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The Crisis Continuum: Building What Comes Next

Findings and Recommendations for California

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Acknowledgements

This report was informed by the insights and experiences of leaders working across California's behavioral health crisis continuum. We are deeply grateful to the executives, clinicians, advocates, policymakers, and system leaders who generously shared their time and expertise through key informant interviews.

Participants represented community-based organizations, county behavioral health, advocacy organizations, crisis service providers, and other stakeholders with direct experience designing, operating, financing, and improving crisis systems. Their perspectives helped shape the findings and recommendations presented throughout this report.

We extend our sincere appreciation to the following individuals for their contributions to this project:

- Steve Adelsheim, MD — Director, Center for Youth Mental Health and Wellbeing, Stanford Medicine Children's Health
- Ruqayya Ahmad, MPP — Senior Policy Manager, California Pan-Ethnic Health Network
- Michelle Cabrera, MPP — Executive Director, California Behavioral Health Directors Association
- Shawn M. Caracoza, LCSW — President and Chief Operating Officer, Pacific Clinics
- Chad Costello, MSW, CPRP — Executive Director, California Association of Social Rehabilitation Agencies
- Kent Dunlap, MPH — President and Chief Executive Officer, Stars Behavioral Health Group
- Darrell Hamilton — Regional Director, Fresno MHSA Programs, Kings View
- Victoria Kelley, LCSW — Chief Executive Officer, Redwood Community Services
- Kathryn Krueger, PhD, BCBA — Senior Clinical Director, Neurodevelopmental Services, Pacific Clinics
- Melissa Lawton, LMFT — Chief Program Officer, Seneca Family of Agencies
- Robb Layne — Executive Director, California Association of Alcohol and Drug Program Executives
- Jana Lord, PsyD — Chief Operating Officer, Sycamores
- Richard Louis III — Director of Business Development, Gateways Hospital and Mental Health Centers
- Kathy McCarthy, Esq. — Chief Executive Officer, Pacific Clinics
- Anete Millers, JD — Vice President, Legal and Regulatory Affairs, California Association of Health Plans
- Lyn Morris, LMFT — Chief Executive Officer, Didi Hirsch Mental Health Services
- Mira Morton, JD — Vice President of Government Affairs, California Children's Hospital Association
- Trent Murphy — Policy Analyst, California Association of Alcohol and Drug Program Executives
- Scott Osborn, MSW, LCSW — Chief Operating Officer, Seneca Family of Agencies
- Selena Liu-Rafael — Senior Advisor for TAY Initiatives, California Alliance of Child and Family Services
- Eric Rosen, PhD, LMFT — Director of Business Development, Kings View
- Mae Sampani, LMFT — Executive Director, Crisis Services, Pacific Clinics
- Adrienne Shilton, MPPA — Senior Vice President, Public Policy & Strategy, California Alliance of Child and Family Services
- Divya Shiv, MPP — Senior Policy Advocate, California Alliance of Child and Family Services
- Shari Sinwelski, MS, EdS, LPCC, NCC — Vice President, Crisis Care, Didi Hirsch Mental Health Services
- Marilyn Sliney, LMFT — Chief Clinical Officer, Kings View
- Petra Steinbuchel, MD — Director, Child and Adolescent Psychiatric Emergency Services, UCSF Benioff Children's Hospital
- Jolene Treadaway, LCSW — Chief Clinical Officer, Redwood Community Services
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- Jessica Wilson Cruz, MPA — Chief Executive Officer, NAMI California

* *Participation does not imply endorsement of this report's findings or recommendations. The authors are responsible for any errors or omissions.*

Executive Summary

Purpose

California has made historic investments in behavioral health crisis services. Since 2021, the state has expanded access to the Suicide and Crisis Lifeline (988), established mobile crisis as a Medi-Cal benefit, invested billions of dollars in crisis infrastructure through the Behavioral Health Continuum Infrastructure Program (BHCIP), and created new funding mechanisms intended to strengthen crisis services over the long term.

These investments have expanded crisis capacity across the state, increasing the availability of crisis response and creating critical infrastructure on which a more complete continuum can be built. Yet providers, counties, and advocates continue to report challenges translating that progress into operational services, connecting individuals to timely care, coordinating services across organizations, and sustaining crisis programs over time.

This report examines a central question facing California's behavioral health system:

> ***Are California's investments building a coordinated crisis continuum, or primarily expanding individual services without the systems needed to connect and integrate them?***

To explore that question, Pacific Clinics conducted 20 key informant interviews with community-based organizations (CBOs), industry representatives, and advocacy leaders working across California's crisis system. Findings were analyzed alongside state reports, published research, and publicly available data sources.

Key Findings

Despite differences in geography, organizational type, and role within the system, respondents identified four consistent themes.

1. The greatest challenge occurs after the crisis.

The most frequently cited concern was the gap between crisis stabilization and ongoing care. Respondents consistently described difficulties connecting individuals to appropriate follow-up services, a finding identified in approximately 85% of interviews and the most consistently raised concern across stakeholder groups. Many participants described a "step-down cliff" in which individuals are successfully stabilized in crisis settings but struggle to access the outpatient treatment, housing supports, care coordination, substance use services, and other resources needed to sustain recovery. As a result, respondents frequently reported individuals remaining in crisis stabilization settings beyond their intended length of stay.

2. Financing challenges are interconnected.

Participants described a financing environment characterized by inadequate or delayed reimbursement, fragmented funding streams, reliance on time-limited funding, inconsistent payer participation, and payment models that often do not align with the operational realities of 24/7 crisis services. These problems rarely occur in isolation. Together, they affect whether providers can recruit staff, keep services available, and sustain programs over time.

3. Fragmentation remains a significant barrier.

Respondents frequently described a system in which crisis lines, mobile crisis teams, emergency departments, law enforcement, counties, and community providers operate under different protocols, funding structures, and accountability mechanisms. Many emphasized that effective crisis care depends on strong partnerships, particularly among counties, law enforcement, hospitals, and community-based providers, to coordinate response, stabilization, and follow-up services. Structural fragmentation was among the most frequently identified findings, appearing in approximately three-quarters of interviews.

The system is especially vulnerable at the handoff from one organization to another. In many communities, successful coordination frequently relies on local relationships rather than standardized processes.

4. Crisis services are increasingly responding to unmet upstream needs.

Interview participants consistently described crisis systems absorbing demand created by gaps in upstream behavioral health care. This dynamic is not new. Hospital emergency departments have long absorbed needs that could have been addressed through accessible primary and outpatient care. The experience offers a caution for behavioral health systems: without investment in prevention, outpatient treatment, substance use services, housing, and other community-based supports, crisis services risk becoming the default response to unmet needs elsewhere in the system. Across both respondent groups, roughly 70–80% of interviews linked growing crisis use to gaps across the broader health and social service systems.

Many stakeholders viewed crisis care as one component of a larger behavioral health continuum rather than a standalone service category.

What a Functional Crisis Continuum Requires

Evidence from the literature, comparison models, and stakeholder interviews suggests that effective crisis systems share several common characteristics:

- A clear and accessible entry point for individuals experiencing a behavioral health crisis, supported by a no-wrong-door approach across crisis pathways
- Community-based response options that reduce unnecessary reliance on law enforcement and emergency departments
- Stabilization services capable of meeting varying levels of need
- Strong transitions to ongoing care and recovery supports
- Shared accountability, financing, and data infrastructure that connect the continuum

California has made substantial progress in building many of these components. The challenge ahead is strengthening the systems, incentives, and partnerships that connect them.

Priority Areas for Action

The findings point to five priorities for policymakers, regulators, counties, health plans, providers, and system leaders.

1. Transitions and Follow-Up

Identify service gaps, expand post-crisis supports, improve care coordination, and establish accountability for successful transitions from stabilization to ongoing care.

