County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division

Salud Mental y Tratamiento del Uso de Sustancias

NOTICE OF PUBLIC MEETING
BEHAVIORAL HEALTH ADVISORY BOARD
NOVEMBER 19, 2026, 3:00 PM-5:00 PM

NOTICE OF MEETING LOCATIONS:

Pursuant to the Ralph M. Brown Act, this meeting will be held simultaneously at the two physical locations listed below. Members of the public may attend, observe the meeting, and provide public comments in person at **either** location:

1. **Primary Location (Quorum Site):**
   South County Government Center
   500 Westridge, Greg Caput Community Room
   Watsonville, CA 95076
2. **Teleconference Location:**
   University of California, San Diego – Geisel Library
   9701 Hopkins Drive, Floor 1, Conference Room B2
   La Jolla, CA 92093

The public may also attend the meeting via Microsoft Teams by clicking: Join Meeting Now or by calling (831)454-2222, and entering Conference ID 819 405 695#. 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 Behavioral Health Advisory Board website.

Board Members: District 1: Xaloc Cabanes (Chair), Kaelin Wagnermarsh
District 2: Valerie Webb, Dean S. Kashino
District 3: Michael Neidig (Co-Chair), Hugh McCormick
District 4: Antonio Rivas, Rachel Montoya
District 5 (one vacancy): Jeffrey Arlt (Secretary)
Transitional Age Youth (one vacancy): Natalie Stott
Board of Supervisor: Kimberly De Serpa

Behavioral Health Director: Dr. Marni R. Sandoval

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4767 (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 (ingles/español o Lenguaje de señas), por favor llame al (831) 454-4767 (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.

BEHAVIORAL HEALTH ADVISORY BOARD AGENDA

Mission: To obtain the highest quality and most effective Behavioral Health Services for the County.

ID	Time	Regular Business
1	3:00-3:15	- Roll Call - Public Comment: No action or discussion will be undertaken today on any item raised during Public Comment period except that Behavioral Health Advisory Board members may briefly respond to statements made or questions posed. Limited to 3 minutes each. - Board Member Announcements - *Approval of October 15, 2026 minutes** - Secretary's Report
		Presentation
2	3:15-3:55	Building Coordinated & Sustainable Crisis Systems: National Trends and Lessons from the States – Margie Balfour, MD, PhD, Coauthor of The Roadmap to the Ideal Crisis System, Associate Professor of Psychiatry of the University of Arizona, Executive Policy Advisor of Connections Health Solutions, and Principal of MultiPass Consulting
		Standing Reports
3	3:55-4:00	October Patients' Rights Report – George Carvalho, Advocacy, Inc. Patients' Rights Advocate
4	4:00-4:10	Board of Supervisors Report – Supervisor Kimberly De Serpa
5	4:10-4:25	Behavioral Health Director's Report – Dr. Marni R. Sandoval, Behavioral Health Director
6	4:25-4:30	Site Visit Ad Hoc Committee – Kaelin Wagnermarsh and Dean Kashino
		New Agenda Items
7	4:30-4:40	Biennial Report – Create Ad Hoc Committee
8	4:40-4:55	Revised BHAB Vision and Goals – Create Ad Hoc Committee
9	4:55-5:00	**Future Agenda Items**
	5:00	Adjourn

*Italicized items with * indicate action items for board approval.*

THE NEXT BEHAVIORAL HEALTH ADVISORY BOARD MEETING IS ON:
JANUARY 21, 2027, 3:00PM – 5:00PM
HEALTH SERVICES AGENCY
1400 EMELINE, CONFERENCE ROOMS 206-207, SANTA CRUZ

County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division
Behavioral Health Advisory Board
1400 Emeline Avenue, Santa Cruz, CA 95060
Phone: 831-454-4767 Fax: 831-454-4663

Salud Mental y Tratamiento del Uso de Sustancias

Draft Minutes
Approved date:

OCTOBER 15, 2026, 3:00 PM - 5:00 PM
HEALTH SERVICES AGENCY, 1400 EMELINE, CONFERENCE ROOMS 206-207, SANTA CRUZ
MICROSOFT TEAMS (831) 454-2222, CONFERENCE 982 648 365#

Present: Dean Kashino, Hugh McCormick (virtual), Jeffrey Arlt, Michael Neidig, Rachel Montoya, Valerie Webb, Xaloc Cabanes, Supervisor De Serpa
Absent: Antonio Rivas, Kaelin Wagnermarsh, Natalie Stott
Staff: Dr. Marni Sandoval, Jane Batoon-Kurovski

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1. Roll Call – Quorum present. Meeting called to order at 3:07 p.m. by Chair Xaloc Cabanes. Hugh McCormick participated remotely due to Just Cause.

2. Public Comment – 2 individuals addressed the BHAB in the conference room
1 individual addressed the BHAB on MS Teams.

3. Board Member Announcements
   - Bullying Awareness Month – provide support to young people who have been impacted by bullying, as well as those who engage in bullying behaviors.
   - November meeting scheduled at the South County Government Center in Watsonville; no meeting in December.

4. Approve September 17, 2026 Minutes
Motion / Second: Mike Neidig / Dean Kashino
Ayes: Kashino, McCormick, Arlt, Neidig, Cabanes, De Serpa
Abstain: Montoya, Webb
Nayes: None
Passed.

5. Secretary's Report – Jeffrey Arlt
   - No training or attendance issues reported.
   - CalBHBC virtual meeting scheduled for Oct 23-24, 2026 which satisfies the training requirement.
   - Crisis Now webinar trainings are held weekly on Wednesday mornings.

6. Patient's Rights Report – George Carvalho, Advocate for Advocacy, Inc.
September report was provided. George was not present at this meeting.

7. Board of Supervisors Report – Supervisor Kim De Serpa
   - Measures on ballot:

- Measure D – discussed efforts to strengthen existing regulations to prevent offshore oil drilling and seabed mining along the California coast. The measure is scheduled to go before voters in November.
- Measure E – discussed anticipated Medi-Cal coverage losses due to new eligibility and renewal requirements, potentially affecting approximately 27,000 Santa Cruz County residents and access to medications, mental health services, food assistance, and IHSS. The proposed ½-cent sales tax is expected to generate approximately $27M locally to help support food security, behavioral health, and healthcare services.

- State of the County – BOS Chair Mónica Martinez and CEO Nicole Coburn

  Accomplishments:
  - Opened Hope Forward, a behavioral health unit serving children and youth.
  - Opened Bridge House, providing 32 beds and a navigation center.
  - Freedom House is under construction and will provide 12 bedrooms (24 beds) for transition age youth aging out of foster care or behavioral health services, with stays of up to three years.
  - Janus is expanding services with new beds for women, infants, and young children.

  Challenges:
  - Ongoing financial and operational impacts related to HR1.
  - Delayed FEMA reimbursements for 2017 and 2023 storm damage, and the need to take out loans to cover repairs and improvements.

  The County is maintaining a focus on fiscal discipline.

8. Behavioral Health Director's Report – Dr. Marni Sandoval, Behavioral Health Director

A. Adult System of Care (ASOC) Update
- Bridge House reached full occupancy; ongoing collaboration with Housing Matters.
- Successfully transitioned to SmartCare EHR on October 1; staff adapting well post-implementation.
- Began BQuIP training to support rollout of the new SUD screening tool in SmartCare.
- Continued partnership with the County SUDS team to enhance client service coordination.
- Provide ongoing training and facilitation support for the MSW intern cohort.
- Advanced BHSA compliance efforts strengthened partner processes, and improved HMIS data accuracy.
- Created a new FSP client on-call support video; updated on-call policies and procedures nearing completion.

B. Children's System of Care (CSOC) Update
- Secured $450K in new funding with the County Office of Education to sustain and expand The Companion Project (TCP).
- TCP provides Behavioral Health Navigators who connect students and families to behavioral health and SUD services countywide.
- Navigators support end-to-end referrals, ensuring warm handoffs across all insurance and coverage types.
- Funding extends TCP operations through FY2026-27 and FY2027-28, including Navigator staffing and cross-system training.
- Sustains the SUD Navigator position in partnership with Janus of Santa Cruz to strengthen substance use support for students and families.
- Continued leveraging BHSSA infrastructure with County and COE partners to improve access to behavioral health and SUD services.

C. Substance Use Disorder Services Update
- Completed and submitted the Opioid Settlement Expenditure Report to ensure compliance and transparency.

- Advanced implementation of the BQuIP SUD Screening Tool in SmartCare to support a countywide transition from Brief ASAM.
- Continue supporting client engagement through the Recovery Incentives program.
- Expanded recovery residence capacity using Prop 47 funding to strengthen long-term recovery housing options.
- Integrated SUD clinicians into Access and Adult Outpatient teams to improve coordinated care.
- Strengthened referral pathways for justice-involved clients through enhanced criminal justice partnerships.
- Improved internal workflows to streamline assessments, service authorizations, and follow-up care.

9. Site Visit Committee – Rountree
   - Houses lower-level offenders, while main jail serves higher-acuity individuals with more serious offenses and mental health or medical needs. The facility is below capacity, while approximately 1/3 of main jail inmates have been booked more than 21 times.
   - Reported that 90 individuals were booked for low-level offenses, averaging 46 arrests each, most likely housed at Rountree.
   - Reviewed the facility's extensive programming, including 24 programs, 7 activities, and 23 services. Classes support skill development and education, including high school diploma completion; however, short stays limit participation and program completion.
   - Facility occupancy is approximately 70%, with low participation in voluntary programs. Incentive structures and limited coordination with the court system may contribute to delays in case processing and program engagement.
   - Chief Deputy Cleveland raised concerns about inadequate funding, staffing, and the lack of a needs assessment to identify the population being served. He also highlighted funding challenges, reentry support needs, and the need for clearer recidivism metrics to accurately track repeat offenders and high-utilization individuals.
   - Clarification that when an individual is arrested and released, it is not counted as recidivism. When an individual goes through a trial or has a conviction, multiple times is considered recidivism. They can have high utilization individuals, but that doesn't count in their number of reported incidences.

10. Revised Mission Statement, Vision and Goals
    Identified potential 2027 priorities:
    - Strengthening board advocacy and public awareness efforts.
    - Support development and sustainability of the clubhouse model (MHCAN).
    - Expand peer support opportunities across systems of care.
    - Promote prevention and early-intervention strategies through collaboration with managed health care plans and community partners.
    - Explore ways to amplify the board's voice and effectiveness in behavioral health advocacy.
    - ➔ Future Agenda Item: Create Ad Hoc committee to confirm these goals are accurate.

11. Adjournment
    Meeting adjourned at 5:02pm.

Building Coordinated & Sustainable Crisis Systems: National Trends and Lessons from the States

Margie Balfour, MD, PhD

Founder & Principal
MultiPass Consulting PLLC
www.multipassconsulting.com

Executive Policy Advisor
Connections Health Solutions
margie.balfour@connectionshs.com

Associate Professor
of Psychiatry
University of Arizona

Most communities in America…



"I'm having chest pain."

"I'm suicidal."





Every system is perfectly designed to get the results it gets.

- **Deadly encounters with police:** One quarter of police shooting deaths involve a person experiencing a behavioral health crisis.
- **Jails are the new asylums:** The prevalence of mental illness in our jails and prisons is 3-4 times that of the general population.
- **ED Boarding:** Over 50% of EDs report they have no psychiatric services available, so patients "board" for hours or days with little or no treatment while awaiting transfer to an outside facility.

Saleh AZ et al.(2018) Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 2018;58:110–6
Steadman HJ et al. Prevalence of serious mental illness among jail inmates. *Psychiatric Services*. 2009;60(6):761-5.
Ellison AG et al. Specialty Psychiatric Services in US EDs and General Hospitals: Results From a Nationwide Survey. *Mayo Clinic Proceedings*. 2022;97(5):862-870

Most communities in America…



"I'm having chest pain."

"I'm suicidal."





SAMHSA's Vision

"Someone to contact"

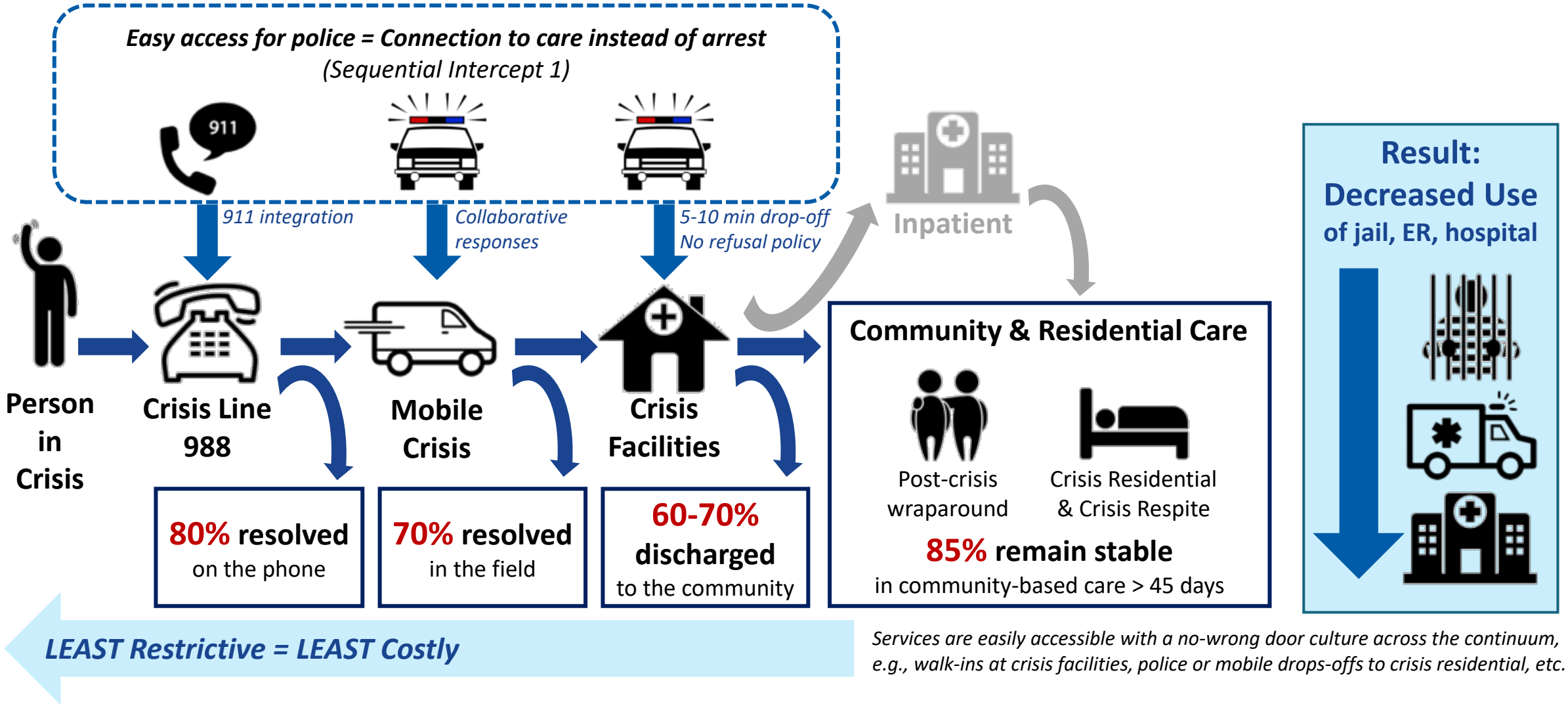
988 SUICIDE & CRISIS LIFELINE

"Someone to respond"
(mobile crisis)

"A safe place for help"
(specialized facilities)

Behavioral Health Coordinated System of Crisis Care (BHCSCC)

Multiple components aligned towards common goals



Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.

