needed to meet mobile crisis needs, we examined: duration of team shifts, shift time needed for call documentation and transition, and average duration of crisis calls. A team is defined as at least two full-time equivalent (FTE) staff including at least one FTE mental health clinician responding

[16] At the time of the assessment, FY23-24 crisis hotline data were not yet available.
[17] Crisis Now: Transforming Crisis Services. Crisis Now Crisis System Calculator. Retrieved May 10, 2024, from https://crisisnow.com/tools/

to all crisis calls; however, the estimates do not specify a particular response model (e.g., police and clinician co-responder model, EMT & clinician co-responder model, dual clinician model, etc.).

As mentioned, the mobile crisis programs in Alameda County vary widely in terms of program model and staffing. However, it was common among ACBH-operated and City-operated mobile crisis teams to work 4, 10-hour shifts in a week. Some mobile crisis teams also spoke of allotting at least two hours during each 10-hour shift for case notes and documentation as well as time to transition between crisis calls and shift changes.

Quantitative data regarding the duration of mobile crisis calls were largely unavailable and call duration was assessed through interviews with mobile crisis teams. Mobile crisis teams shared that the duration of calls varies widely based on the client's needs and whether transportation to a crisis receiving center is needed, with some calls lasting as short as a few minutes and other calls lasting several hours. ACBH and CATT leadership shared that on average, crisis calls last approximately 2 hours, and teams typically have capacity to respond to up to 3 to 4 crisis calls per shift.

To account for variability in program models and crisis call duration, Indigo modeled several scenarios exploring the number of mobile crisis teams needed in order to respond to 2,050 additional crises (i.e., the number of crises that would need mobile response to align with the national average of 32% of crises addressed by mobile crisis teams). Each scenario utilized a different average crisis call duration (ranging from 2 to 4 hours) and/or different average calls responded to during each shift (ranging from 2 to 4 crisis episodes). In all scenarios, estimations assume one team works 4, 10-hour shifts each week—including 8-hours per shift when teams are available to respond to crisis calls and 2-hours for documentation and transitions. Findings are presented in Table 6.

Table 6. Estimated Number of Additional Mobile Crisis Teams Needed in Alameda County

Additional Mobile Crises	Average Duration of Crisis Episodes	Average Crisis Episodes per Shift	Average Crisis Episodes per Year	Additional Mobile Crisis Teams Needed
2,050 Crises	2 Hours	4 Episodes	832 Episodes	**2.5 FTE Teams**
	2.5 Hours	3.2 Episodes	665 Episodes	**3.1 FTE Teams**
	3 Hours	2.7 Episodes	562 Episodes	**3.7 FTE Teams**
	4 Hours	2 Episodes	416 Episodes	**4.9 FTE Teams**

In order to meet the mobile crisis need, Alameda County needs a minimum of 2.5 to 5 additional mobile crisis teams. On the low end of the estimate, Alameda County would require 2.5 additional mobile crisis teams if each team responds to an average of 4 mobile crisis calls every

shift (average of 2 hours per call), equating to 832 mobile crisis episodes per team per year. On the high end of the estimate, Alameda County would require 5 additional mobile crisis teams if each team responds to an average of 2 mobile crisis calls every shift (average of 4 hours per call), equating to 416 calls per team per year.

How can Alameda County meet the mobile crisis need?

When are the gaps in mobile crisis coverage?

Based on mobile crisis team operating hours and time of mobile crisis calls, there are gaps in mobile crisis coverage overnight and on weekends.

As described in the current state of mobile crisis response in Alameda County, most mobile crisis programs operate on weekdays during typical business hours (e.g., 8am-6pm, 7am-5pm, etc.). The CATT, Alameda CARE, Berkeley SCU, and MACRO teams are the only programs that provide overnight and weekend coverage. Additionally, CATT did not implement an overnight team until May 2024.