Ensure stabilization leads to recovery

- Seamless transitions between levels of care
- Post-crisis recovery support
- Accountability beyond stabilization

MOST FREQUENTLY IDENTIFIED CHALLENGE

2. Financing Reform

Develop sustainable financing across the crisis care continuum to support workforce stability, timely reimbursement, and long-term operations while clarifying public and commercial payer responsibilities.

Align financing with crisis system needs

- Pay for readiness, not just encounters
- Sustainable 24/7 response infrastructure
- Shared accountability across all payers

3. Shared Accountability

Improve coordination across crisis lines, mobile crisis teams, emergency departments, law enforcement, health plans, counties, and providers through shared protocols, data infrastructure, and performance measures.

Make the crisis continuum function as a system

- Clear ownership of system performance
- Shared outcomes and public reporting
- Regional governance and coordination

4. Workforce Development

Invest in peer services, strengthen workforce pipelines, and create sustainable pathways for recruiting and retaining crisis workers.

Build and sustain the crisis workforce

- Expand peer and clinical workforce pipelines
- Improve recruitment and retention
- Support workforce well-being and resilience

5. Upstream Investment

Expand access to prevention, early intervention, outpatient treatment, and substance use services to reduce avoidable crisis utilization.

Reduce avoidable crises before they occur

- Expand access to outpatient treatment
- Strengthen prevention and early intervention
- Address unmet behavioral health needs earlier

The organizations interviewed for this paper were largely aligned on one point: building additional crisis capacity remains important, but improving how existing services work together may ultimately determine whether California achieves the vision of a truly integrated behavioral health crisis system.

SECTION 1

The Moment: Why This Matters Now

Mobile crisis response in Los Angeles County
Sycamores

1.1 Introduction

California is moving from historic investment in crisis services to the more difficult work of sustained implementation. The expansion of the 988 Suicide and Crisis Lifeline, mobile crisis, and behavioral health infrastructure has created many of the components of a modern crisis continuum. California also established a statewide vision for crisis system development through the 2023 Behavioral Health Crisis Care Continuum Plan. Few states have undertaken crisis system reform at this scale. The challenge now is ensuring those components are adequately staffed, financed, coordinated, and connected into a functioning system[1,2,3,4]

These investments have expanded crisis infrastructure across California. Yet providers, counties, health plans, advocates, and policymakers continue to report challenges connecting individuals to timely care, coordinating services across organizations, sustaining crisis programs, and ensuring successful transitions from crisis stabilization to ongoing support.[5,6,7]

The contrast between historic investment and persistent gaps raises an important question. While California has expanded individual components of the crisis continuum, many stakeholders continue to question whether those components function together as a coordinated system.

This paper examines that question.

Drawing on interviews with behavioral health leaders across California, state reports, published research, administrative data, and policy guidance, the paper examines the financing, workforce, accountability, and coordination structures that shape how crisis services operate together. The goal is not to evaluate individual programs or organizations, but to understand the conditions that help or hinder a functioning continuum.

California has built substantial crisis response capacity. The next challenge is making sure the systems around those services are strong enough to hold them together: sustainable financing, a stable workforce, clear accountability, and reliable coordination across organizations and levels of care. Grounded in voices from the field, this paper is written for policymakers, counties, providers, health plans, advocates, and system leaders. It is intended as an entry point for further discussion rather than a comprehensive solutions toolkit. The recommendations offered here will require continued exploration and refinement across California's diverse local systems.

Kern County Psychiatric Health Facility in Bakersfield
Stars Behavioral Health Group

Why Now

California is entering a pivotal implementation period following years of significant investment and expansion in behavioral health crisis services, including 988, mobile crisis services, crisis stabilization, and other crisis infrastructure. These efforts have substantially expanded the state's capacity to respond to behavioral health crises. Many of the challenges identified by stakeholders are not new. Workforce shortages, fragmented service delivery, financing instability, and difficulties transitioning individuals between levels of care have persisted across multiple reform efforts and investment cycles.

That implementation is occurring amid new fiscal uncertainty. Federal Medicaid changes enacted through H.R. 1 may place additional pressure on state and local behavioral health systems. At the same time, the temporary enhanced federal match for qualifying mobile crisis services, which allows the federal government to cover 85 percent of eligible costs, is scheduled to expire at the end of 2026.

Crisis service expansion is already underway. Whether those investments mature into a functioning continuum will depend on whether financing, staffing, coordination, and accountability keep pace with the infrastructure being built.

How This Paper Was Developed

This paper draws on multiple sources of information to examine the current state of California's behavioral health crisis continuum.

The primary qualitative component consists of 20 semi-structured interviews conducted between December 2025 and April 2026 with leaders from community-based organizations, industry groups, and advocacy organizations representing 17 organizations and 31 interview participants across California's crisis system. Although the research team sought to include people with lived experience of the crisis system, scheduling constraints prevented those interviews from being completed, and their absence is an important limitation of this study.

Two interview protocols were used to capture both operational and policy perspectives on the same system. Interview transcripts were converted into a structured dataset and analyzed using a coding methodology designed to identify recurring themes, areas of alignment, and differences across stakeholder groups. Coding was supported by a large language model (LLM) using a standardized codebook applied consistently across all interviews. A subset of responses was independently coded by the research team to validate the approach, resulting in 85% agreement. Analysis included assessment of code frequency, interview-level prevalence, and differences across respondent groups. Additional methodological detail is provided in Appendix A.

How Interviews Became Findings

Interview

- 20 semi-structured interviews
- Two protocols - one for CBOs, one for industry and advocacy
- Background survey for each respondent

Transcript

- Interviews transcribed verbatim
- Converted into a structured dataset for systematic analysis

Categorizing the interview data

- Responses sorted into 47 categories
- Large language model (LLM)-assisted coding across all interviews
- Categories grouped into 6 domains
- Human reviewers and the LLM agreed 85% of the time

Theme analysis

- Code frequency
- Interview-level prevalence
- Differences between CBO and industry/advocacy respondents

Findings

- Recurring themes
- Areas of alignment
- Differences across stakeholder groups
- Priority actions

These findings were supplemented by three complementary sources of evidence: California policy and administrative documents that establish the state's crisis system landscape; published research and federal guidance on behavioral health crisis systems, including Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care and the Crisis Now framework; and publicly available population health and administrative data used to characterize behavioral health need, access barriers, and service utilization trends.

Together, these sources provide a field-informed assessment of the opportunities and challenges shaping California's behavioral health crisis continuum.

1.2 Growing Demand for Crisis Care

The behavioral health crisis system is responding to a level of need that has grown steadily over the past decade and accelerated in recent years. Across California, millions of residents experience serious mental illness, substance use disorders, or behavioral health conditions that increase the likelihood of crisis.

An estimated 17% of Californians age 12 and older have a substance use disorder, representing roughly 5.6 million people.[8] Nearly 1 in 7 California adults have a mental illness, and 1 in 26 have a serious mental illness, representing roughly 4.4 million and 1.2 million Californians, respectively.[8,9] Rates of serious mental illness increased substantially between 2008 and 2019, with young adults ages 18 to 25 experiencing the highest prevalence of any adult age group.[7,9] Among children and adolescents, approximately one in thirteen experience a serious emotional disturbance, with significant disparities across demographic groups.[9]

1 in 7

California adults experience a mental illness[8,9]

1 in 5

Emergency department visits involve a behavioral health condition[5,11]

The impact of these trends is visible throughout the health care system. In 2022, 4,164 Californians died by suicide.[5,10] Behavioral health conditions account for approximately one in five emergency department visits and one in three inpatient hospitalizations.[5,11] Drug-related emergency department visits continue to increase, while psychiatric patients routinely experience substantially longer emergency department stays than individuals presenting with non-psychiatric conditions.[5,12,13,14]

Many stakeholders view rising crisis utilization as both a reflection of increasing behavioral health need and ongoing challenges accessing prevention, outpatient treatment, substance use services, and other community-based supports. More than four in ten Californians seeking mental health care report difficulty finding an in-network provider, and many individuals with serious behavioral health conditions never receive specialty treatment at all.[7,9]

Justice-involved populations, Black Californians, LGBTQ+ youth, American Indian and Alaska Native communities, and other historically underserved groups often experience both higher behavioral health needs and greater barriers to care.[7,15,16,17,18,19,20]

The picture is clear: California's crisis system is operating amid growing demand, uneven access, and persistent disparities. Those pressures shape who reaches care, how quickly they receive it, and whether the system has the capacity to respond.