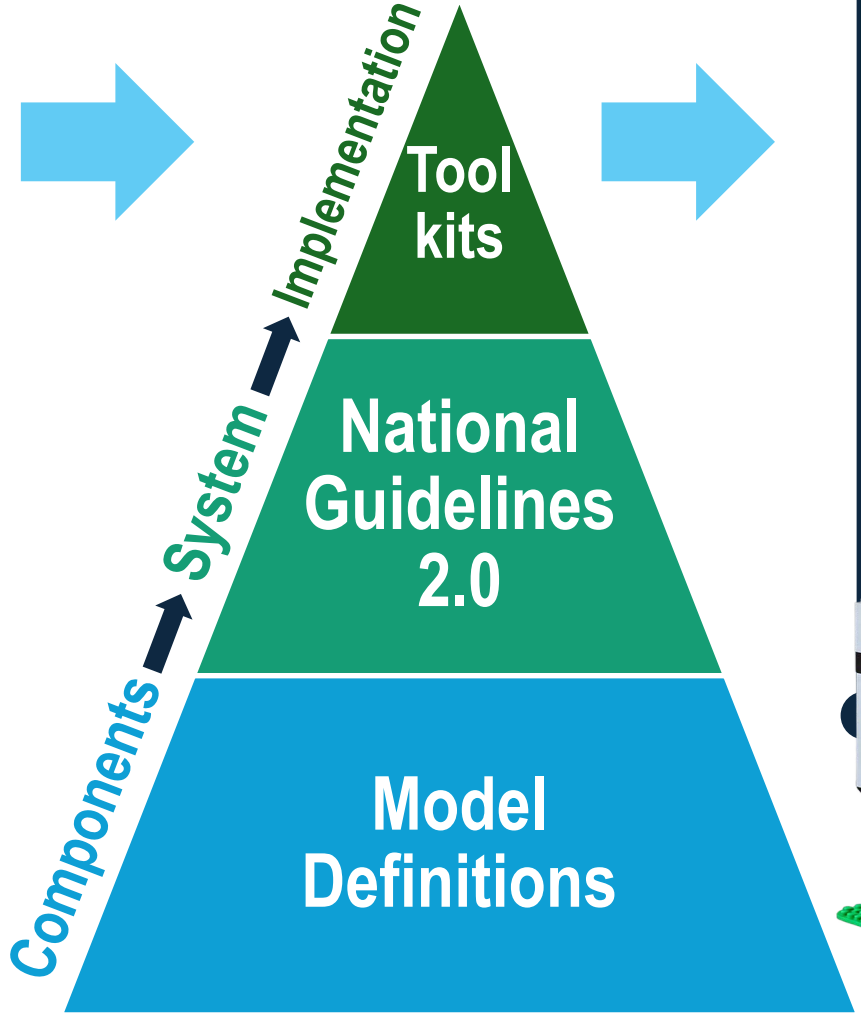
Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to BH Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

SAMHSA Crisis Guidance

988 Crisis Systems Response
Training & TA Center
www.CrisisSystemsHelp.samhsa.gov

"Crisis Stabilization Unit"





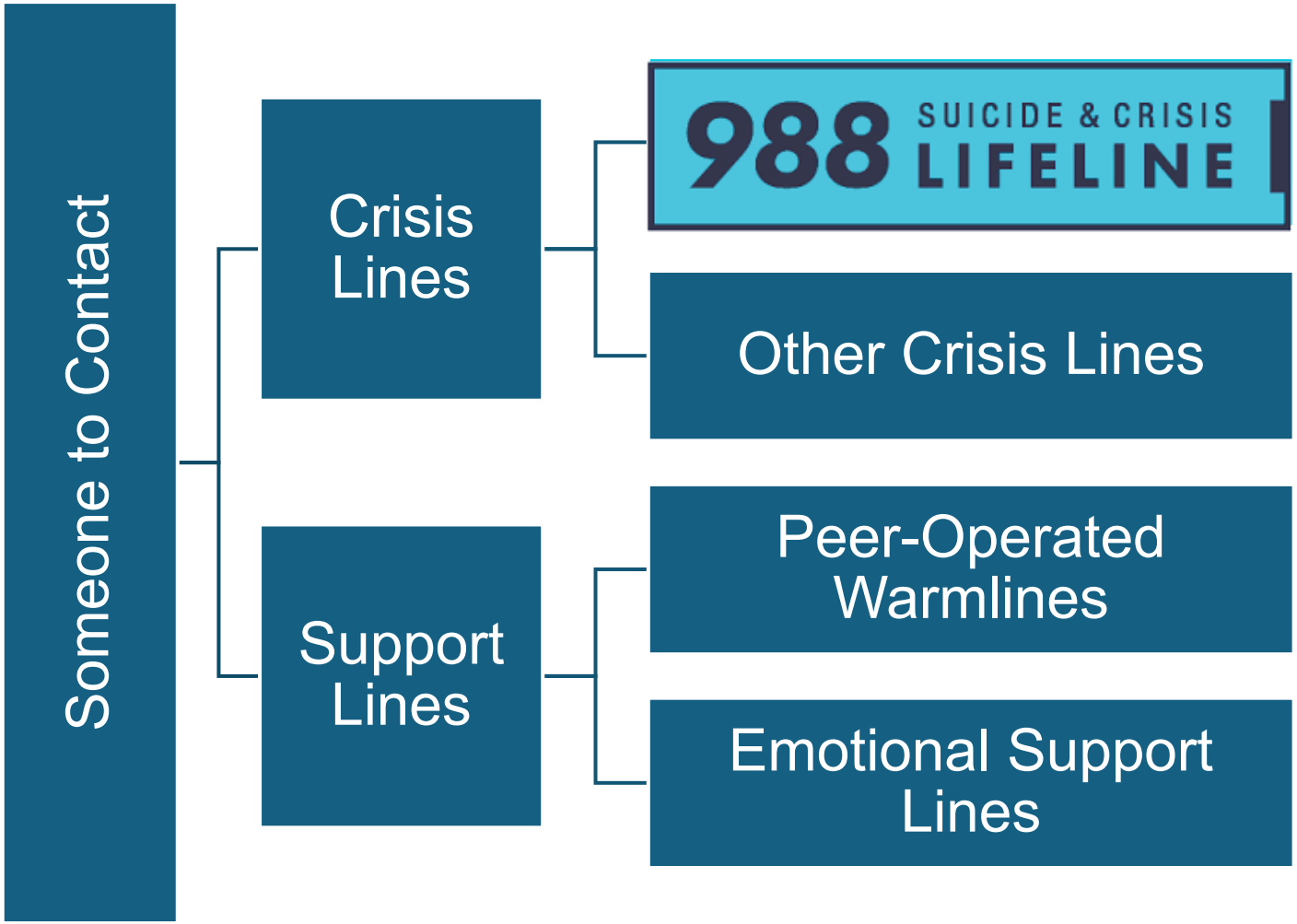
Standardization
language – quality - consistency

Sustainability
public & private payers



https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care

SAMHSA Definitions: Someone to Contact



Key Discussions & Decisions

- Crisis Lines v. Support Lines
  - Ability to support/manage crises, stratify, mitigate risk
- Warmlines = Peer
- Emotional support lines provide similar services to warmlines, but are not predicated upon the peer relationship

Connecting 988 calls to the right response

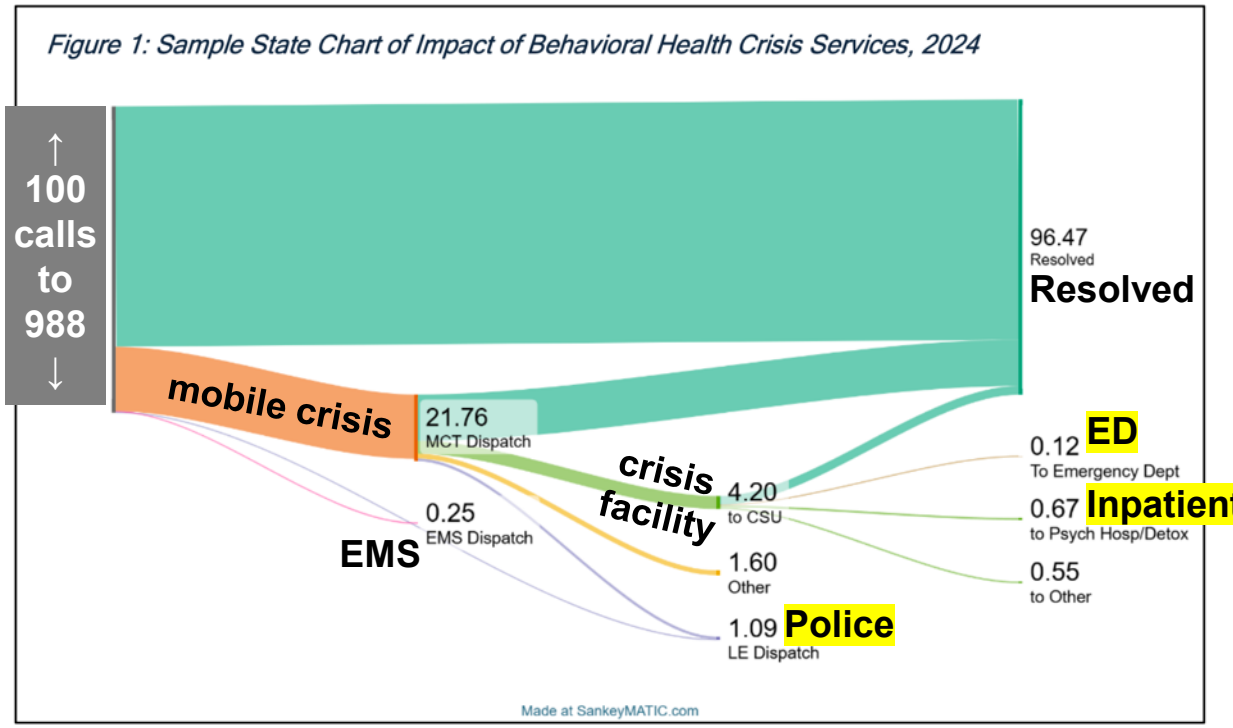
Fear of law enforcement & hospitalization are barriers to using 988

Survey & Polling Data

% Indicating they had concerns about using 988 for the following reasons:	2023 (Pew)	2026 (NAMI)
Law enforcement would be sent	41%	52%
Would be forced to go to the hospital	40%	48%
Call would not remain private & others might find out	37%	49%
Would end up charged for services and couldn't pay	36%	54%
988 responders wouldn't be able to handle the issue I contacted them about	34%	50%
Would end up in jail	23%	42%

The more crisis services a community has, the less need to involve law enforcement & hospitals

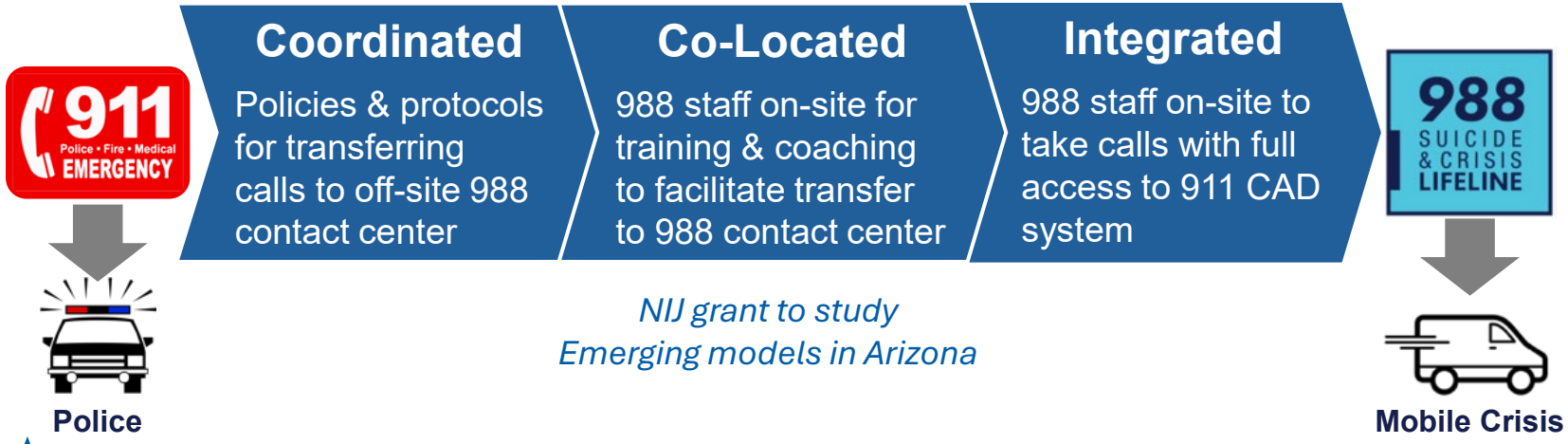
NASMHPD / NRI State Reports



NAMI Poll: https://www.nami.org/research/publications-reports/survey-reports/poll-of-public-perspectives-on-988-crisis-response-2026/
Pew Survey: https://www.pewtrusts.org/en/research-and-analysis/articles/2023/05/23/most-us-adults-remain-unaware-of-988-suicide-and-crisis-lifeline
NRI Chart: https://nri-inc.org/media/25wi5ugz/nri-report-on-bh-crisis-system-outcome-august-2025-update_september-2025.pdf More at https://nri-inc.org/profiles

Connecting 911 calls to the right response

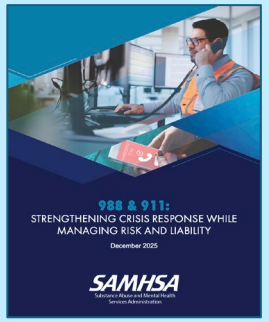
- Over 9000 Public Safety Answering Points (PSAPs) in the United States → solutions are local
- Local 988 centers & PSAPs are experimenting on ways to identify & re-route BH calls
- Different solutions for different situations (urban vs. rural, availability of services, state structure, etc.)
- Best practices are emerging but research is needed



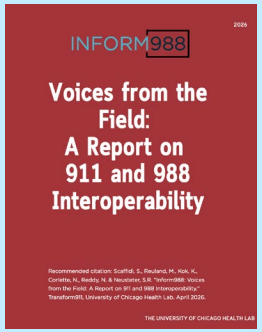
NIJ grant to study Emerging models in Arizona