We examined the number of CATT mobile crisis calls by time of day to identify periods with higher or lower call volume. The time of CATT mobile crisis calls were then compared to the time of Emergency Department (ED) admissions for mental health needs and the time of 988 and crisis hotline calls to assess if there are differences in the utilization patterns of mobile crisis services compared to other crisis interventions.

Table 7. Time of Day of Crisis Interventions, by Mobile Crisis and Non-Mobile Crisis Episodes

Time of Day of Crisis Intervention	CATT Episodes in FY23-24	ED Admissions in FY23-24	Crisis Hotline Calls in FY2-23
12am – 8am	26 (2%)	**653 (25%)**	**97 (13%)**
8am – 12pm	**336 (28%)**	361 (14%)	129 (17%)
12pm – 4pm	**458 (38%)**	569 (21%)	132 (18%)
4pm – 8pm	**331 (28%)**	515 (19%)	210 (28%)
8pm – 12am	49 (4%)	**566 (21%)**	**180 (24%)**
TOTAL EPISODES	**1,200 (100%)**	**2,664 (100%)**	**748 (100%)**

Data Notes: CATT episode data and ED admission data reflect episodes in FY23-24. Crisis Line data reflect calls in FY22-23. Time of day of mobile crisis episodes was not available for other ACBH-operated mobile crisis teams or City-operated teams. Day of the week data was also unavailable. The 12am-8am category reflects 8 hours whereas the other categories are 4 hours.

As shown in Table 7, nearly all CATT mobile crisis episodes in FY23-24 occurred between 8am-8pm (94%). Only 6% of CATT mobile crisis calls in FY23-24 occurred overnight (from 8pm to

8am), reflecting the program's operating hours of 7am-11pm before overnight coverage was implemented in May 2024. In comparison, ED admissions for mental health needs and crisis hotline calls were more evenly distributed throughout the day. Nearly half of ED admissions (46%) and 37% of crisis hotline calls occurred overnight. These findings further demonstrate there are crisis events occurring overnight that may benefit from mobile crisis response.

Where are the gaps in mobile crisis coverage?

Additional mobile crisis coverage may be needed in North County, particularly Oakland.

Mobile crisis programs serve the entire county, with CATT and ACBH MCT programs operating countywide and the remaining programs serving designated cities. To identify if there are specific regions or areas within the county that may require more mobile crisis coverage, we first examined ACBH-operated/contracted mobile crisis call volume by the mobile crisis clients' region of residence. We then compared this information to the region of residence for individuals admitted to crisis receiving centers and the general ACBH client population with high utilization of crisis services.

The county regions were defined as follows:

- **North County:** Alameda, Albany, Berkeley, Emeryville, Oakland, Piedmont
- **Central County**: Castro Valley, Hayward, San Leandro, San Lorenzo
- **South County:** Fremont, Newark, Union City
- **East County:** Dublin, Livermore, Pleasanton, Sunol

Table 8. Client Region of Residence, by Mobile Crisis and Non-Mobile Episodes and ACBH Population

Region of Residence	ACBH Mobile Crisis Episodes in FY23-24	Crisis Receiving Center Admissions in FY23-24	ACBH Population in FY22-23
North County	**1,115 (48%)**	**10,148 (55%)**	**2,829 (59%)**
Central County	776 (33%)	5,207 (28%)	1,450 (30%)
South County	137 (6%)	1,279 (7%)	356 (7%)
East County	114 (5%)	713 (4%)	175 (4%)
Unknown	192 (8%)	1,167 (6%)	--
TOTAL EPISODES	**2,501 (100%)**	**18,514 (100%)**	**4,810 (100%)**

Data Notes: Location of mobile crisis episodes was only available for the CATT team. Client residence was therefore used as a proxy for location of mobile crisis interventions for all ACBH-operated/contracted programs. County Team Mobile Crisis episode and ED admission data reflect episodes in FY23-24. Out-of-County residents receiving mobile crisis services or admitted to an Alameda County ED were excluded from analysis. ACBH population includes FY22-

23 FSP clients, Service Team clients, and individuals not enrolled in FSP or Service Teams with high incidence of admission to crisis receiving centers and/or incarceration.