1.3 Expansion of Crisis Services

California has responded to rising behavioral health needs with a significant expansion of crisis infrastructure. Understanding the scale of these investments requires first understanding what a crisis continuum is designed to do.

California defines a behavioral health crisis as a situation in which a person's mental health condition places them at risk of harm to themselves or others, or leaves them unable to provide for their basic needs, requiring immediate evaluation and intervention.[21,22] While involuntary intervention is reserved for the most acute circumstances, behavioral health crises often emerge well before those legal thresholds are reached.[21,22]

A behavioral health crisis continuum encompasses the services, programs, and supports intended to prevent crises when possible, respond effectively when crises occur, stabilize individuals in the least restrictive setting appropriate to their needs, and connect them to ongoing care and recovery supports.[5] While specific models vary, effective crisis systems generally include four core functions: someone to call, someone to respond, somewhere to go, and someone to follow up.[27,28]

The Crisis Continuum

Someone to Call
Crisis Call Centers

Immediate support, assessment, and connection to care

EXAMPLES
- 988
- Crisis hotlines
- Behavioral health access lines

Someone to Respond
Mobile Crisis Teams

Community-based crisis intervention, assessment, and de-escalation

EXAMPLES
- Mobile crisis teams
- Outreach teams
- Community responders

Somewhere to Go
Crisis Stabilization and Inpatient Care

Facility-based observation, stabilization, and treatment when community intervention is not sufficient

EXAMPLES
- Crisis stabilization units
- Crisis receiving centers
- Crisis residential programs
- Behavioral Health Urgent Care

Someone to Follow Up
Ongoing Community Support

Follow-up services that promote recovery and connection to ongoing care

EXAMPLES
- Follow-up outreach
- Peer support
- Enhanced Care Management
- Outpatient treatments

California's recent investments have touched nearly every part of this continuum, as the timeline below illustrates.

2013–2016: Mental Health Wellness Act Established County Crisis Infrastructure (SB 82; amended by SB 833)[12]
Laid the groundwork for the crisis stabilization and residential facilities that California counties operate today; SB 82 (2013) provided the first state funding for mobile crisis teams and other related crisis services, later amended by SB 833 (2016) to expand the Act's focus to children and youth.

2020: Federal Designation of 988[2,23]
Established a nationwide three-digit crisis number and laid the foundation for a modern behavioral health crisis response system.

2021: Behavioral Health Continuum Infrastructure Program (BHCIP)[1]
$2.2 billion investment to expand behavioral health treatment capacity, crisis facilities, and related infrastructure statewide.

2021–2022: Mobile Crisis Financing Established[1]
Centers for Medicare & Medicaid Services (CMS) guidance and California policy established a sustainable Medicaid financing pathway for community-based mobile services.

July 2022: 988 Launches[3,5]
California transitions to the national 988 Suicide & Crisis Lifeline, expanding access to behavioral health crisis support.

September 2022: AB 988 (Miles Hall Lifeline Act) Enacted[2,4,5,24]
Established a dedicated funding mechanism for 988 and strengthened coverage requirements for behavioral health crisis services.

January 2023: Medi-Cal Mobile Crisis Benefit Begins[4,24]
Mobile crisis response becomes a statewide covered Medi-Cal service.

2023: CalHHS Behavioral Health Crisis Care Continuum Plan Released[5]
State roadmap articulating a vision for an equitable, coordinated behavioral health crisis care system; spanning prevention, response, and stabilization, to guide implementation of California's crisis infrastructure investments.

March 2024: Proposition 1 Approved[1,3,5]
Authorized approximately $6.4 billion in bond financing and restructured behavioral health funding to expand treatment, housing, and crisis infrastructure.

2025–2026: Historic Crisis Infrastructure Expansion[1,25]
More than $4 billion in bond-funded BHCIP awards support crisis stabilization, residential treatment, and behavioral health facility development statewide.

These investments have produced measurable gains. California's 988 system now answers the vast majority of in-state calls, mobile crisis services continue to expand, and new crisis facilities are being developed across the state.[5] Together, these investments reflect growing recognition that behavioral health crises require alternatives to emergency departments, inpatient hospitalization, and law enforcement response alone. The central questions are now whether infrastructure is expanding quickly and equitably enough to meet demand, and whether funding will remain stable enough to sustain these services over time.

1.4 Capacity, Access, and System Readiness

Funding and physical infrastructure do not by themselves create usable crisis capacity.

Services must also be licensed, staffed, sustainably financed, connected to referral and dispatch systems, and ready to accept individuals when they are needed.

While California has made significant progress expanding crisis services, substantial gaps remain in workforce availability, geographic coverage, service capacity, and system coordination.

Workforce shortages remain one of the most significant constraints. Building adequate capacity also requires a diverse workforce that reflects the cultural, linguistic, and community needs of the populations being served. California continues to face shortages across multiple behavioral health professions, with hundreds of designated mental health professional shortage areas and persistent recruitment challenges reported by counties and providers.[5,6,8,10] In some counties, crisis programs have received funding but experienced delays in implementation because organizations have been unable to recruit and retain sufficient staff.[5,7,9,12]

Capacity also remains unevenly distributed. As recently as 2022, 14 counties reported having no mobile crisis teams and 25 counties reported having no crisis stabilization unit capacity.[2,7,12] While recent investments have improved availability, substantial regional disparities remain, particularly in rural communities and other historically under-resourced areas.[5,12,26] Infrastructure may also remain unavailable or underused because of licensing barriers, financing challenges, or limited integration with referral, dispatch, and law-enforcement systems.

The gap between available infrastructure and operational readiness is especially visible during transitions between levels of care.[5,7] Individuals may successfully access crisis lines, mobile crisis teams, emergency departments, or crisis stabilization services, yet still encounter difficulties connecting to timely outpatient appointments, housing supports, care coordination, substance use treatment, and other services needed to sustain recovery after stabilization.[5,7] Emergency departments continue to experience behavioral health boarding, and follow-up rates after psychiatric emergencies remain inconsistent across populations and payer types.[5]

California also lacks many of the tools needed to fully assess crisis system performance. Stakeholders and researchers have identified challenges related to inconsistent data collection, varying definitions of crisis services, limited visibility into real-time capacity, and the absence of standardized measures across jurisdictions.[5,12] No comprehensive statewide crisis infrastructure registry currently exists, making it difficult to assess capacity, identify shortages, and monitor performance across the continuum.[5,12]

California therefore faces two jobs at once: closing the service gaps that remain and connecting the investments already made. The next phase will depend on whether crisis services are adequately staffed, sustainably financed, equitably distributed, and linked through the referral, data, and accountability structures needed to function as a continuum.