Recent Resources

NENA Standard for 911-988 Interactions
www.nena.org



SAMHSA
911 & 988: Strengthening Crisis Response While **Managing Risk & Liability**

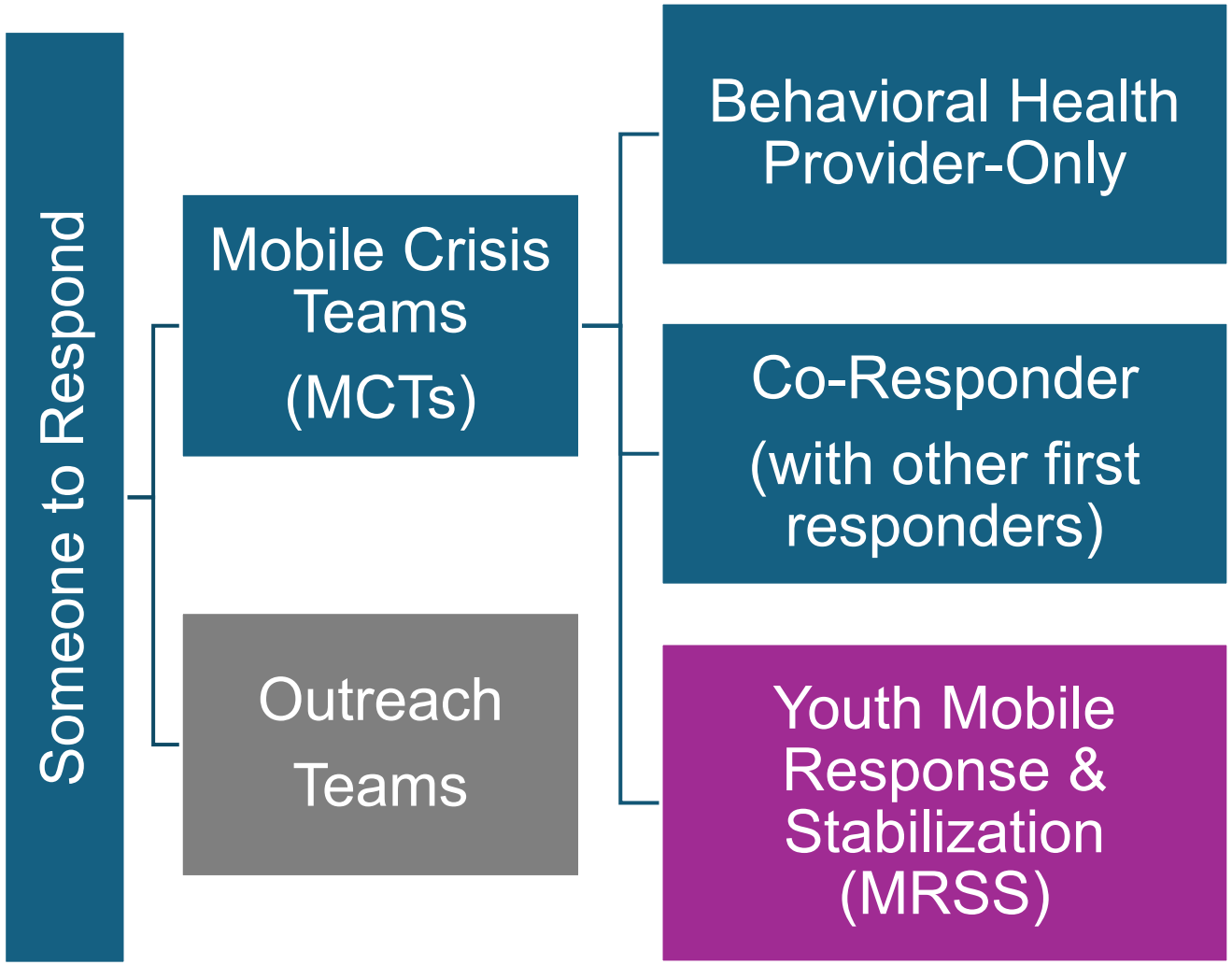


Inform988 Report on **911 & 988 Interoperability**: Univ of Chicago Health Lab
www.transform911.org

Someone to respond



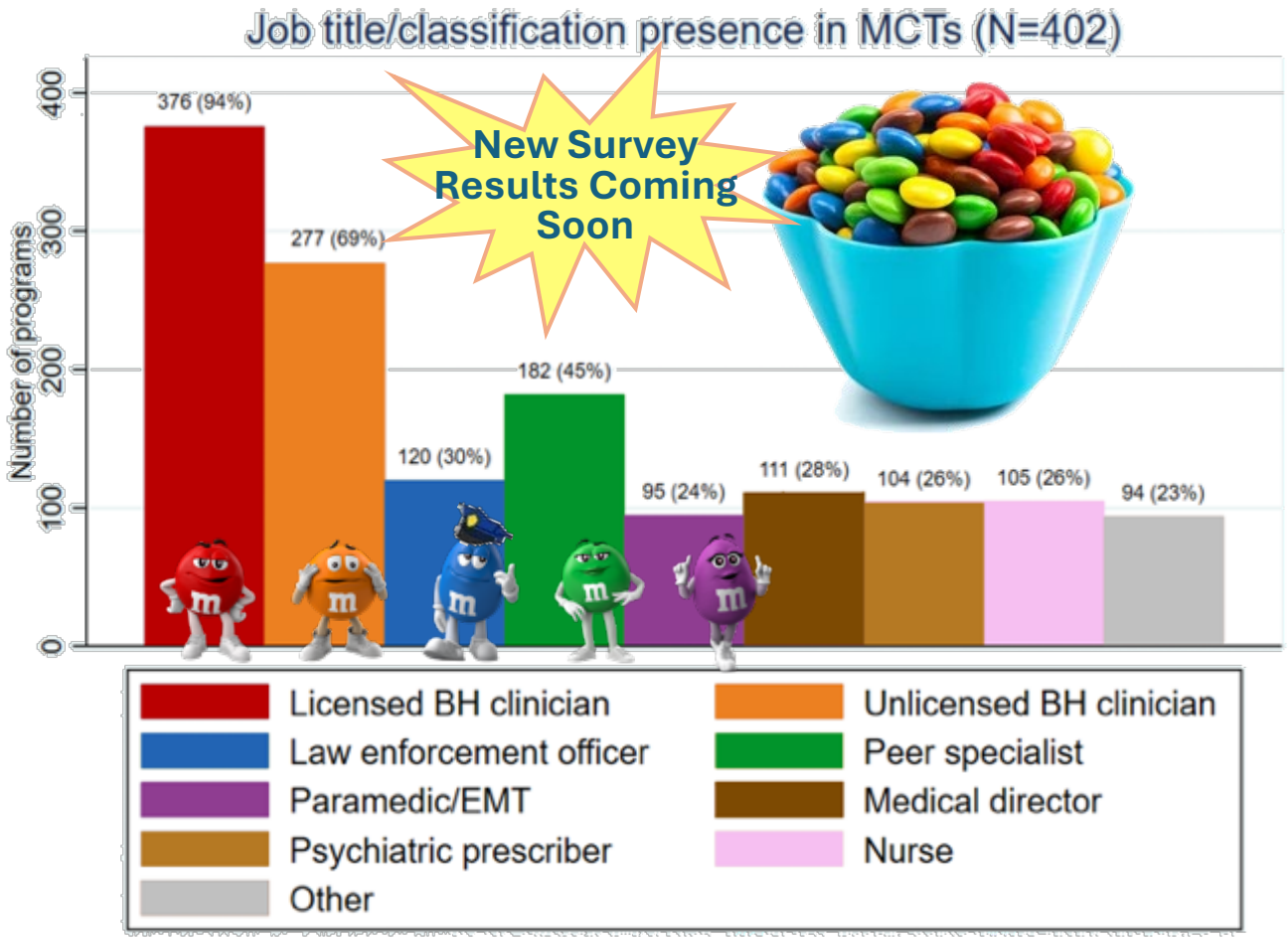
SAMHSA Definitions: Someone to Respond



Key Discussions & Decisions

- Distinct from “outreach teams” (violence interruption, homeless, veterans, etc.)
- Co-responder teams are MCTs
- Licensed/credentialed clinician engagement in the response (possibly via telehealth)
- Telehealth is an adjunct, but service must be “mobile”
- Rapid, on-demand aspect of the service
- Youth Mobile Response and Stabilization has a component of MCTs with an additional stabilization component

Mobile Crisis Teams (MCTs) come in many combinations



Clinician-only MCTs (most common)

- Licensed BH clinician + unlicensed clinician or peer



Rural areas: 1 person teams +/- telemed backup

Co-Responder Teams

- Law enforcement + BH clinician or peer

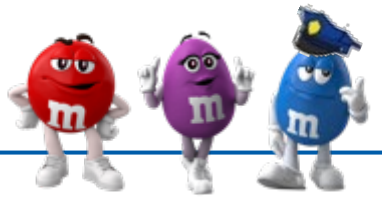


- Civilian only: EMT + BH clinician
  CAHOOTS (Eugene, OR); STAR (Denver)



Multi-Disciplinary Response Teams (MDRT)

- BH Clinician + Paramedic + Officer
  RIGHT Care (Dallas)



Survey of over 400 mobile crisis teams in the US. Courtesy Preston Looper & Matt Goldman.
Final report at: https://www.samhsa.gov/sites/default/files/national-mobile-crisis-survey-report-summary.pdf

Finding the right solution to fit your community's needs:

Evolution of Tucson's Co-Responder Model

Co-Responder 1.0: LA Model



MHST Team Officers
already employed by TPD

1 Mobile Crisis Team
already employed by mobile provider financed via RBHA/Medicaid



2 Co-Responder Teams
Cost neutral

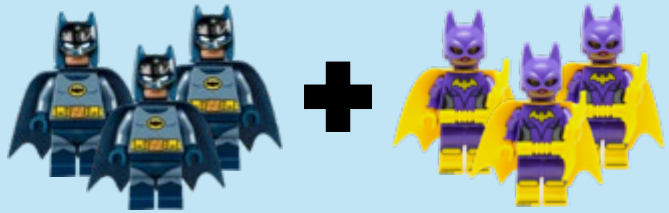
Officer + clinician ride and respond to crisis calls together

Co-Responder 2.0



Dedicated mobile team with officers and clinicians in their own vehicles

Co-Responder 3.0



Dedicated MHST Team Officers & Detectives

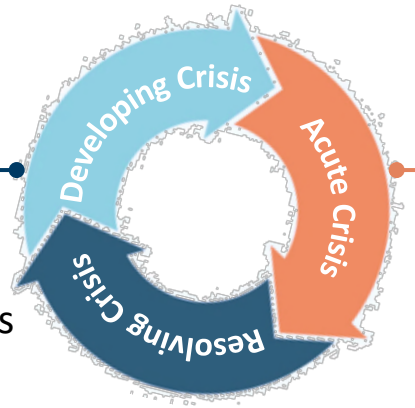
CM/Peer Support
Employed by Connections can bill case mgmt. codes

Targeted follow-up and wraparound for high-risk individuals

Tucson's Police-MH Collaborative Response Model

Prevention

- Outreach
- Follow-up
- Multiple touches
- Lower urgency



Response

- De-escalation
- Intervention
- Discrete event
- Higher urgency

Breaking the Crisis Cycle

Outreach & follow-up can "break the cycle" by ensuring that the person is connected to the care they need to stay well in the community. Community-based peers and/or clinicians work with LE to help with engagement and navigating the mental health system.

Health-First Response

With 911/crisis line integration, calls are **triaged to a clinician-only response as early and often as possible**, with law enforcement involvement reserved for cases with higher safety risk or criminal nexus. Responding officers are CIT-trained and can request additional assistance if needed.

	Outreach & Follow-up	Acute Response
Safety Risk: Collaborative	**Collaborative** ***Dedicated LE specialty teams working with peer co-responders*** - Follow-ups after OD or SUD deflection - Public safety risks: investigations & f/u - Homeless outreach	**Collaborative** ***CIT Trained Officer + assistance from the crisis system to fit the situation*** - CIT officer transport to crisis facility - Mobile crisis assist at suicidal barricades
Safety Risk: Clinician-Only	**Clinician-Only** ***BH System is responsible*** - "Second responders" - Case management - Timely access to needed care	**Clinician-Only** ***BH System is responsible*** - Crisis Line/988 - Mobile Crisis Teams - Transport to crisis facilities

Urgency

Margie Balfour, MD PhD
MULTIPASS CONSULTING

A safe place for help



SAMHSA Definitions: A Safe Place for Help

High Intensity EMERGENCY

- *Any level of BH acuity*
- *Can be involuntary*
- *Emergency meds*
- *S/R as last resort*
- *Police drop off*
- *24/7 capacity*

Moderate Intensity CRISIS

- *Voluntary only*
- *Not equipped to serve highest BH acuity*
- *Some services may not be on site 24/7*
- *May be limited hours*

"Emergency Capable" No/Low Barrier Crisis Stabilization Services

- Hospital-Based BH Emergency Stabilization Units (e.g., EmPATH)
- High-Intensity BH Emergency Centers → High-Intensity BH Extended Stabilization
- Moderate Intensity BH Crisis Centers → Mod Intensity BH Extended Stabilization
- BH Urgent Care
- Sobering Centers
- Peer Crisis Respite

24 hours

Shared understanding of

- **WHO is (and isn't) served**
- **WHAT the services are**
- **HOW to access**
- **HOW MUCH they will cost**

Referral Based Crisis Residential Services

- Moderate Intensity Crisis Residential
- Low Intensity Crisis Residential
- Community Crisis Respite Apartments

← days to weeks →

+ Services Specific to Youth & Families

- *Youth & Family Crisis Respite*
- *In-Home Stabilization (e.g., MRSS)*

The need for crisis facilities that can serve highly acute and involuntary individuals

First-responder with high acuity individual

AGITATED / INVOLUNTARY



Arrest & Jail

- High cost / high recidivism / criminal record

Emergency Department

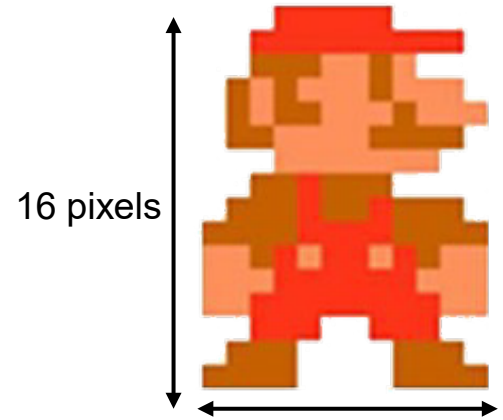
- Little to no treatment in a stressful environment
- Less than half have psychiatric services available
- Hours or days boarding waiting for transfer to a psychiatric hospital
- More likely to be arrested for assaulting staff