As shown in Table 8, nearly half (48%) of individuals receiving ACBH-operated/contracted mobile crisis services in FY23-24 resided in North County and one-third (33%) resided in Central County. The remaining individuals resided in South County, East County, or their residence location was unreported.

Trends were similar across individuals admitted to crisis receiving centers and the general ACBH client population with high utilization of crisis services. However, a slightly greater proportion ACBH clients and individuals admitted to crisis receiving centers lived in North County (59% and 55%, respectively). This data suggests that individuals in North County may be slightly more likely to be admitted to crisis receiving centers rather than receive mobile crisis services. Additionally, the high percentage of ACBH clients living in North County and who have a high incidence of crisis receiving center admissions further suggest there may be a need for more mobile crisis coverage in North County.

Mobile crisis programs and community stakeholders corroborated these findings, sharing that Oakland in particular needs more mobile crisis coverage to respond to the high volume of crises occurring in the city.

Who is not receiving mobile crisis services?

Male and Black and African American individuals were less likely to participate in mobile crisis services and were more likely to be admitted to crisis receiving centers.

To identify if there are differences in populations that receive mobile crisis services as compared to other crisis interventions, we examined demographic characteristics of individuals utilizing ACBH-operated/contracted mobile crisis services compared to individuals admitted to crisis receiving centers. Demographic data were incomplete for mobile crisis episodes and crisis receiving admissions in FY23-24; given this limitation, FY22-23 data were examined.

As shown in Table 9, males comprise half of county mobile crisis episodes (51%), but two-thirds of crisis receiving center admissions (67%). Additionally, Black and African American individuals comprised about one-third of county mobile crisis episodes (35%), but half of crisis receiving center admissions (48%). This data suggests males and Black and African American individuals were more likely to be admitted to crisis receiving centers than to participate in mobile crisis services.

In comparison, females and Asian individuals and Pacific Islanders appeared more likely to participate in mobile crisis services than to be admitted to crisis receiving centers. Females comprise half of mobile crisis episodes (49%), but only one-third of crisis receiving admissions (33%). Asian individuals and Pacific Islanders made up 14% of mobile crisis episodes, compared to 6% of crisis receiving center admissions.

Among other race / ethnic groups, the proportion participating in mobile crisis services was similar to the proportion admitted to crisis receiving centers. There were no differences in language, with

94% of individuals receiving mobile crisis services or admitted to crisis receiving centers speaking English, 4% speaking Spanish, 2% speaking another language, and <1% with language information unknown or unreported.

Table 9. Demographic Characteristics of Individuals Receiving Mobile Crisis Services compared to Individuals Admitted to Crisis Receiving Centers

Demographic Characteristics	ACBH Mobile Crisis Episodes in FY22-23	Crisis Receiving Center Admissions in FY22-23
Gender		
Female	1,313 (49%)	5,491 (33%)
Male	**1,349 (51%)**	**11,126 (67%)**
Race / Ethnicity		
Black / African American	**925 (35%)**	**7,900 (48%)**
White	729 (27%)	3,930 (24%)
Hispanic / Latino	390 (15%)	2,263 (14%)
Asian / Pacific Islander	**373 (14%)**	**1,050 (6%)**
Other	154 (6%)	901 (5%)
Unknown	99 (4%)	560 (3%)
TOTAL EPISODES	**2,670 (100%)**	**16,626 (100%)**

Data Notes: Demographic data were incomplete for FY23-24. Given this limitation, FY22-23 data were examined for County Mobile Crisis Teams and Crisis Receiving Centers. Race/Ethnicity information sums to greater than 100% as some individuals may have reported more than one race/ethnicity.