The Human Crisis Journey

Call
Access and connection

EXAMPLES
- 988 Suicide & Crisis Lifeline
- Regional / local crisis line
- Warm line / peer support line

COMMON FRICTION POINTS AND BARRIERS

"I don't know where to turn."
- Multiple crisis lines
- Language, cultural and accessibility barriers
- Fear of law enforcement involvement

Response
In-person support

EXAMPLES
- Mobile crisis team
- Co-responder team (clinician + law enforcement)
- Peer crisis response team

COMMON FRICTION POINTS AND BARRIERS

"No one came when I needed help."
- Delayed or unavailable response
- Response did not match needs
- Law enforcement responded

Stabilization
Safe place and support

EXAMPLES
- Crisis stabilization unit (23-hour)
- Crisis residential program
- Psychiatric emergency services/ emergency department

COMMON FRICTION POINTS AND BARRIERS

"There was nowhere for me to go."
- No available crisis beds
- Inappropriate settings for needs
- Emergency department was the only option

Transition
Connect to next steps

EXAMPLES
- Intensive care coordination
- Short-term post-stabilization support
- Peer respite or support services

COMMON FRICTION POINTS AND BARRIERS

"I ended up in crisis again."
- No place to go next
- Loss of support after stabilization
- Limited follow-up and care coordination

What Makes the Journey Work

- **Clear entry points and coordinated response**
- **A sufficient, well-supported workforce**
- **Sustainable and adequate financing**
- **Shared accountability and common protocols**
- **Adequate step-down and follow-up options**

1.5 The Central Question

As California moves from infrastructure development to system implementation, significant challenges remain, including workforce shortages, uneven geographic access, fragmented financing, inconsistent accountability, and weak transitions between levels of care. The central challenge is no longer simply whether the state can build more crisis services, but whether stakeholders can strengthen the structures needed to connect those services into a functioning continuum.

CENTRAL QUESTION

Are California's investments building a coordinated crisis continuum, or primarily expanding individual services without the systems needed to connect and integrate them?

How California answers this question will determine whether recent investments become a true continuum of care, one that can move people from response through recovery, without requiring individuals and families to navigate the gaps between systems on their own.

The sections that follow examine how community-based organizations, industry representatives, and advocacy leaders working across California's behavioral health system answered that question and what their perspectives suggest about the next phase of crisis system development.

SECTION 2

Voices From the Field: What We Heard

The interviews did not produce a single uniform perspective, but they did reveal a shared diagnosis.

Community-based providers focused more often on staffing shortages, financing instability, and day-to-day service barriers. Industry and advocacy leaders emphasized governance, accountability, and system design. Even from these different vantage points, the core concerns were remarkably consistent across stakeholder groups.

What California's crisis system stakeholders told us

Share of interviews where each theme appeared

Post-crisis gap
Post-crisis supports remain the greatest gap — 85%

Fragmentation
Crisis services operate in silos — 75%

Informal integration
Coordination relies on relationships, not systems — 70%

Financing mismatch
Financing is misaligned with crisis system needs — 65%

Workforce strain
Workforce shortages limit system capacity — 60%

Where CBO and industry/advocacy perspectives diverged

Shared diagnosis — different vantage points

FOR THIS ANALYSIS:

Community-based organizations (CBOs): Organizations directly providing crisis and behavioral health services

Industry/advocacy organizations: Associations, policy organizations, advocates, and other system-level stakeholders

Community-based organizations emphasized:

Operational challenges of crisis care
Day-to-day realities affect the ability to deliver services

Workforce strain and sustainability
Shortages, burnout, and secondary trauma impact capacity and retention

Gaps in care transitions and follow-up
Breakdowns across the continuum make sustained recovery difficult

Industry and Advocacy organizations emphasized:

Equity and access disparities
Geographic variation, insurance status, race, language, and other factors drive unequal outcomes

Accountability and system governance
Fragmented financing, unclear responsibilities, and limited oversight hinder performance

Upstream prevention and community supports
Outcomes are shaped by access to outpatient care, housing, and community-based services

Several findings appeared with unusual consistency across interviews. The post-stabilization gap was the most frequently identified concern, appearing in 85% of interviews. Structural fragmentation appeared in approximately 75%, and upstream system failure appeared in roughly 70–80% across respondent groups.

The takeaway was straightforward: California's challenge is not only capacity, but connection. The state has made substantial investments in crisis infrastructure, expanding access to services that provide critical support to individuals and families in moments of acute need. The next challenge is ensuring those services operate as a coordinated path through care rather than as separate programs.

2.1 Three Ways the Crisis System Breaks

2.1.1 It Breaks Before the Crisis Happens

Many participants described crisis systems as absorbing demand created by broader gaps in behavioral health care. This was one of the strongest areas of alignment across respondents, with both CBO and industry/advocacy participants describing crisis systems as absorbing needs that could not be met earlier in the continuum. Challenges accessing prevention services, outpatient treatment, substance use care, housing supports, and other community-based resources were frequently cited as contributors to increasing crisis utilization.

Stakeholders emphasized that crisis services are designed to respond to acute needs, not substitute for the broader continuum of care that helps prevent crises from occurring in the first place. When individuals are unable to access services earlier, crisis systems increasingly become the default point of entry into behavioral health care. As a result, crisis services often function as both emergency response and de facto access points to care.

Participants also described a fragmented front door to the crisis system. Individuals experiencing a behavioral health crisis may encounter 988, county access lines, emergency departments, law enforcement, emergency medical services, or provider-operated crisis lines, each operating under different protocols and referral pathways. Respondents frequently noted that navigating these entry points can be difficult for individuals, families, and even providers.

> **"The crisis continuum has become a catch-all for failures elsewhere in the system. When residential placements are unavailable and people cannot access outpatient care, needs escalate until they wash up on the shores of the crisis system."**
>
> — Shawn M. Caracoza
> Pacific Clinics

Law enforcement response remained a recurring concern. Participants described inconsistent practices across communities, including situations where law enforcement remained the default responder and others where agencies were unavailable or unwilling to assist with behavioral health situations that did not involve an active crime or immediate safety threat. These differences can create gaps when behavioral health providers determine that law enforcement support is necessary for safety or involuntary intervention. While California has expanded alternatives such as mobile crisis teams and 988, participants emphasized the need for clearer and more reliable coordination between behavioral health and law enforcement when circumstances require both.

Several stakeholders also highlighted challenges addressing substance use crises within systems historically designed around mental health emergencies. Recognizing that substance use disorders and mental health conditions often co-occur, participants described overdose, withdrawal, and substance-induced psychosis as situations that often require different expertise, resources, and care pathways than those traditionally available through behavioral health crisis services.

2.1.2 It Breaks Under Structural Pressure

Participants consistently described financing as one of the most significant challenges facing crisis providers. Rather than identifying a single issue, respondents described a set of interconnected pressures affecting service availability, workforce stability, and long-term sustainability.

Many stakeholders noted that traditional fee-for-service reimbursement models often do not align with the operational realities of crisis care. Crisis services must maintain staff, vehicles, facilities, and response capacity around the clock, regardless of whether a billable encounter occurs. The value of crisis services lies not only in the encounters they provide, but in their continuous readiness to respond when needed. Respondents frequently described a mismatch between how crisis systems are expected to operate and how they are financed.

Concerns regarding reimbursement adequacy, fragmented funding streams, administrative complexity, and uncertainty regarding payer responsibility frequently appeared together in interviews. Participants often viewed these issues as symptoms of a broader financing structure that has not fully adapted to the requirements of a modern crisis continuum.

Workforce challenges further compound these pressures. Participants described persistent difficulties recruiting and retaining behavioral health professionals, peer support specialists, and crisis responders. Community-based providers, in particular, emphasized burnout, secondary trauma, and the emotional demands associated with crisis work.

> **“You can have the best model, the best trained staff, the best relationships — but if the funding isn’t there to sustain it, it falls apart.”**
>
> — Adrienne Shilton
> California Alliance for Child and Family Services

Administrative requirements were frequently cited as an additional burden. Providers described credentialing delays, reporting requirements, billing complexity, and contract administration as activities that consume resources without directly contributing to patient care. Taken together, participants viewed financing, workforce, and administrative pressures not as separate challenges, but as interconnected conditions that affect the stability and effectiveness of the entire crisis system.