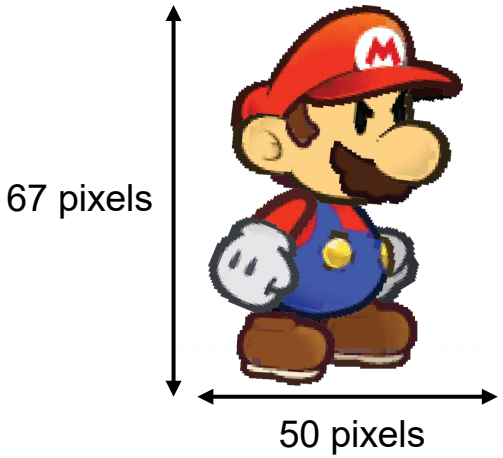
High Intensity Emergency BH Centers

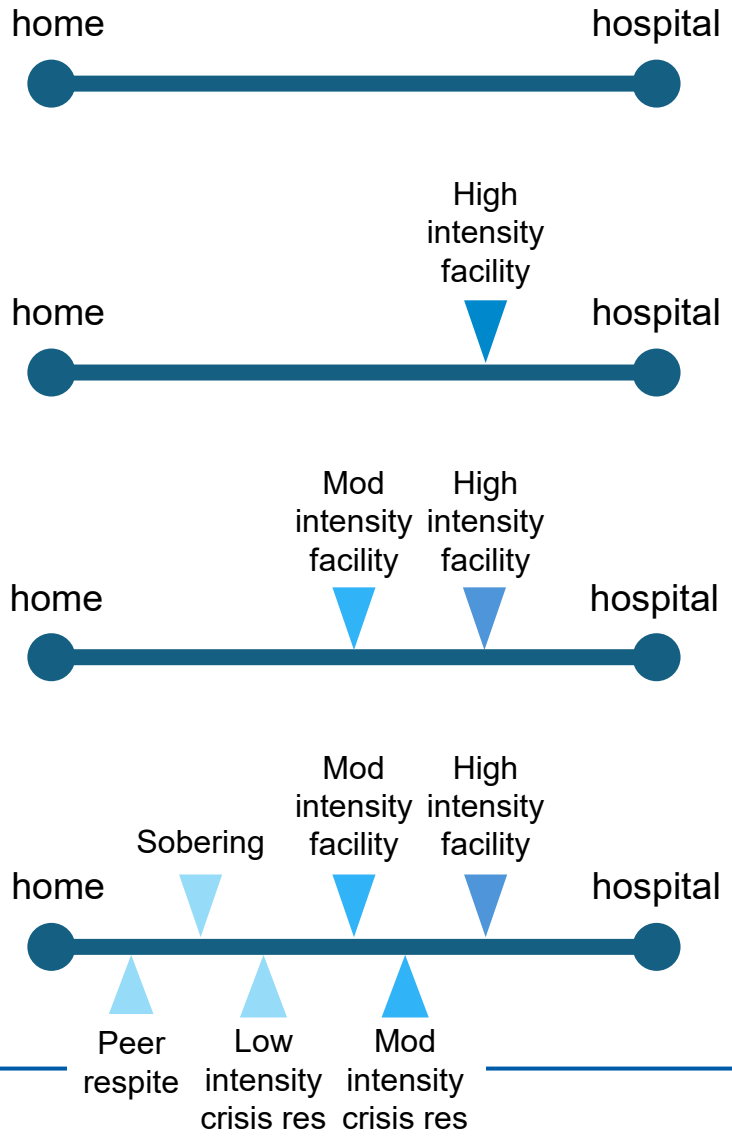
- Specialized treatment with a therapeutic milieu/space
  Specialized staff including psychiatrists, social workers, peers (without security guards)
- Most can be stabilized and discharged to community
- Research shows 60% can be converted to voluntary and remain stable in the community

For review see: Balfour ME and Carson CA. Crisis Receiving and Stabilization Facilities: Designing Systems for High-Acuity Populations. *Psychiatric Clinics of North America*. 2024 Sep;47(3): 511-30. https://doi.org/10.1016/j.psc.2024.04.022

Building a “high resolution” crisis continuum







Different levels of intensity ability to match level of care to what the person needs throughout the course of their crisis

Least restrictive / least costly: because when the “best fit” option is missing, disposition often defaults to the higher level of care

For definitions see
https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care

Serving multiple levels of acuity under one roof

Supports No Wrong Door / Emergency Capable approach

Individuals arrive via:

- Walk-in
- ED Transfer
- Friend/Family
- First Responder
  - Mobile
  - Police
  - EMS



Low Acuity

Urgent Care Clinic
Walk-in access to a psychiatric provider **within 90 min**

"Bridge Clinic" Services
Continued outpatient services for individuals who need bridging or post-crisis care, with warm handoff to community-based services after **a few weeks to month**

High Acuity

High Intensity BH Emergency
23-Hour Observation Unit: Rapid assessment, treatment, stabilization, and discharge planning via interdisciplinary team-based care **for < 24 hours**

High Intensity BH Extended Stabilization
Crisis Stabilization Unit (CSU): Continued care for those who need it **for an additional 3-5 days**

+/ separate involuntary unit for states that require it

Connection to community-based care

70%
Assessed and discharged

60%
Converted to voluntary

90%
Recommend to friends and family

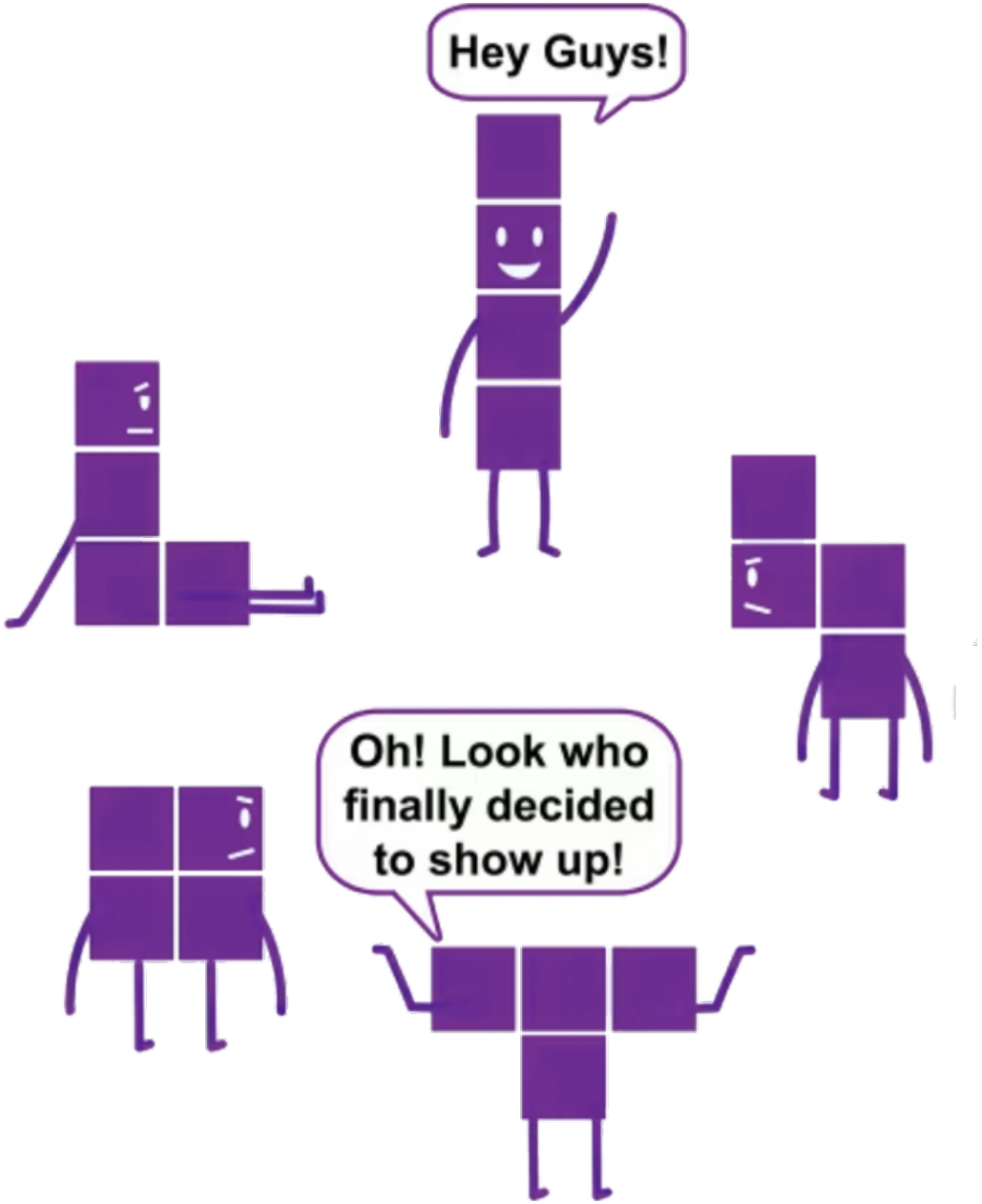
Overcoming regulatory barriers

It's much easier to advocate for these things with the SAMHSA guidelines in hand!



Clinical/Operational Need	Regulatory / Policy Issue
Co-occurring SUD treatment / withdrawal management	Separate funding streams, separate licensure requirements
Accept involuntary patients / law enforcement drop-offs	Civil commitment statutes, local process, separate units
Emergency meds for acute agitation	Med administration (e.g. Pyxis), pharmacy board
Seclusion/Restraint	Licensure and state regs, human rights commission
Transfers from EDs	Local hospital policies / interpretation of EMTALA
EMS drop-offs	Local regs, financing, trauma councils & triage criteria
Capacity	IMD

Putting the pieces together...





SAMHSA Guidelines

BH Coordinated System of Crisis Care (BHCSCC)

Accountable Entity Essential Functions

- Authority & Accountability
- Community assessment & planning
- Coordination & integration
- System flow, continuity & throughput
- Financing
- Regulations
- Data, Evaluation & Quality Improvement

Why an accountable entity matters

The same crisis services can function very differently depending on whether someone is accountable for the connections between them. The accountable entity does not replace providers—it makes coordination and system performance SOMEBODY'S JOB.

WITHOUT AN ACCOUNTABLE ENTITY Strong services, but no one may own the connections.		WITH AN ACCOUNTABLE ENTITY One entity is accountable for how the continuum works together.
✗ No single owner for overall system performance	OWNERSHIP	✓ Clear authority for coordination and system performance
✗ Handoffs rely on local relationships and variable protocols	HANDOFFS	✓ Shared protocols support consistent, reliable transitions
✗ Programs manage capacity separately; bottlenecks shift downstream	CAPACITY + FLOW	✓ Capacity, continuity and throughput are managed system-wide
✗ Siloed data limit visibility across the continuum	DATA + QI	✓ Shared data evaluate performance and drive improvement
✗ Funding and requirements are fragmented across programs	FINANCING + RULES	✓ Funding and regulations are aligned to support the system

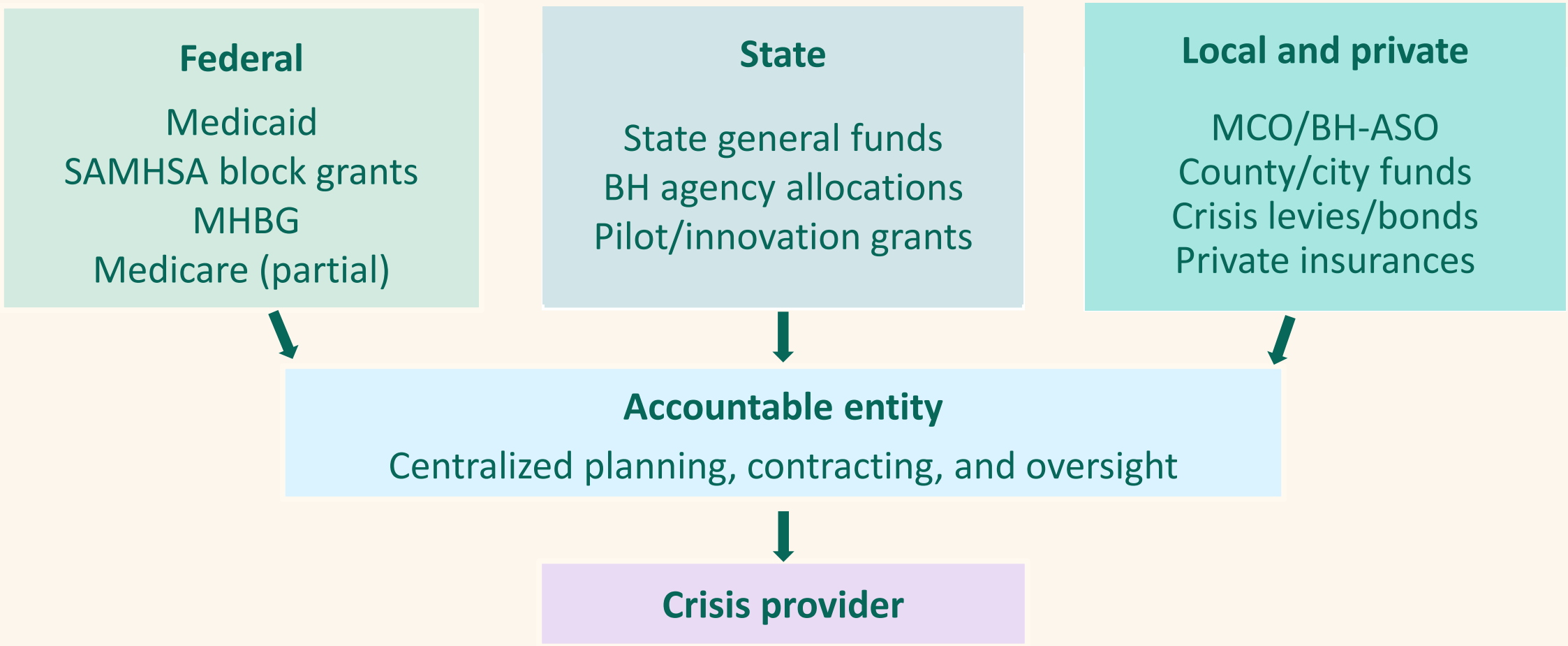
SYSTEM EFFECT Fragmented handoffs + limited visibility → Clear authority + reliable flow + measurable performance