Findings Summary

The aim of the mobile crisis assessment was to identify the number of mobile crisis teams needed to provide county-wide mobile crisis services that deliver timely and effective in-person crisis response 24-hours a day, 7 days per week. The assessment found that ACBH needs a minimum of 2.5 – 5 additional FTE Mobile Crisis Teams from the baseline identified in this assessment in order to meet the estimated mobile crisis need, based on the Crisis Now benchmark that 32% of known crisis events are responded to by mobile crisis intervention.

During the assessment process, the County expanded mobile crisis coverage and has added or plans to add the following four mobile crisis teams:

- **ACBH MCT #3:** ACBH implemented an MCT East County team in March 2024. As this is a new team, the team was still ramping up services during the assessment period, and their services were not yet at full capacity. As implementation progresses, ACBH anticipates call volume will increase to full capacity.
- **CATT #9:** In partnership with ACBH, Bonita House and Falck implemented the first overnight CATT team in May 2024, operating Sunday – Wednesday from 7pm-7am. As this is a new team, the team was still ramping up services during the assessment period, and their services were not yet at full capacity. As implementation progresses, ACBH anticipates call volume will increase to full capacity.
- **CATT #10:** In partnership with ACBH, Bonita House and Falck planned to implement the second overnight CATT team in November 2024, operating Wednesday – Sunday 7pm-7am. With the addition of this team, CATT will provide overnight coverage 7 days a week.[18]
- **CATT #11:** In partnership with ACBH, Bonita House and Falck plan to implement an 11th CATT team in 2025. Based on identified mobile crisis coverage gaps, the County may wish to consider operating this team out of CATT's Oakland staging post to provide more coverage in the Oakland area and North County region.

While these teams are not reflected in the data for this assessment because they were not yet fully operational, they are or will soon be part of the landscape of crisis services in Alameda County. With these new and planned expansion of mobile crisis programming, ACBH has fulfilled the identified mobile crisis need identified in this assessment.

The assessment also identified existing gaps in mobile crisis coverage. Based on mobile crisis team operating hours and time of mobile crisis calls in FY23-24, mobile crisis coverage is needed

[18] In November 2024, ACBH also began a pilot program with Crisis Support Services of Alameda County wherein CATT can be dispatched through the 988 Suicide and Crisis Lifeline on nights and weekends. Moving forward, the County expects to expand 988 dispatch to 24 hours a day, seven days a week.

overnight and on weekends. Mobile crisis coverage is also needed in North County, particularly Oakland. Males and Black and African American individuals also appeared less likely to participate in mobile crisis services and were more likely to be admitted to crisis receiving centers. Based on ACBH's mobile crisis team expansion of 4 FTE mobile crisis teams, including 2 overnight CATT teams and an MCT East County team, the County has fulfilled the addition of 2.5 – 5 FTE mobile crisis teams necessary to address mobile crisis needs. However, going forward, ACBH should regularly monitor mobile crisis capacity and coverage to ensure mobile crisis services continue to meet community needs.

Appendix. Supplemental Data

Admissions to Alameda County Crisis Receiving Centers in FY23-24

In FY23-24, there were 18,514 admissions to crisis receiving centers in Alameda County. Most admissions were to John George PES and Cherry Hill Sobering Center.

Table 10. Number of Admissions to Crisis Receiving Centers in Alameda County in FY23-24, by Crisis Receiving Center

Crisis Receiving Center	FY23-24 Alameda County Crisis Receiving Center Admissions
John George Psychiatric Emergency Services	7,214 (39%)
Amber House Crisis Stabilization Unit (Adult)	751 (4%)
Telecare Crisis Stabilization Unit (Adolescent)	159 (1%)
Willow Rock Psychiatric Health Facility (Youth)	326 (2%)
Cherry Hill Sobering Center	7,400 (40%)
Hospital Emergency Departments	2,664 (14%)
TOTAL EPISODES	**18,514 (100%)**