2.1.3 The System Breaks at the Handoff

No finding emerged more consistently than the challenge of connecting individuals to ongoing support after the immediate crisis has been resolved.

Participants repeatedly described a "step-down cliff" in which individuals successfully access crisis services, receive stabilization, and then encounter significant barriers to follow-up care. Challenges securing outpatient treatment, housing supports, substance use services, care coordination, and recovery supports were frequently identified as the point at which the continuum begins to break down.

Many respondents described crisis stabilization settings operating beyond their intended purpose because appropriate next-step services are unavailable. Others noted that emergency departments, crisis providers, and community organizations often struggle to identify appropriate placement options for individuals who no longer require acute intervention but still need ongoing support. In many ways, the effectiveness of a crisis system is determined less by how well it responds in the moment and more by what happens next.

While many communities have developed strong local partnerships, respondents noted that coordination often depends on personal relationships rather than standardized processes.

> **"You call, someone comes, the person gets stabilized or put on a hold, and then they're released and there's no follow-up, no pathway to ongoing care, no case manager who's tracking this person. And it happens again. And again."**
>
> — Jessica Wilson Cruz
> NAMI California

Participants frequently emphasized that effective crisis systems require more than individual services. They require reliable transitions between services. Across interviews, the ability to connect individuals from crisis response to stabilization, treatment, housing, and recovery supports emerged as one of the most important determinants of whether the continuum functions as intended. Stabilization is often treated as the end of a crisis episode, but participants consistently described it as the beginning of the next challenge.

2.2 Why These Challenges Persist

The challenges described throughout the interviews did not emerge as isolated problems. Participants consistently described them as interconnected conditions that reinforce one another. Financing affects whether organizations can recruit and retain staff. Workforce shortages limit available capacity. Fragmentation makes coordination harder, and weak transitions send people back into already strained services. Participants described a cycle in which strain in one part of the system creates additional pressure somewhere else.

Community-based crisis response in Tulare County
Kings View

Across interviews, four structural drivers emerged repeatedly: financing, governance and accountability, workforce capacity, and system integration. The strength of these themes varied by respondent type. Community-based providers more often emphasized operational strain, including workforce shortages, administrative burden, and financing instability. Industry and advocacy respondents more often emphasized governance, accountability, and system design. The pattern was not disagreement, but different vantage points on the same underlying system failures.

2.2.1 Financing Models Lag Behind Crisis System Needs

Participants consistently described financing challenges as one of the most significant barriers to building a sustainable crisis continuum. Many noted that traditional fee-for-service reimbursement models do not align with the operational realities of crisis care. Unlike scheduled outpatient services, crisis programs must maintain staff, vehicles, facilities, and response capacity regardless of whether a billable encounter occurs. Funding crisis response only when a billable encounter occurs is like funding a fire department only when there is a fire. The value of crisis services depends on readiness and availability, not simply utilization.

Participants also described ongoing challenges securing reimbursement from commercial health plans for crisis services. Several respondents noted that when commercial claims are denied, delayed, reimbursed below cost, or otherwise unpaid, counties and community providers often absorb the cost of care rather than turn individuals away during a behavioral health emergency. In practice, participants described counties as functioning as a payer of last resort, creating concerns that public behavioral health systems may be subsidizing emergency services that commercial insurers are also obligated to cover.

Together, participants described a financing environment characterized by reimbursement limitations, fragmented funding streams, administrative complexity, and uncertainty regarding payer responsibility.

> **“Medi-Cal rates for crisis services vary widely from county to county, often requiring county behavioral health systems to provide additional funding to support safe and effective services.”**
>
> — Kent Dunlap
> Stars Behavioral Health Group

RECURRING THEME FROM INTERVIEWS

Funding crisis response only when a billable encounter occurs is like funding a fire department only when there is a fire.

2.2.2 Accountability Remains Fragmented

Stakeholders frequently described a crisis system in which responsibility is distributed across counties, health plans, crisis centers, providers, hospitals, law enforcement agencies, and state departments. While each organization plays an important role, respondents often struggled to identify who is ultimately responsible for ensuring the continuum functions as a coordinated system.

Participants noted that accountability for system-wide performance remains fragmented. No single entity consistently convenes partners, establishes common protocols, tracks outcomes, or manages transitions across the continuum. Respondents frequently pointed to the need for stronger state-level leadership and clearer regional governance to establish an overarching framework while preserving regional responsibility for implementation. As a result, accountability often exists within programs rather than across the broader system.

> **"Nobody's actually in charge of making the crisis continuum function, and in the absence of leadership, everyone defaults to their silo."**
>
> — Chad Costello
> California Association of Social Rehabilitation Agencies

2.2.3 Workforce Development Has Not Kept Pace with System Growth

Crisis systems ultimately depend on people. Participants consistently identified workforce shortages as a constraint affecting nearly every part of the continuum, from crisis response and stabilization to outpatient treatment and recovery supports.

Respondents described persistent challenges recruiting and retaining clinicians, peers, and crisis responders, while also highlighting burnout, secondary trauma, compensation concerns, and limited career pathways. Several stakeholders emphasized that expanding crisis infrastructure without comparable investment in workforce development risks creating capacity on paper that cannot be fully operationalized in practice.

2.2.4 Coordination Relies on Relationships More Than Systems

Partnerships were one of the clearest strengths described in the interviews. Participants pointed to strong working relationships among providers, hospitals, law enforcement agencies, counties, crisis centers, health plans, schools, and community organizations, often noting that these relationships are what allow local crisis systems to function despite broader structural barriers.

At the same time, respondents noted that coordination frequently depends on local relationships rather than standardized processes, shared infrastructure, or formal accountability mechanisms. Without shared data, real-time visibility into capacity, consistent service definitions, and common performance measures, even strong local partnerships can be difficult to sustain, scale, or replicate across regions.

Structural Drivers of a Functioning Crisis Continuum

A functioning crisis continuum depends on all four drivers

The message from the field was consistent: these are not isolated program problems. They reflect broader structural conditions that shape what services can be sustained, how organizations work together, and what happens to people as they move through the system. Section 3 examines what more functional crisis systems do differently.

SECTION 3

A Functional Crisis System: What It Requires

Redwood Community Crisis Center in Ukiah
Redwood Community Services

Section 2 showed where California's crisis continuum most often breaks down: before a crisis, under structural pressure, and during the handoff to ongoing care.

This section examines what more functional systems do differently. While no model can be applied wholesale to California, several states and communities offer useful lessons that respond to the same recurring gaps: weak transitions, unstable financing, fragmented accountability and coordination, and limited community based alternatives.

3.1 What a Functioning System Looks Like: Evidence from Arizona

The Crisis Now framework, developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Council for Mental Wellbeing, is one of the most widely recognized models for a comprehensive behavioral health crisis system.[27,28] Arizona's implementation is frequently cited as one of the nation's most mature examples of crisis system integration at scale.

Arizona's Regional Behavioral Health Authorities (RBHAs) serve as single accountable entities responsible for organizing, financing, and overseeing the crisis continuum within defined geographic regions. Rather than operating crisis services as separate programs, Arizona aligns crisis call centers, mobile crisis teams, crisis stabilization services, residential programs, inpatient resources, and follow-up care within a coordinated regional structure. This creates clear accountability for system performance and reduces fragmentation between levels of care.[29,30,31]

WHAT ARIZONA SHOWS

Arizona organizes crisis care as a regional system, not a collection of separate programs. Within each region, a single accountable entity aligns financing, operations, and performance across the continuum.[29,30,31]

Financing is designed to support system readiness and capacity rather than simply reimbursing individual encounters. While multiple payer sources still exist, crisis services operate within a coordinated structure that allows individuals to access care without navigating separate funding streams or eligibility pathways during a behavioral health emergency.[27,28,29]

Performance is measured across the continuum, including access, response times, diversion from emergency departments and law enforcement, service utilization, and linkage to ongoing care. Regional entities are responsible not only for operating services, but also for ensuring those services function effectively together. This creates incentives for collaboration, data sharing, and continuous system improvement.[27,28,29]

Arizona is not a blueprint for California; the states differ significantly in governance, financing, geography, population, and local service environments. Its value is in showing what becomes possible when crisis call centers, response teams, stabilization services, and follow-up care are organized around shared accountability rather than operating as separate programs with separate incentives.