SAMHSA Substance Abuse and Mental Health Services Administration

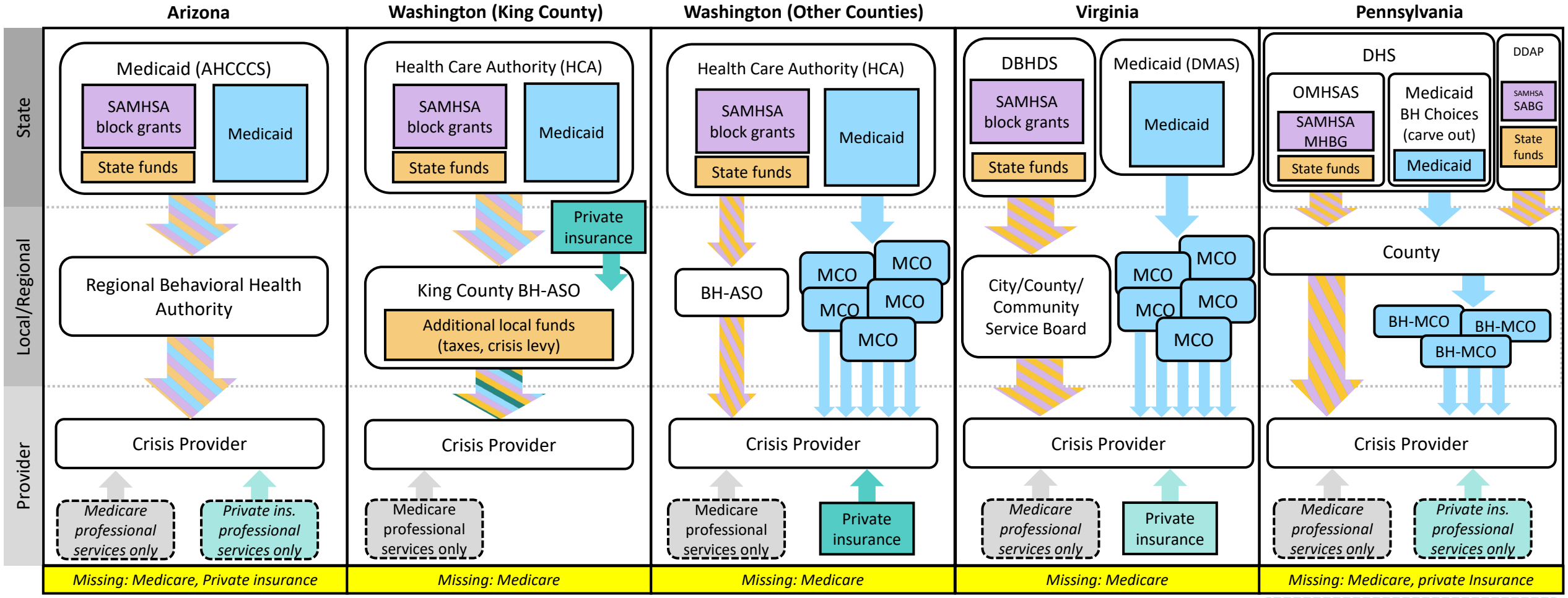
Source: SAMHSA, 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, pp. 59–61.

988 SUICIDE & CRISIS LIFELINE

Every sustainable crisis system relies on three main funding sources



Crisis Funding Models by State



But making progress with health systems (e.g., Geisinger) & Blue Cross plans

Key Points:

- **Funding from multiple sources is needed to serve everyone.**
- **Braided funding by an "accountable entity" supports centralized planning and oversight.**
- **Capacity funding supports "firehouse model" readiness**

connections Health Solutions

CRII funding gumbo

Medicaid

New CMS NTAC:
Best Practices for Implementing the Continuum of Crisis Services Under Medicaid and CHIP

CCBHC

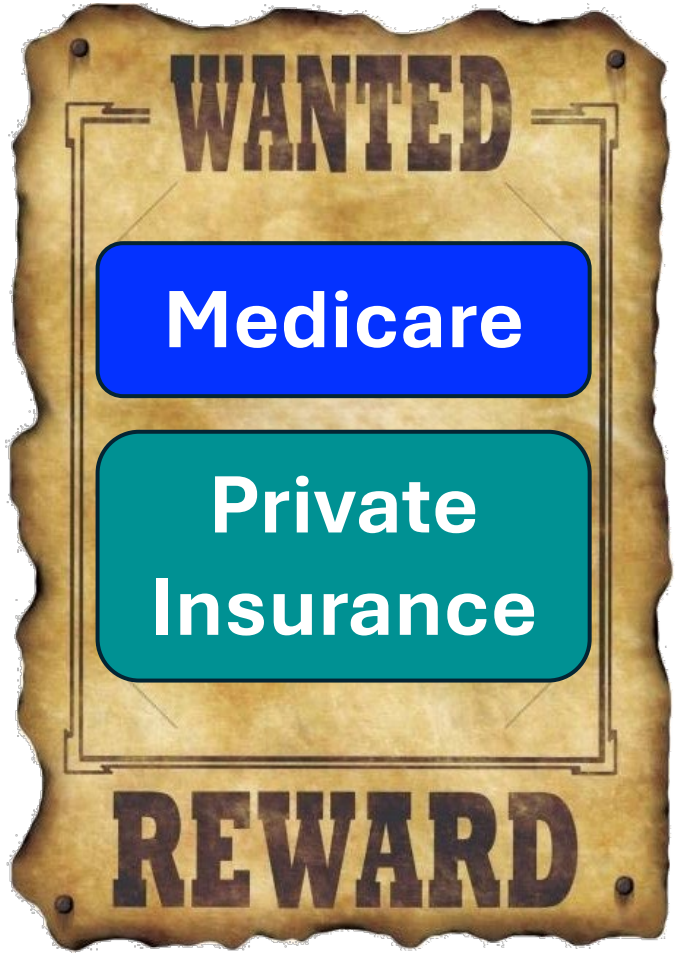
National Council for Mental Wellbeing resource:

The Role of CCBHCs in Crisis Services & Systems

SAMHSA block grants

State & Local
General revenue, 988 telecom fees, taxes & levies, etc.

Other
grants, hospitals, etc.






Your Jedi mind tricks don’t work on me, only data

Return on Investment

An analysis of the crisis system in Phoenix estimated that a **$100 million investment in crisis care** resulted in savings of

- **$260 million** in psychiatric inpatient spending
- **$37 million** in emergency room costs
- **45 years** of psychiatric ER boarding hours
- **37 FTE** of police officer time and salary

In 2016, metro area Phoenix law enforcement engaged 22,000 and transferred them *directly* to crisis facilities and mobile crisis without visiting a hospital ED.

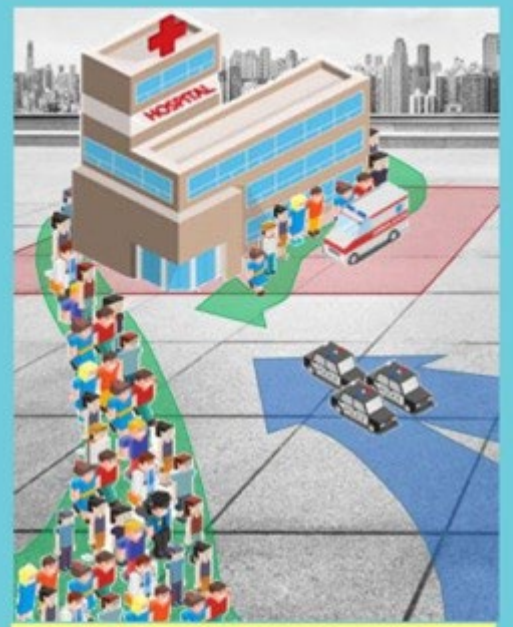
Aetna/Mercy Maricopa 2017 report

What difference did it make?

Improved Crisis Clinical Fit to Need (CCFN) by 6x

Reduced potential state inpatient spend by $260m





Saved hospital EDs $37m in avoided costs/losses

Reduced total psychiatric boarding by 45 years

Calculated from "Impact of psychiatric patient boarding in EDs" (2012) (Nicks and Manthey)

Calculated from Arizona data, 2017

Saved the equivalent of 37 FTE Police Officers



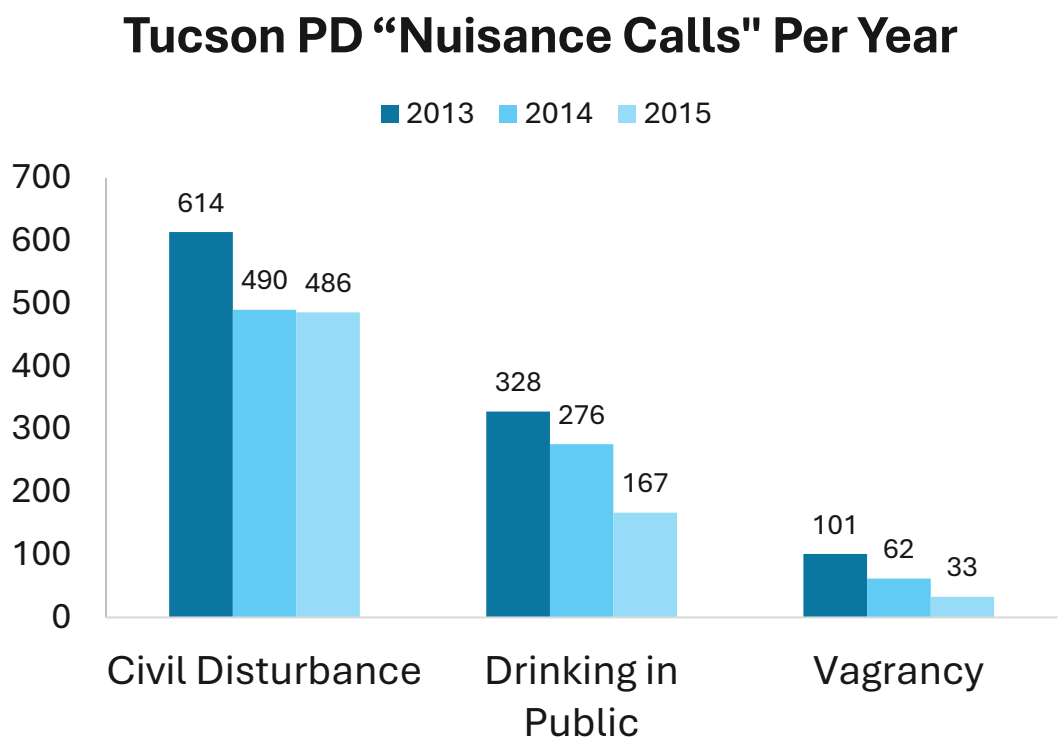
Fire savings just starting.

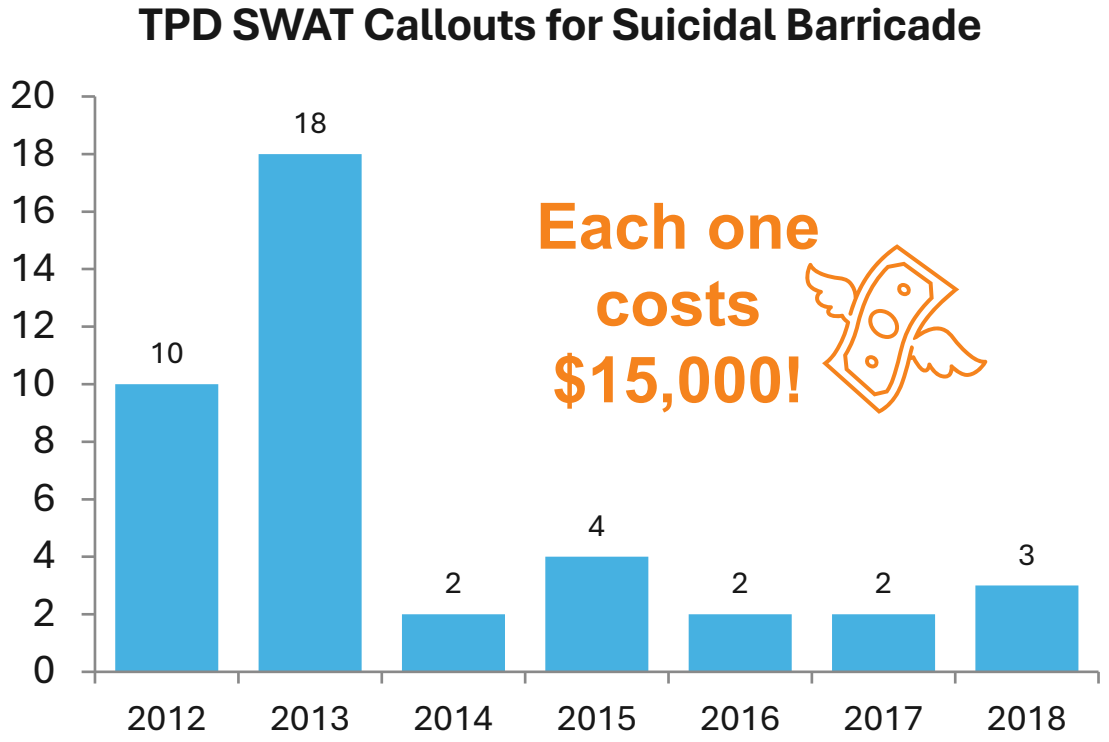
BJA presentation at ISMICC (2017), Madison, Wisconsin data

Impact on Justice Services

Fewer calls for low-level crimes that tend to land our people in jail.

Culture change in how law enforcement responds to mental health crisis.





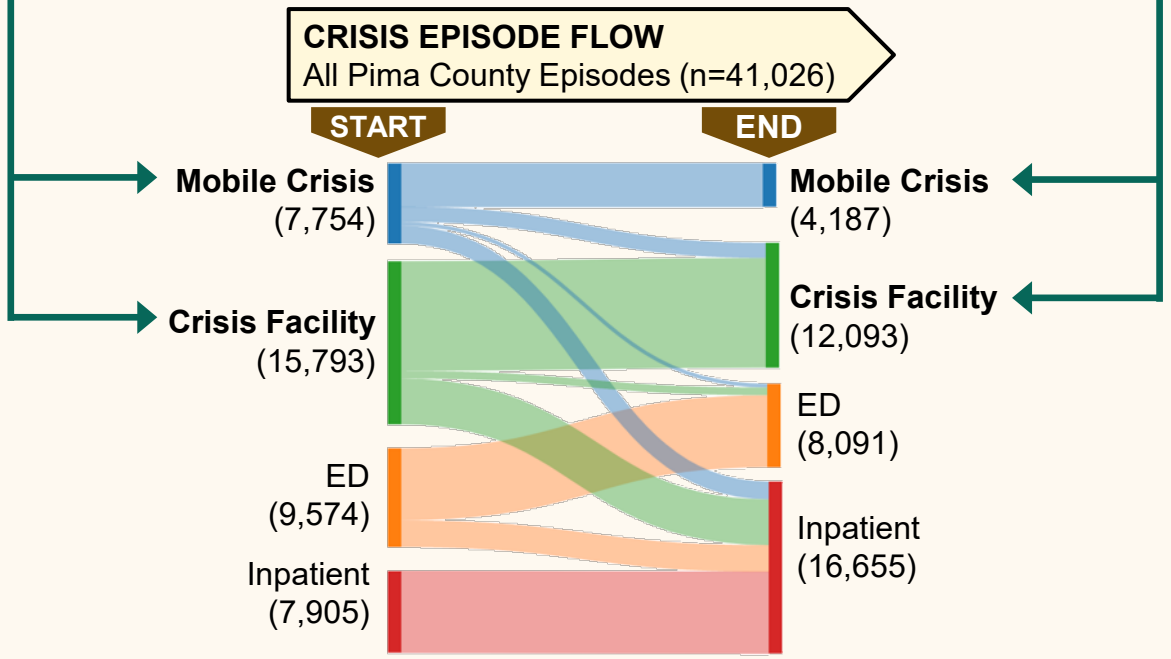
Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. *Psychiatric Services.* 2017;68(2):211-212; https://dx.doi.org/10.1176/appi.ps.68203

Research Study: Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System

Crisis Episode Flow

57.4% of the crisis episodes **began** with a mobile crisis team or crisis facility rather than the emergency department (ED) or inpatient.