Data Notes: Hospital ED data reflect admissions to the Hospital EDs in Alameda County for mental health concerns. ED data were not available for all hospitals, including Children's Hospital and Alta Bates – Herrick Campus. Admission data was available for Alameda Hospital, Alta Bates (Alta Bates & Merritt campuses), Eden Medical Center, Highland Hospital, San Leandro Hospital, St. Rose Hospital, and Washington Hospital. Data for some hospital EDs in Alameda County were unavailable. Out-of-county residents admitted to these EDs for mental health concerns were excluded from analysis.

Mobile Crisis Episodes Resulting in Transport to a Crisis Receiving Center in FY23-24

Of the 5,309 mobile crisis episodes in FY23-24, at least 1,577 mobile crisis episodes (30%) resulted in transport to a crisis receiving center due to voluntary transport or placement of a 5150/5585 psychiatric hold during the crisis episode. Slightly less than half (45%) of all ACBH-operated/contacted episodes resulted in transport to a crisis receiving center, while 16% of City-operated mobile crisis episodes resulted in transport to a crisis receiving center (based on 5150/5585 psychiatric hold placement).

Table 11. Number of Mobile Crisis Episodes resulting in Transport to Crisis Receiving Centers in FY23-24, by Mobile Crisis Team

Crisis Team	FY23-24 Mobile Crisis Episodes with Transports to Crisis Receiving Centers
County Mobile Crisis Teams	**1,129**
CATT	486
ACBH MCT	357
ACBH MET	140
ACBH HMET	146
City Mobile Crisis Teams	**448**
Alameda CARE	74
Berkeley MCT	198
Berkeley SCU	63
Livermore MET	43
Pleasanton ARU	70
TOTAL EPISODES	**1,577**

Data Notes: Transport data were only available for the CATT program. For other programs, individuals placed on a psychiatric hold are assumed to be transported to a crisis receiving center (PES, Willow Rock, or Hospital ED). For MCT, MET, and HMET episodes, dispositions of "Voluntary PES" were considered voluntary transports to a crisis receiving center. *Livermore MET began operations in January 2024 and data were available through June 30, 2024. Livermore MET data were annualized to estimate total calls in a full year of operations.

Admissions to Alameda County Crisis Receiving Centers in FY23-24

In FY22-23, Crisis Support Services of Alameda County received and connected to 25,653 crisis calls. Of these calls, 748 (3%) had a medium-high risk level (risk level of 3 or 4 on a scale of 0 to 5), suggesting that may benefit from in-person, mobile crisis intervention.

Suicide risk levels are defined as follows:

- Risk Level 0: No reported suicidal thoughts or feelings
- Risk Level 1: Some desire for suicide but no/low intent & no means
- Risk Level 2: suicidal desire present, some intent & limited access to means
- Risk Level 3: suicidal desire present, some intent, & ready access to means
- Risk Level 4: suicidal desire present, resolved intent, & ready access to means
- Risk Level 5: caller has already or is resolved to make a suicide attempt

Table 12. Suicide Risk Level of Crisis Hotline Calls in FY22-23

Suicide Risk Level	FY22-23 Crisis Calls to Crisis Support Services of Alameda County
Risk Level 0	17,242 (67%)
Risk Level 1 or 2	7,588 (30%)
Risk Level 3 or 4	**748 (3%)**
Risk Level 5	75 (<1%)
TOTAL CALLS	25,653 (100%)

Data Notes: Data reflect completed incoming crisis calls to and follow-up/outreach calls from the Crisis Support Services of Alameda 24-hour Crisis Line and 988 National Suicide Prevention Lifeline. Calls that received an out-of-county referral were presumed to be out-of-county callers and were excluded. Incomplete calls, calls for inappropriate use of the crisis line, and afterhours calls for the ACBH MH ACCESS line and SU Helpline were excluded.