California already possesses many of the foundational components of a modern crisis continuum, including 988 call centers, mobile crisis teams, crisis stabilization programs, residential services, community-based providers, county behavioral health systems, and multiple state and federal funding streams.[1,2,3,4,5] Important service gaps remain, particularly in rural and under-resourced communities. The broader challenge is the absence of a structure that consistently aligns incentives, accountability, financing, and coordination across the continuum. Arizona offers a useful example of what becomes possible when those elements are intentionally organized as a system.

3.2 What Other Models Tell Us

Arizona is not the only example of crisis system innovation. Other states and communities offer targeted approaches to challenges identified throughout the interviews, including alternative response, dispatch integration, and sustainable financing.

The Crisis Assistance Helping Out on the Streets (CAHOOTS) model in Eugene, Oregon, launched in 1989, helped establish the concept of alternative crisis response. During its decades of operation in Eugene, CAHOOTS demonstrated that many behavioral health-related emergency calls could be safely diverted from law enforcement to community-based responders. At its height, CAHOOTS was reported to handle approximately 17–20% of Eugene's 911 call volume while requiring police backup in fewer than 1% of encounters. While California has since expanded mobile crisis services statewide, CAHOOTS remains influential because it shifted the conversation from who responds to behavioral health crises to how communities design response systems that match clinical needs rather than public safety defaults. CAHOOTS ceased operating in Eugene in 2025 amid financial and contractual challenges, underscoring the importance of sustainable financing for even well-established crisis models.[32,33]

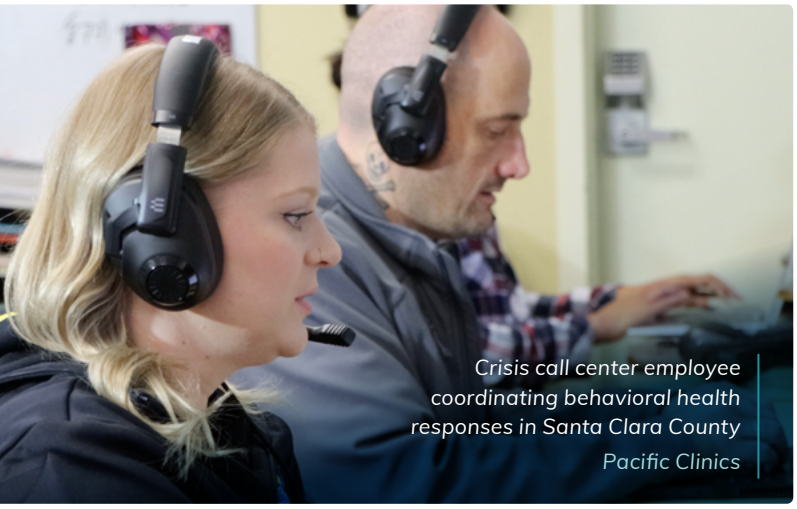
> WHAT CAHOOTS DEMONSTRATED
>
> **Alternative response can be embedded directly into the emergency response system.** The response should be designed around clinical need, not the default public safety pathway.

Denver's Support Team Assisted Response (STAR) program illustrates the importance of integrating behavioral health crisis teams directly into emergency dispatch. Under the STAR model, certain low-risk behavioral health, substance use, and social service-related 911 calls are routed to a mental health clinician and paramedic rather than law enforcement. Since launching in 2020, STAR has responded to thousands of calls without requiring police involvement and has been associated with reductions in low-level criminal justice enforcement in areas where it operates.[34,35,36]

STAR's broader lesson is that crisis outcomes are shaped not only by who responds, but by how individuals enter the system. Many California communities continue to rely on separate 911, 988, and mobile crisis pathways with varying dispatch protocols and handoff processes. By embedding clinical decision-making directly within emergency 911 dispatch, STAR helps ensure callers receive the most appropriate response from the outset rather than relying on secondary transfers after law enforcement or emergency medical services have already been deployed.

> WHAT STAR DEMONSTRATES
>
> **The right response begins with the right routing.** STAR integrates behavioral health decision-making into 911 dispatch so eligible calls can go directly to a clinician-paramedic team rather than first defaulting to law enforcement.

Colorado has taken a broader statewide approach, investing in coordination among 988, mobile crisis teams, co-response programs, crisis stabilization services, and law enforcement. In 2021, voters approved a statewide behavioral health crisis response fee to support 988 implementation and expansion of crisis services, creating a dedicated financing mechanism for long-term system development. While individual programs vary across communities, Colorado has focused on establishing shared expectations regarding who responds, where individuals are transported, and how transitions occur across the continuum. The state's experience illustrates the importance of pairing individual crisis services with governance, financing, and accountability structures that support coordination at scale.[37,38]



Crisis call center employee coordinating behavioral health responses in Santa Clara County
Pacific Clinics

Across these models, the lesson is straightforward: the strength of a crisis system lies less in any single program than in the connections between services. High-performing systems offer clear entry points, appropriate alternatives to law enforcement and emergency departments, reliable transitions between levels of care, meaningful roles for community-based responders, and accountability for outcomes across the continuum. The details differ by state and community, but the underlying question is the same: can people move through the system without having to navigate its fragmentation on their own?

3.3 What Functional Systems Have in Common

Despite differences in governance, geography, and financing, the models described above point to a consistent conclusion: functional crisis systems are built around the structures that connect programs, not the programs alone.[25,26,27,28,29,30,31,32,33,34,35,36]

Five characteristics emerged across the comparison models, stakeholder interviews, and broader evidence reviewed for this paper:

STRONG TRANSITIONS AND CONTINUITY OF CARE

Effective crisis systems recognize that stabilization is not the endpoint of care. They invest in follow-up services, care coordination, recovery supports, and community-based behavioral health resources that reduce future crises and promote long-term recovery.

SUSTAINABLE FINANCING

Crisis services require staffing, facilities, vehicles, and response capacity regardless of utilization volume. Systems built entirely around fee-for-service reimbursement struggle to support the readiness that crisis response requires, particularly when state, county, and managed care plan financing responsibilities are unclear.

SHARED ACCOUNTABILITY

Functional crisis systems establish clear responsibility for system performance. Organizations may play different roles, but accountability exists for how the continuum functions as a whole rather than how individual programs perform in isolation. Financing and accountability are inseparable: responsibility for system performance must be matched by responsibility for sustaining the services required to achieve it.

WORKFORCE CAPACITY

Infrastructure alone does not create capacity. Successful systems invest in recruitment, retention, peer workforce development, supervision, and workforce well-being. Workforce sustainability is treated as core infrastructure rather than an operational afterthought.

UPSTREAM SUPPORTS

Functional crisis systems are supported by accessible prevention, outpatient treatment, substance use services, housing, and other community-based resources that reduce avoidable crisis demand. Without sufficient upstream capacity, crisis services become the default entry point for needs that could have been addressed earlier.

These characteristics are not unique to Arizona, Oregon, or Colorado. They are the same themes repeatedly identified by stakeholders throughout this study. The distinction is that successful systems have translated these principles into structures, incentives, and accountability mechanisms that operate at scale. The question for California is not whether these elements are necessary, but how they can be adapted and implemented within California's unique policy, financing, and governance environment.