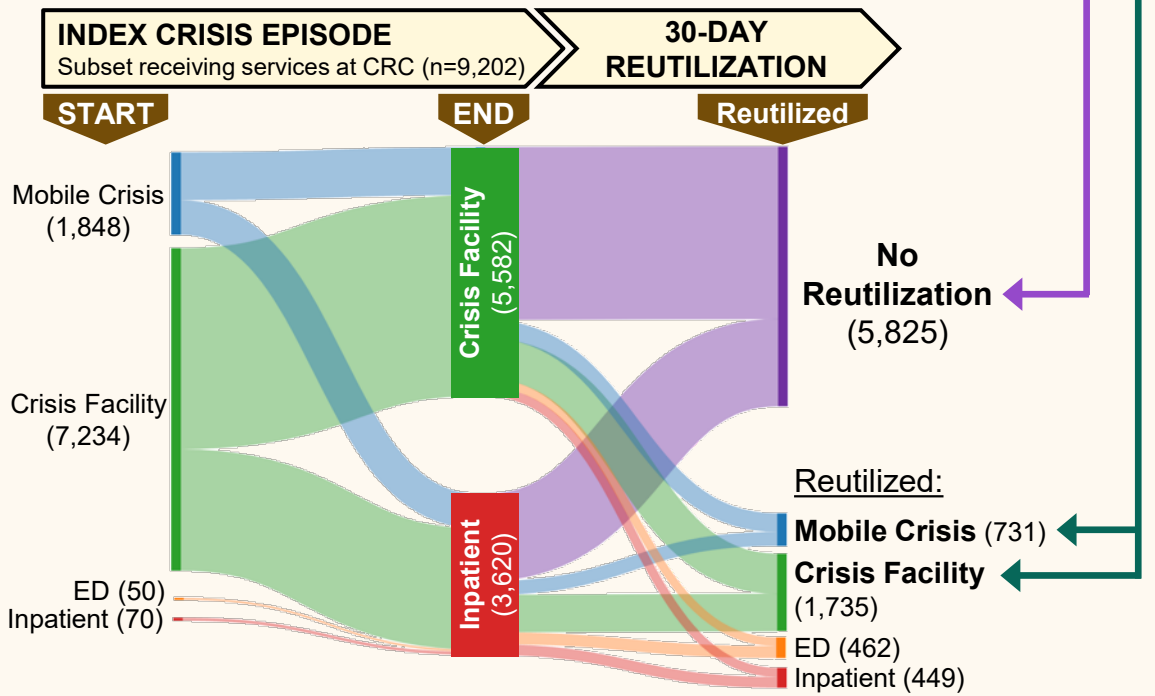
Of those, 69.1% **remained** in the crisis system (ending in mobile crisis or crisis facility).



Reutilization within 30 days

63.3% did not reutilize any services.

Of those that did, 73.0% occurred in a crisis setting (mobile crisis team or crisis facility) rather than the emergency department (ED) or inpatient.

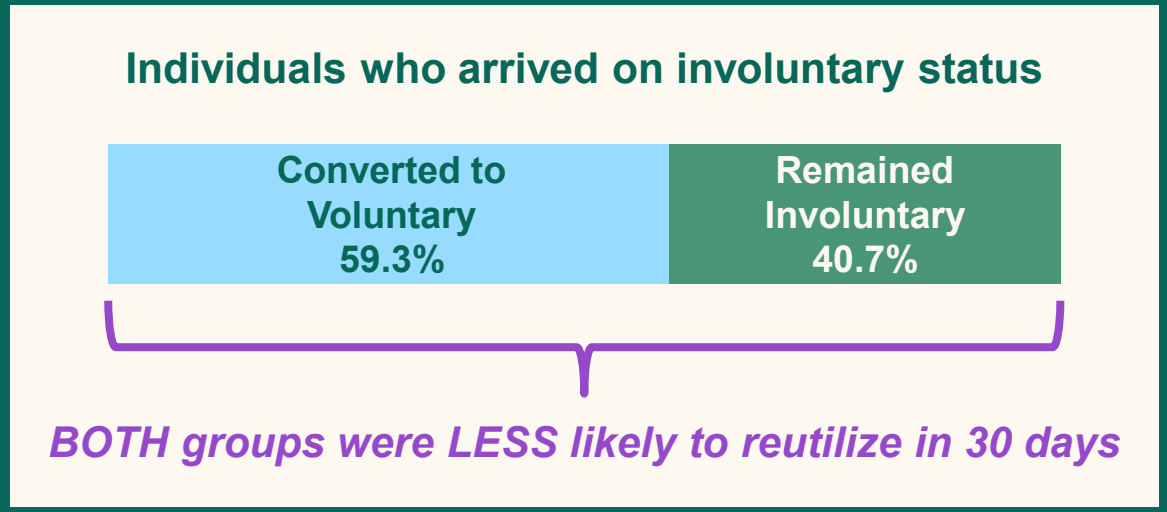


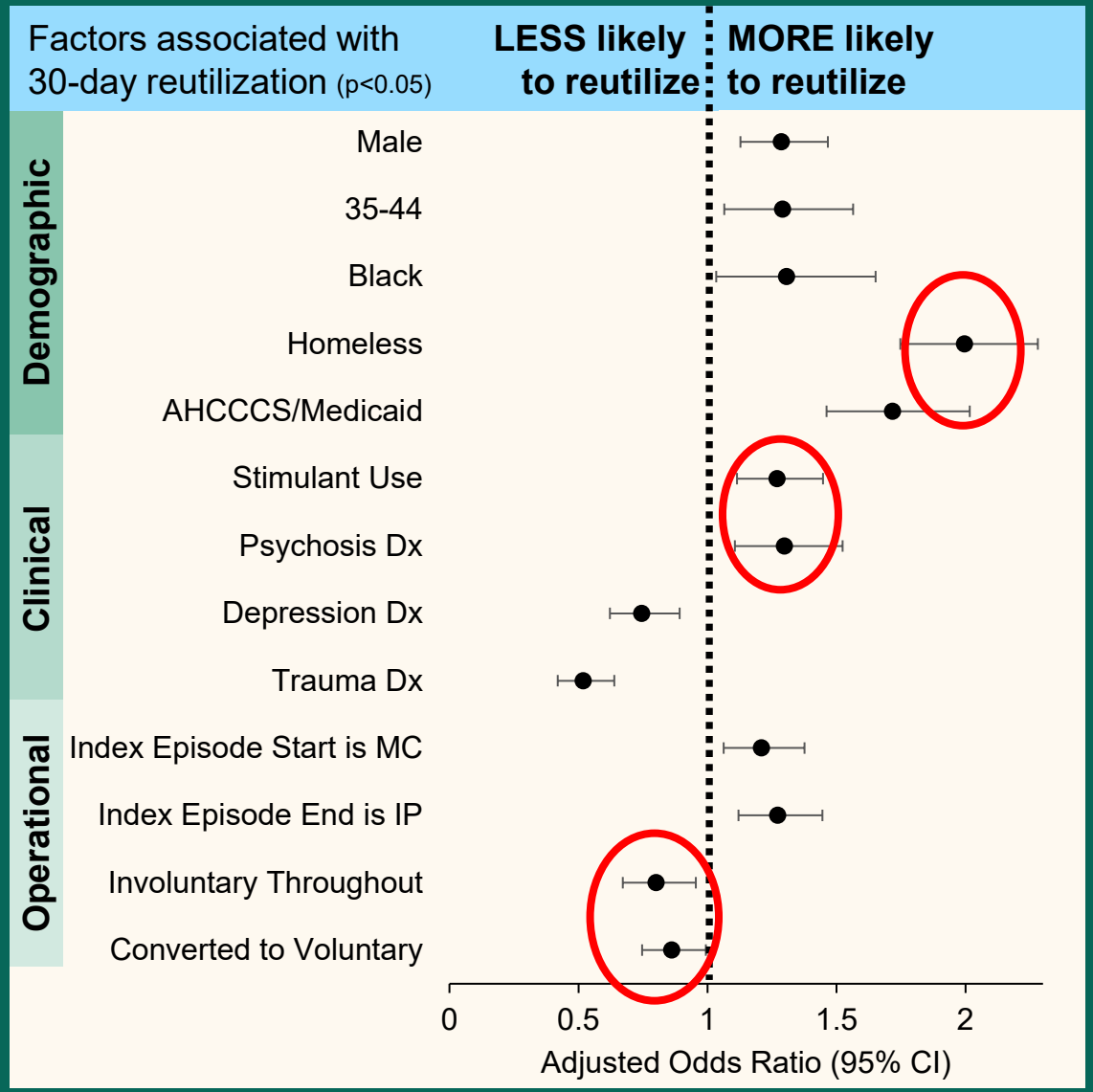
AHCCCS claims analyzed by the ASU Center for Health Information and Research

Tomovic M, Balfour ME, Cho T, Prathap N, Harootunian G, Mehreen R, Ostrovsky A, Goldman ML. (2024) Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System. *Psychiatric Services.* 2024 Jul 1;75(7):614-621. https://doi.org/10.1176/appi.ps.20230232

Research Study: Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System

- To identify factors associated with reutilization, we merged Medicaid claims with Connections EHR data for the 9,202 episodes that included a Crisis Response Center (CRC) visit.
- We also examined the trajectory of individuals who received care at the CRC under an involuntary commitment due to danger to self or others.





AHCCCS claims analyzed by the ASU Center for Health Information and Research

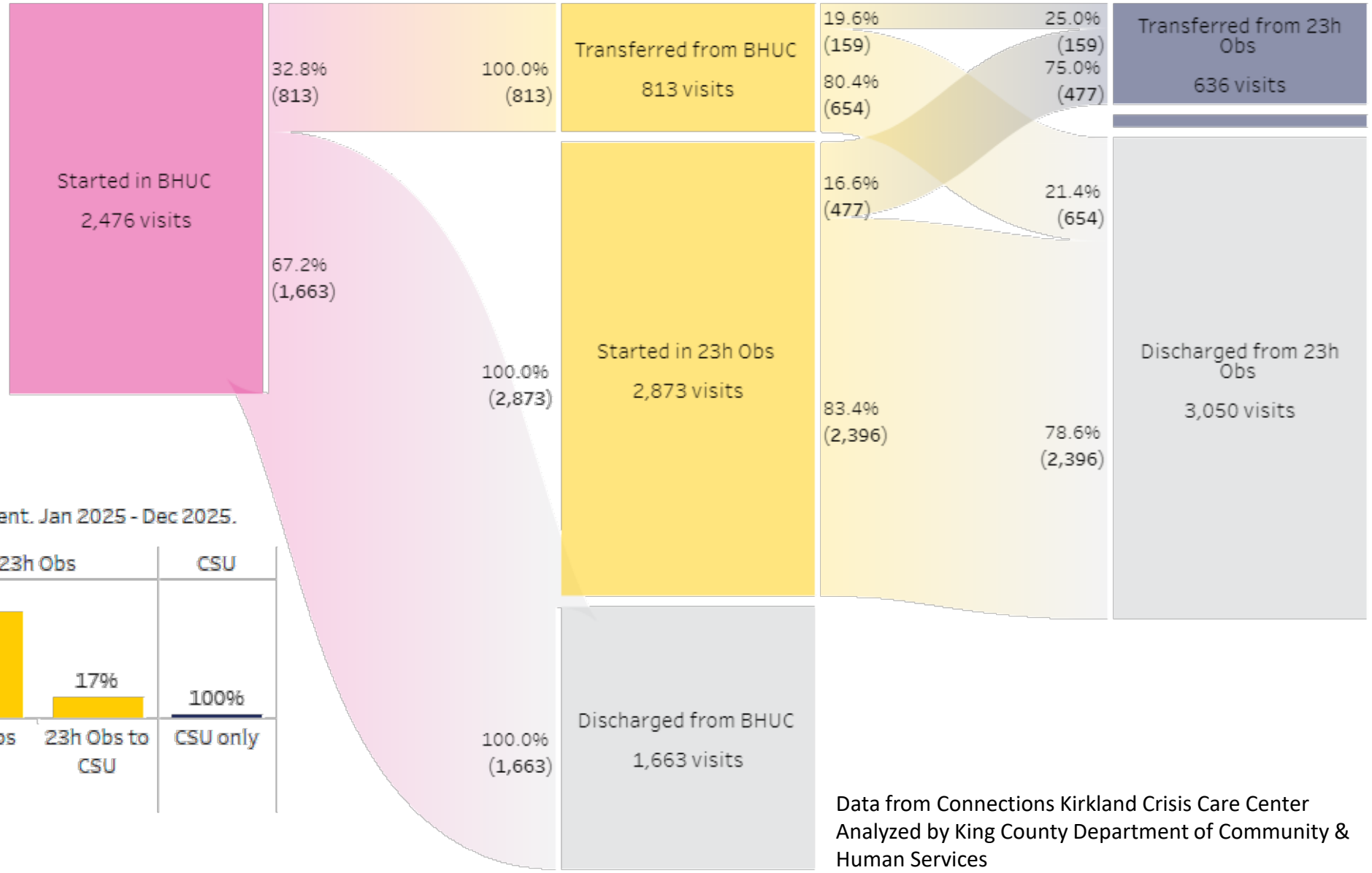
Tomovic M, Balfour ME, Cho T, Prathap N, Harootunian G, Mehreen R, Ostrovsky A, Goldman ML. (2024) Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System. *Psychiatric Services.* 2024 Jul 1;75(7):614-621. https://doi.org/10.1176/appi.ps.20230232

Similar Trends in King County WA

Flow through clinical components (Jan 2025 - Dec 2025)

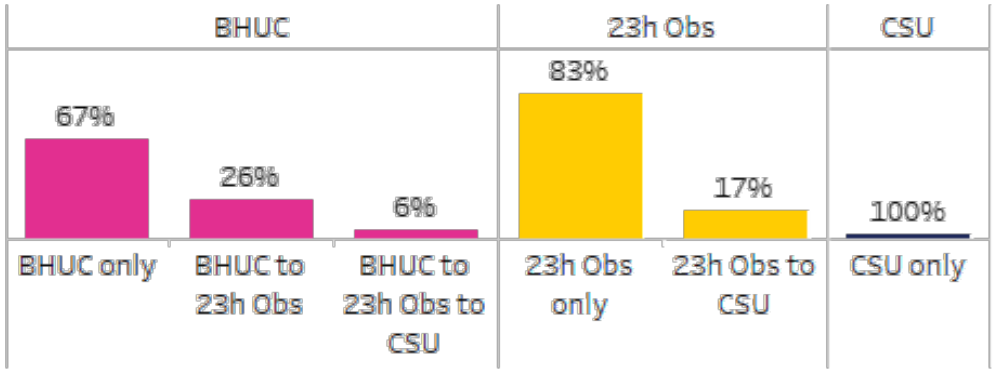
*** Data is preliminary, and subject to change, as we expect ongoing QA and changes to the methodology that bundles authorizations into visits will affect results.

Prepared by DCHS Performance Measurement and Evaluation (PME). Data source: King County BH Database. Last updated: 1/20/2026.



Starting clinical component

Percent of visits starting in a clinical component. Jan 2025 - Dec 2025.



Data: PHP96. Total: 5,425 visits.

Data from Connections Kirkland Crisis Care Center
Analyzed by King County Department of Community & Human Services

Dauphin-Cumberland-Perry Counties, PA

Walk-in Center + Mobile Crisis

Community impact: Year 1



19%

Reduction

302 Emergency Commitments

1415 vs 1753, 2025 vs 2024

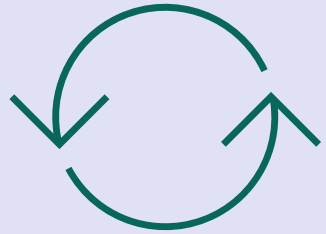


23%

Reduction

police involvement
in crisis encounters

676 vs 876, 2025 vs 2024



20%

Reduction

crisis encounters
per person

1.86 vs 2.32, 2025 vs 2024

Prince William County, Virgina

CRC Community impact: first 6 months

1,580
ED days saved

9,489
Inpatient days avoided

5,433
Law enforcement hours saved

=

6.3
FTE of officers back on the street

In the first 6 months:		**5-minute drop-off replaces**
68%	of ECOs dropped off at CRC	Hours of waiting at the ED
68%	of TDOs placed at CRC	
70%	reduction of state hospital admissions from PWC	Hours of transportation driving time
79%	reduction of PWC out-of-area placements	



Quality Measurement in Crisis Services

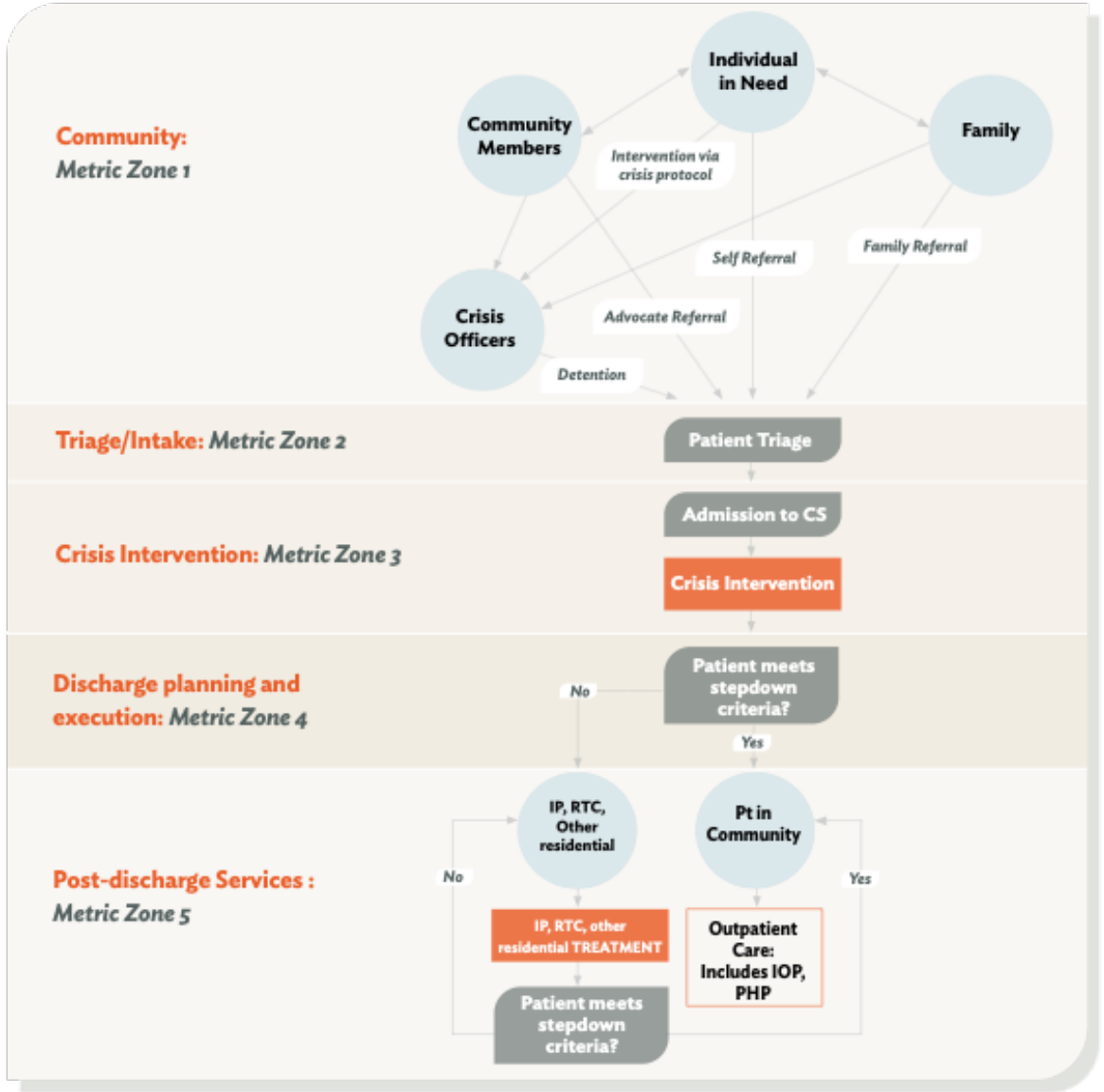
NATIONAL COUNCIL for Mental Wellbeing

MEDICAL DIRECTOR INSTITUTE

Crisis Services Committee

A companion to the *Roadmap to the Ideal Crisis System* report

Download the Report



	Value	Meaning	Examples
A	*Accessible/ Affordable*	I am welcomed wherever I go. I am not turned away.	• Percentage of help-seekers who receive appropriate care vs. all who have sought care. • Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care.
C	*Collaborative*	Helpers work in partnership with me, my family, my caregivers, and other responders.	• The programs assess consumer/family satisfaction surveys and/or net promoter scores.
C	*Comprehensive*	I get help for all my issues that are part of the crisis.	• Access to medical screening. • Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc.
E	*Equitable*	The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc.	• Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations?
S	*Safe*	My experience of help is safe and not harmful. I am never traumatized by asking for help.	• What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so?
S	*Successful*	The care I receive meets my needs.	• Readmission rates. • Symptom reduction.

	Value	Meaning	Examples
T	*Timely*	I get help quickly enough to meet my needs.	• Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times). • Abandonment rate (e.g., call abandonment, left without being seen, etc.). • Lag time between seeking care and receiving care.
O	*Ongoing*	I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive.	• Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up.

	Value	Meaning	Examples
H	*Hopeful*	I am helped to feel more hopeful, and I make better decisions as a result.	• Decrease in suicide, violence, self-harm. • Personal Outcome Measures (POMS).
E	*Engaging*	I am treated as a valuable customer, with respect and dignity.	• Complaints, adverse incidents, escalation.
L	*Least Intrusive*	I receive help in a place that is designed to meet my needs.	• Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion.
P	*Publicized*	I know who to call and/or where to go.	• Information about call lines and walk in centers, increased use of 988 vs. 911.

Disparities in the Response to Emergencies

Medical vs. Behavioral Health

Call for Help

911 has been in place for decades and has evolved into a system that is viewed as an essential service with dedicated funding.

988 was established in 2022. Infrastructure is still developing. Financing mechanisms are variable across states.

Emergency Response

Trained healthcare personnel (EMTs, paramedics) are available 24/7 and respond within minutes. Emergency medical services are reimbursed by Medicare, Medicaid, and private insurance.

Law enforcement is often the default 1st responder, resulting in death and over-incarceration. Mobile crisis is growing, but availability and practice vary widely. Funded mostly by local and SAMHSA funds, and (in some states) Medicaid. Not reimbursed by Medicare or private insurance. Fee for service reimbursement is challenging for sustainability of firehouse model staffing and 2 person teams..

Emergency Transport

Ambulances transport patients to the appropriate emergency department (ED) and/or trauma center based on their needs. Transport is reimbursed by Medicare, Medicaid, and private insurance.

Ambulances are not reimbursed (or at a much lower rate) for transport to a behavioral health crisis facility, contributing to unnecessary ED utilization. Involuntary patients must often be transported by law enforcement.

Emergency Care Facilities

Patients arrive at a facility equipped to meet their needs. Trauma classification system facilitates clear understanding of the capabilities of different facilities. ED visits are reimbursed by Medicare, Medicaid, and private insurance.

BH patients “board” for hours in EDs, without treatment, awaiting transfer to a psychiatric hospital. Most could be stabilized in crisis facilities, but lack of standard licensure and reimbursement creates barriers to implementation. Community-based facilities are reimbursed by Medicaid & SAMHSA funds but not Medicare or private insurance.

Step-Down / Alternatives to Hospitalization

A variety of community-based step-down options exist (skilled-nursing facilities, home-health, etc.) and are reimbursed by Medicare, Medicaid, and private insurance.

Community-based crisis services (crisis residential, peer respite) exist but lack of standard reimbursement creates barriers to implementation. Reimbursed by Medicaid & SAMHSA funds but not Medicare or private insurance.

Policy Action Needed

Support the 988 Suicide & Crisis Lifeline
Continue to strengthen the new 988 Suicide & Crisis lifeline so that it can become an essential and sustainable service like 911.

Reimbursement for Mobile Crisis Services
- Make permanent the state option to provide Medicaid reimbursement for mobile crisis (expires in 2027)
- Provide Medicare payment for mobile crisis services
- Require all federally regulated health plans to cover mobile crisis services

Equitable Transportation Reimbursement
- Provide parity reimbursement for EMS transport to BH crisis facilities
- Encourage states to examine involuntary commitment statutes to allow non-police transportation

Reimbursement for Crisis Stabilization
- Provide Medicare coverage of behavioral emergencies and reimbursement of the full continuum of crisis services
- Include 23-hour observation and crisis stabilization provided at Medicare certified hospitals (including psychiatric and pediatric hospitals) as well as free-standing community-based programs
- Require all federally regulated health plans to cover behavioral emergencies and reimbursement of the full continuum of crisis services

119th Congress' 988/Crisis Legislative Package

Proposals intended to strengthen the Crisis Continuum

H.R. 10240

Behavioral Health Crisis Services Expansion Act of 2026

Sponsor: Rep. Jennifer McClellan VA-04

Co-Sponsors: Rep. Nanette Barragán (CA-44), Rep. Doris Matsui (CA-07), Rep. Adam Smith (WA-09), Rep. Lori Trahan (MA-03), Rep. Seth Moulton (MA-06)

H.R. 10245

988 & 911 Integration Act

Sponsor: Rep. Becca Balint

Co-Sponsors: Rep. Nanette Barragán (CA-44), Rep. Doris Matsui (CA-07), Rep. Jennifer McClellan (VA-04), Del. Eleanor Holmes Norton (DC-At Large), Rep. Adam Smith (WA-09), Rep. Lori Trahan (MA-03)

H.R. 10246

988 Community Infrastructure Act

Sponsor: Rep. Nanette Barragán CA-44

Co-Sponsors: Rep. Jim Costa (CA-21), Rep. Doris Matsui (CA-07), Rep. Jennifer McClellan (VA-04), Del. Eleanor Holmes Norton (DC-At Large), Rep. Adam Smith (WA-09), Rep. Lori Trahan (MA-03), Rep. Jill Tokuda (HI-02) Rep. Shri Thanedar (MI-13)

H.R. 10270

Supporting 988 Crisis Stabilization Act

Sponsor: Rep. Dan Goldman NY-10

Co-Sponsors: Rep. Nanette Barragán (CA-44), Rep. Doris Matsui (CA-07), Rep. Jennifer McClellan (VA-04), Rep. Adam Smith (WA-09), Rep. Lori Trahan (MA-03)

H.R. 10287

988 Crisis Response Act

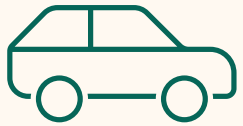
Sponsor: Rep. Kim Schrier WA-08

Co-Sponsors: Rep. Nanette Barragán (CA-44), Rep. Brian Fitzpatrick (PA-01), Rep. Doris Matsui (CA-07), Rep. Jennifer McClellan (VA-04), Rep. Adam Smith (WA-09), Rep. Lori Trahan (MA-03), Rep. David Valadao (CA-22)

H.R. 10280 The 988 Implementation Act

Endorsed by over 60 organizations







SOMEONE TO CONTACT

988 Lifeline & Contact Centers

- $441M for 988 call centers
- 24/7 response capacity
- Technology, staffing & training
- National awareness campaign

SOMEONE TO RESPOND

Mobile Crisis Response

- $100M for mobile crisis teams
- Clinicians, peers & counselors
- Community-based response
- Workforce development support

A SAFE PLACE FOR HELP

Stabilization & Receiving Centers

- Crisis stabilization facilities
- Expanded capital grants
- Insurance coverage requirements
- Medicaid & IMD reforms

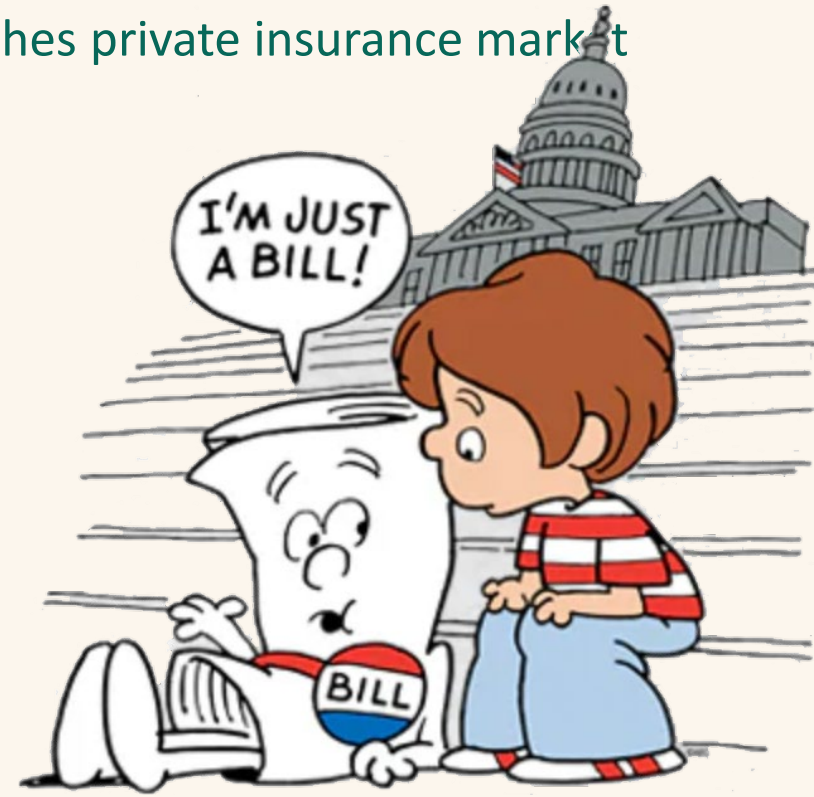
Federal investments + workforce development + insurance coverage + Medicaid modernization =