SECTION 4

Building The Next Phase of California's Crisis Continuum

The findings presented throughout this paper point to a clear conclusion: California's next challenge is not building more crisis services, but strengthening the structures that connect them.

The recommendations that follow respond directly to the recurring gaps identified in the environmental scan, stakeholder interviews, and comparison models: weak transitions to ongoing care; financing that does not support crisis readiness; fragmented accountability and coordination; workforce constraints; and unmet upstream needs. They are presented separately for clarity, but remain interconnected.

Taken together, these recommendations represent a roadmap for moving from a collection of crisis services toward a coordinated crisis continuum.

4.1 Strengthen Transitions and Handoffs

The post-stabilization gap was the most consistently identified challenge in this study. The most effective crisis response is only as strong as the transition that follows it, yet individuals too often encounter significant barriers when moving from crisis intervention to ongoing care.

California should establish transition infrastructure as a core component of the crisis system rather than an optional enhancement. Every major transition point, including mobile crisis to crisis stabilization, crisis stabilization to step-down care, crisis residential care to outpatient treatment, and emergency departments to community-based follow-up, should be supported by defined protocols, designated points of responsibility, and shared expectations regarding continuity of care. State guidance should establish common expectations and measures while allowing counties to adapt implementation to local conditions.

FROM STABILIZATION TO RECOVERY

The most effective crisis response is only as strong as the transition that follows it.

Strengthening transitions will require both operational and financial investment. Formal data-sharing agreements, shared intake protocols, and interoperable referral pathways should be established across 988, mobile crisis teams, hospitals, law enforcement, emergency medical services, and community-based providers. Coordination should be built into the system itself rather than relying on personal relationships between organizations.

California must also expand the availability of step-down services that bridge the gap between crisis stabilization and long-term treatment.[7,12] Crisis step-down programs, peer respite services, short-term stabilization beds, care navigation, and recovery support services play a critical role in preventing individuals from cycling repeatedly through emergency departments, inpatient settings, law enforcement encounters, and crisis response systems.

Finally, performance measurement should extend beyond the immediate crisis event. Metrics such as successful linkage to follow-up care, completion of step-down services, 30-day follow-up rates, and crisis recidivism provide a meaningful assessment of whether the continuum is functioning as intended. These measures should also identify where services are unavailable or disappearing from the continuum. A crisis system should be evaluated not only by how effectively it responds to emergencies, but by how successfully it connects individuals to the support needed to prevent the next one.

Behavioral Health Urgent Care Center in Long Beach
Stars Behavioral Health Group

4.2 Finance Crisis Readiness, Not Crisis Encounters

To address the financing instability described across interviews, California must better align payment with the operational realities of crisis care. Unlike traditional outpatient care, crisis programs must maintain staff, vehicles, facilities, and response capacity regardless of daily utilization.

Much of California's crisis infrastructure continues to be financed through reimbursement mechanisms designed for scheduled services and predictable utilization patterns. As a result, providers are expected to maintain 24/7 response capacity while bearing significant financial risk associated with fluctuations in call volume, reimbursement, and funding availability. Crisis services should be financed as essential public infrastructure, similar to emergency departments, fire departments, and 911 systems, where readiness is recognized as a core function rather than an unreimbursed cost.

California must also address the growing disconnect between payer responsibility and payer participation. Medi-Cal systems frequently absorb the cost of crisis services for individuals whose coverage resides elsewhere, particularly when commercial reimbursement is unavailable, delayed, wrongfully denied, or inadequate. Given the substantial share of Californians covered through commercial insurance, a sustainable crisis continuum intended to serve the general public requires all payers to contribute equitably to the systems upon which their members rely.[7,9]

If California intends to build a durable crisis continuum, financing must evolve from paying for activity to supporting readiness, availability, and system performance. It must also establish clear accountability for how crisis services are financed across Medi-Cal, commercial insurance, counties, and uninsured populations.

Mobile crisis response vehicles in Santa Clara County
Pacific Clinics

4.3 Establish Shared Accountability for System Performance

To address the fragmentation identified across the continuum, California must establish clearer responsibility for system performance across counties, health plans, hospitals, emergency departments, law enforcement, emergency medical services, crisis providers, and community-based organizations. Each controls a different part of the system, yet no single entity is consistently accountable for the full journey from response to stabilization to ongoing care.

A functional crisis system requires accountability that extends beyond individual programs. Performance should be measured not only by the activities of individual organizations, but by how effectively the continuum functions as a whole. Access, response times, successful transitions, follow-up engagement, crisis recidivism, and diversion from emergency departments and law enforcement should be treated as shared outcomes rather than isolated program metrics.

SHARED ACCOUNTABILITY

When organizations are collectively accountable for outcomes, collaboration becomes a financial necessity rather than a voluntary activity.

Accountability should also be reinforced through financial incentives. Counties, health plans, and providers are currently rewarded primarily for operating individual programs rather than achieving shared system outcomes. Once adequate base funding and readiness capacity are established, California should move toward value-based approaches that tie a portion of funding to measures such as timely response, successful diversion from emergency departments and law enforcement, linkage to follow-up care, reduction in repeat crisis utilization, and continuity across levels of care. When organizations are collectively accountable for outcomes, collaboration becomes a financial necessity rather than a voluntary activity.

California should establish clear governance structures that define roles, responsibilities, and expectations across the continuum, including for call routing, dispatch, referral, and handoffs. These expectations should also clarify when law enforcement support is appropriate and how behavioral health providers can reliably access that support when safety or involuntary intervention requires it. Counties, health plans, providers, hospitals, emergency departments, law enforcement agencies, and state partners should be held accountable for the portions of the system they influence, while also sharing responsibility for broader system outcomes through aligned performance expectations, reporting requirements, and financial incentives. Coordination should be supported through formal agreements, shared protocols, common performance measures, and regular cross-system planning rather than relying primarily on informal relationships.

Strengthening accountability will also require greater system visibility. Shared definitions, consistent reporting standards, and transparent performance measurement can help communities identify gaps, evaluate outcomes, and direct resources where they are most needed. Effective accountability depends not only on assigning responsibility, but on creating the information infrastructure necessary to assess whether the continuum is functioning as intended.

Ultimately, crisis systems perform best when responsibility for outcomes is clearly defined. Individuals experiencing a behavioral health crisis should encounter a coordinated continuum of care rather than a collection of disconnected programs. Achieving that goal requires accountability structures that match the complexity of the system they are intended to govern.

988 Suicide & Crisis Lifeline counselor at the crisis call center in Los Angeles County
Didi Hirsch Mental Health Services Group

4.4 Build and Sustain the Crisis Workforce

To address the workforce constraints that limit operational capacity, California must pair infrastructure expansion with sustained investment in the people who deliver crisis care. Facilities, mobile teams, and new service models create capacity only when qualified people are available to staff them.

California should treat workforce development as core crisis infrastructure. Recruitment, retention, supervision, compensation, and workforce well-being are all essential to sustaining crisis response capacity. Expanding crisis services without comparable investment in the people who staff them risks creating infrastructure that exists on paper but cannot be fully operationalized in practice.

Particular attention should be given to the peer workforce, which is increasingly recognized as a critical component of crisis response, engagement, and recovery support. Peer roles can improve trust, engagement, and continuity of care while expanding the range of professionals available to support individuals experiencing behavioral health crises.[27,28] As peer-led models continue to expand, funding should support supervision, training, career pathways, and workforce wellness as standard components of program design rather than optional enhancements.

California should also modernize workforce pathways into crisis services. Community-rooted workers, individuals with lived experience, and professionals from nontraditional backgrounds often possess skills that are uniquely effective in crisis settings but remain underrepresented within existing credentialing structures. Expanding training pipelines, creating alternative entry pathways, and strengthening partnerships with community colleges and local workforce programs can help build a more diverse and sustainable crisis workforce.