Fully Functioning Crisis Care Continuum

CARE (Crisis Care Access & Support) for BH Act

H.R. 10419 - 118th Congress (2023-2024)

- Bipartisan legislation was introduced by Rep. Tony Cardenas (D-CA)
- Rep. Fitzpatrick (R-PA) and Rep. DelBene (D-WA) are leading reintroduction post election
- Creates a Medicare demo for coverage of crisis services, including crisis stabilization
- Important because Medicare covers over 64 million Americans & establishes private insurance market (over 150 million Americans)
- ***Tell your Congressperson to co-sponsor!***
- For more info contact Chris.Santarsiero@connectionshs.com



Supported by

National Association of Counties NACo

NACBHDD Empowerment Community Advocacy

American Psychiatric Association

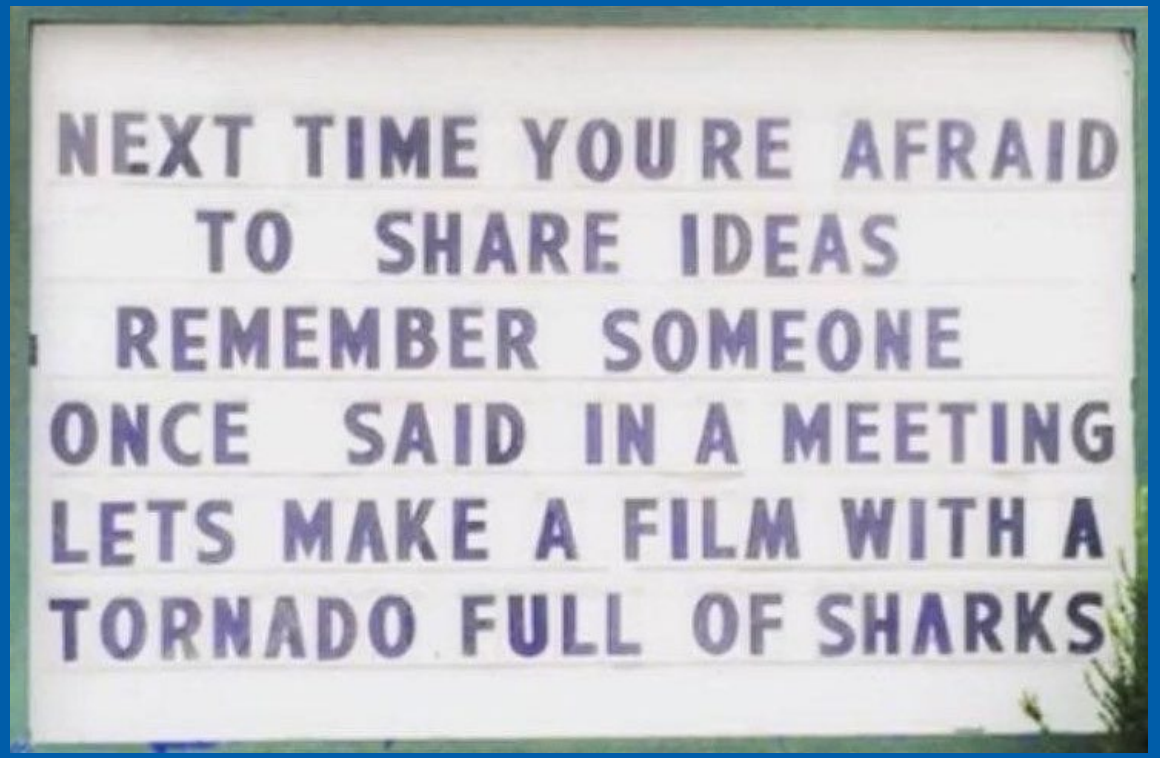
Connections Health Solutions

RI International

Meadows Mental Health Policy Institute

NASMHPD

Questions?



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Executive Policy Advisor
Connections Health Solutions
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Associate Professor
of Psychiatry
University of Arizona

Patients' Rights Advocate Report
October 2026

The October 2026, Patients' Rights Advocate Report from the Patients' Rights Advocacy Program summarizes telephone calls, Certs, emails, certified clients, hearings, contested hearings, and Riese hearing activity.

TELECARE

On October 12, 2026, while on vacation this writer received a voice mail from a client detained on a 5250. The client vehemently denied the grounds of the hold and complained that his rights were illegally denied. This call was forwarded to Ms. Davi Schill, who represented the client at a Certification Review Hearing. The 5250 detention was upheld by the hearing officer

On October 15, 2026, while on vacation this writer received a message from a client detained on a 5250 hold. The client had recently been re-admitted to the facility and felt the detention to be unwarranted. This writer forwarded the message to Ms. Davi Schill who advised the caller of their rights under LPS

On October 22, 2026, this writer received a voice message from a client on the Psychiatric facility. This client accused the staff of treating him disrespectfully. This writer received permission to speak with the Clinical director. Who spoke with the client and the two staff members. The clinical director followed up with the client regarding the allegations. The client did not agree with findings and was informed about his right to the issue to the county level. The client as of this writing did not contact me to take the issue to the next level.

7th Avenue Center
On October 23, 2026, This writer responded to a report of resident-to-resident abuse. The alleged perpetrator refused to meet with this writer However the reported victim chose to do so although the client did not wish to focus upon the incident but voice several complaints concerning lack of medical attention and lack of response from his conservator. In a subsequent phone conversation, the client voiced his desire to contest his conservatorship and provided contact information. The client will have a conversation with his conservator regarding his concerns. At this juncture, the client stated he will contact my office after this occurs. The issues presented to this PRA remain ongoing and require careful follow up.

Certification Review Hearings
October 2026

1. TOTAL NUMBER CERTIFIED	28
2. TOTAL NUMBER OF HEARINGS	24
3. TOTAL NUMBER OF CONTESTED HEARINGS	5
4. NO CONTEST PROBABLE CAUSE	23
5. CONTESTED NO PROBABLE CAUSE	0
6. VOLUNTARY BEFORE CERTIFICATION HEARING	0
7. DISCHARGED BEFORE HEARING	4
8. WRITS	
9. CONTESTED PROBABLE CAUSE	5
10. NON-REGULARLY SCHEDULED HEARINGS	0

Riese Hearings / Capacity Hearings

Total number of Riese petitions filed by the Telecare treating psychiatrist: 2
Total number of Riese Hearings conducted: 2
Total number of Riese Hearings lost:
Total number of Riese Hearings won: 0
Total number of Riese Hearings withdrawn: 0
Hours spent on conducted hearing representation: 1 hours
Hours spent on hearings not conducted: 0
Hours spent on all Riese hearings:
Riese appeals: 0

Respectfully Submitted: Davi Schill, PRA
George Carvalho, PRA

Salud Mental y
Tratamiento del Uso
de Sustancias

Behavioral Health Director's Report

Dr. Marni R. Sandoval

Behavioral Health Advisory Board Meeting – November 19, 2026

Adult System of Care Update

💻 Technology & Training	🔒 Care Coordination	🏠 Housing Access
- SmartCare transition completed - BQuIP implementation - Improved client referrals	- ASCMI training completed - Secure information sharing - Integrated care delivery	- Harvey West Studios opening - 120 supportive housing units - Expanded housing opportunities



Participation at California Health and Human Services (CalHHS) Agency CARE Act Convening along with County Teams from across the State.

NEARLY 12,000 PEOPLE REACHED: Governor Newsom thanks county-level teams and state partners at CARE Act convening | Governor of California

Children's System of Care Update

Breaking Barriers Integrated Care Symposium



Key Highlights

- COE Funding: Supported Children's System of Care staff to attend the annual symposium.
- Santa Cruz County Representatives: Dr. Marni Sandoval and Dr. Lisa Gutierrez-Wang
- Collaborative Learning: Shared innovated county interagency approaches and integrated care models.
- Strategic Planning: Provided opportunities for teams to exchange ideas, problem-solve, and explore adaptable strategies.

Why It Matters for Santa Cruz County

Strengthen Partnerships
Build stronger interagency relationships and collaboration.

Inspire Innovation
Identify promising practices and ideas for other counties.

Advance Integrated Care
Apply new strategies to improve coordination across Santa Cruz County's Children's System of Care.

Substance Use Disorder Update

New Sr BH Program Manager!

Andrea Turnbull, LCSW

- Brings clinical expertise, operational leadership, and systems thinking.
- Previously led initiatives across Access to Care, Crisis Services, suicide prevention, housing partnerships, and SUD services.
- Experienced in staff development, system implementation efforts, and critical community partnerships.

- Integrated Behavioral Health Services
  Stronger Cross-Program Collaboration
  - SUDS continues integrating with Access and Outpatient teams.
  - Enhancing coordinated care and reducing program silos.
  - Expanding clinical capacity across Behavioral Health.

- Criminal Justice Partnerships
  Strengthening Continuity of Care
  - Continued collaboration with Probation, Courts, and Custody staff.
  - Improving connections to treatment for individuals with substance use needs.
  - Refining workflows to support timelier assessments, streamlined service authorizations, stronger follow-up and care coordination.
  - SUDS staff trained on appropriate sharing of allowable treatment information with partners.

Accessing Care

Medi-Cal Members

Salud Mental y
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de Sustancias

Mild – Moderate Level of Care

Managed Care Plan (MCP)

Central California Alliance for Health (CCAH)

How Members Access BH Care



Member in need of BH Services

- Member can self-refer by calling Alliance directly
- Member can call contracted BH provider directly for services and bypass Alliance
- Member can call/walk into local MHP access for screening and assessment
- PCP can access referral forms online at Behavioral Health - Central California Alliance for Health (will be updated for internal processes come 7/1/25)

MCP or MHP completes DHCS Screening Tool

- If member is referred to Alliance or the Mental Health Plan (MHP), a BH CM staff member will screen member for correct system of care and need and provide appropriate referrals within timely access requirement. The Alliance and our 5 MHPs coordinate daily on these referrals

Member Connected to Care

- Member will be offered appointment assistance and to be connected to a provider with an appointment within timely access requirements

Members can call 800-700-3874
All members will be getting new CCAH ID cards

Mild – Moderate Level of Care

Managed Care Plan (MCP)

Central California Alliance for Health (CCAH)

Behavioral Health CM Referral



Providers can call the alliance case management line 800-700-3874 X5512



Providers can submit a care management referral form directly through the Alliance website. Care Management Referral Form - Central California Alliance for Health or Referrals via fax to (831)430-5850.



Referral via e-mail to list CM behavioral health team ListBHCMintakecoordinators@thealliance.health



"CCAHs website is not current for referral pathways until 7/1/25. Current CM referral is on our Provider Care Management landing page Behavioral Health - Central California Alliance for Health



Specialty Mental Health & Substance Use Level of Care

Behavioral Health Plan (BHP)

Santa Cruz County Behavioral Health (SCCBH)

Member can call for screening and assessment/referral anytime Monday-Friday 8:00-5:00
800-952-2335

Member can self-refer by walking into our offices:
1400 Emeline Ave., Santa Cruz
1430 Freedom Blvd., Watsonville
Monday –Friday 8:00-4:00

Member will talk to a clinician who will offer a screening to determine appropriate level of care

- **Will be referred to CCAH if screened mild to moderate**
- **Will be scheduled for an assessment with a licensed clinician if screened severe**
- **Will be offered ongoing behavioral health services at the appropriate level of care**

Substance Use Services will be screened for and services offered depending on level of care determined

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Easy Referral to Care

Mild-Moderate

Managed Care Plan - CCAH

Online Portal
https://thealliance.health/for-providers/care-management-referral-form/

800-700-3874 x5512

Severe

County Behavioral Health Plan

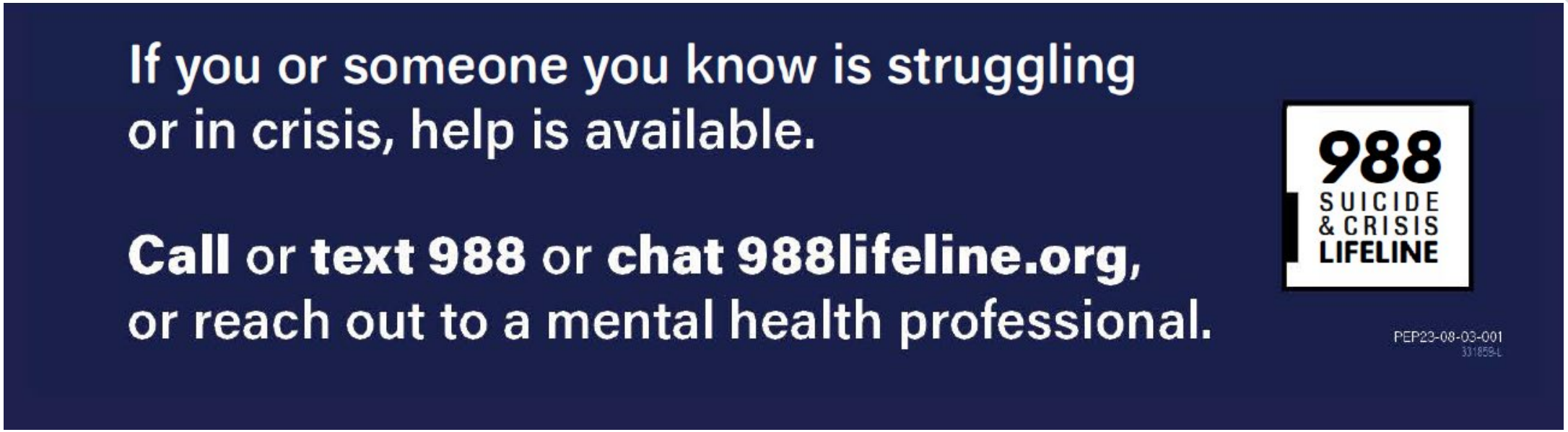
Access Line

800-952-2335
(24 hour line)

Salud Mental y Tratamiento del Uso de Sustancias

Crisis




If you or someone you know is struggling or in crisis, help is available.
Call or text 988 or chat 988lifeline.org, or reach out to a mental health professional.
988
SUICIDE & CRISIS LIFELINE
PEP23-08-03-001
331858-L


YOU MATTER
Text.
Call.
Chat.
988
SUICIDE & CRISIS LIFELINE

Questions?

Thank You

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Tratamiento del Uso
de Sustancias