Finally, workforce strategies must reflect California's geographic diversity. Rural and frontier communities face unique challenges recruiting and retaining crisis professionals, often making traditional staffing models difficult to sustain. Regional partnerships, shared staffing arrangements, telehealth integration, and other flexible workforce models will be necessary to ensure crisis services remain accessible across all parts of the state.

4.5 Reduce Crisis Demand Through Early Intervention and Prevention

No crisis system can respond its way out of a prevention problem. To address the upstream gaps that stakeholders linked to growing crisis demand, California must strengthen prevention, early intervention, and community-based care. Long-term system performance depends on reducing avoidable crises.

California should strengthen access to the community-based services that help individuals receive care before conditions escalate to the point of requiring crisis intervention. Persistent gaps in access to mild to moderate outpatient behavioral health care, including shortcomings in commercial insurance behavioral health networks, along with barriers to substance use treatment, housing supports, and other community-based services, continue to push individuals toward crisis systems that were never designed to function as the primary point of entry into care.[8,16]

UPSTREAM INVESTMENT

No crisis system can respond its way out of a prevention problem. Long-term success depends on reaching people before unmet needs escalate into crisis.

California should also continue investing in community-based prevention strategies, including school-based behavioral health services, community outreach, mental health literacy, peer-led supports, and culturally responsive engagement efforts. These services strengthen local behavioral health infrastructure while creating pathways to care that do not require individuals to first experience a crisis. This need is particularly important as California transitions from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), which restructures prevention funding and may reduce or shift local funding available for school-based and other community prevention programs.

Finally, future crisis system planning should better integrate substance use disorder services. Many communities continue to report challenges responding to overdose, withdrawal, substance-induced psychosis, and co-occurring conditions within systems historically designed around mental health emergencies. Building a truly comprehensive crisis continuum will require crisis response models capable of addressing the full spectrum of behavioral health needs.

The long-term success of California's crisis continuum will ultimately depend not only on how effectively it responds to crises, but on how effectively it helps prevent them.

4.6 Priority Actions by Stakeholder

State Leadership (Legislature, Governor, DHCS, CalHHS)	• Preserve the statewide Medi-Cal mobile crisis benefit and associated crisis funding. • Establish sustainable financing for 988 crisis centers and clarify their role within the broader crisis continuum. • Clarify payer responsibility across Medi-Cal, commercial plans, counties, and uninsured populations.	• Establish statewide transition standards, crisis performance measures, and a public accountability dashboard. • Simplify administrative requirements through standardized billing, contracting, and documentation. • Advance capacity-based financing models for crisis infrastructure.	• Invest in upstream behavioral health, substance use, housing, and community-based services that reduce avoidable crisis utilization. • Establish statewide expectations for coordination among behavioral health crisis systems, law enforcement, and EMS, including when law enforcement support is appropriate and how it can be accessed when needed.
Counties	• Designate clear accountability for care transitions, post-crisis follow-up, and continuity of care. • Expand crisis residential, respite, and other sub-acute alternatives to emergency department and inpatient hospitalization.	• Convene crisis governance structures that include providers, hospitals, health plans, EMS, law enforcement, and individuals with lived experience. • Collaborate with health plans, providers, and regulators on crisis coverage and care transitions.	• Measure and publicly report crisis system performance, including access, diversion, linkage to care, follow-up outcomes, and service gaps. • Develop local cross-agency protocols with law enforcement and EMS that define roles, response expectations, and escalation pathways.
Health Plans	• Include crisis providers within network development, contracting, and care coordination strategies. • Collaborate with counties and regulators to clarify coverage responsibilities and ensure timely payment for covered crisis services.	• Ensure access to medically necessary crisis services across the continuum, including out-of-network care when clinically appropriate. • Invest in upstream behavioral health, substance use, and community-based services that reduce avoidable crisis utilization.	• Report crisis utilization, access, denials, reimbursement, and outcomes. • Incorporate value-based incentives that reward diversion, continuity of care, and recovery.
Regulators (DMHC, CDI, CMS, DHCS Oversight)	• Enforce the Mental Health Parity and Addiction Equity Act (MHPAEA), SB 855, and Knox-Keene requirements for crisis services, network adequacy, and timely access. • Clarify, monitor, and enforce health plan coverage obligations across the crisis continuum.	• Utilize APLs, BHINs, audits, and managed care oversight to establish consistent expectations for crisis coverage, reimbursement, and care coordination. • Publicly report compliance findings, enforcement actions, and plan performance related to crisis services.	• Establish meaningful consequences for failure to provide timely access to crisis services. • Coordinate oversight across agencies to align accountability and support consistent statewide implementation.
Providers and Community-Based Organizations	• Build formal partnerships that strengthen care transitions, follow-up, and continuity of care. • Measure and communicate outcomes that demonstrate the impact of crisis services.	• Quantify and advocate around uncompensated care, cost-shifting, and the infrastructure required to maintain crisis readiness. • Invest in peer workforce development and create pathways to leadership.	• Engage collectively in regional planning, policy development, and crisis financing discussions.
Advocacy Organizations	• Protect and advance policies that strengthen the crisis continuum, including preservation of the statewide mobile crisis benefit.	• Advocate for clear payer accountability, parity enforcement, and sustainable crisis funding. • Elevate consumer, family, peer, and provider experiences in legislative, regulatory, and budget processes.	• Build coalitions that advance shared accountability across counties, health plans, providers, and state leadership

Index of State Leadership and Regulatory Agency Acronyms: *Legislature, Governor, Department of Health Care Services (**DHCS**), California Health & Human Services Agency (**CalHHS**), Department of Managed Health Care (**DMHC**), California Department of Insurance (**CDI**), Centers for Medicare & Medicaid Services (**CMS**), Department of Health Care Services (**DHCS**).*

SECTION 5

Conclusion

California has made substantial progress expanding crisis services and building the infrastructure of a modern crisis continuum. The next task is making sure those investments function as a coordinated continuum rather than as a collection of programs operating alongside one another.

Across California, these services are already reaching people at some of the most vulnerable moments of their lives, providing timely support, alternatives to emergency departments and law enforcement, and pathways toward stabilization and recovery. For many individuals and families, that expansion has been meaningful and potentially life-changing. The interviews, comparison models, and state data reviewed throughout this study consistently pointed to the same underlying conditions. Transitions between services frequently break down. Financing structures remain poorly aligned with 24/7 crisis readiness. Accountability and coordination are fragmented across organizations and funding streams. Workforce shortages constrain capacity. Prevention and early intervention remain insufficient to reduce avoidable crisis demand.

California has made historic investments in behavioral health crisis infrastructure. The next phase of that work will require equal attention to the systems, incentives, governance structures, and financing models that allow individual services to function together. Effective crisis systems are not defined by any single program. They are defined by the strength of the connections between programs.

The examples highlighted throughout this paper demonstrate that these challenges are not inevitable. Other states and communities have shown that crisis systems can be organized around shared accountability, sustainable financing, coordinated response, and continuity of care. California possesses many of the same foundational components. The opportunity now is to align them into a system that functions as a true continuum.

Ultimately, the question facing California is not whether effective crisis care is possible. The evidence suggests that it is. The question is whether the state can build on its historic investments by creating the structures, accountability, and coordination necessary to connect those investments into a functioning system. California has spent the past several years building the pieces of a modern crisis continuum. The work ahead is ensuring those pieces operate not as isolated programs, but as a system capable of meeting people where they are, when they need it most.

Mobile crisis employee engaging with a community member during an outreach response in Solano
Pacific Clinics

California has spent the past several years building the pieces of a modern crisis continuum. The work ahead is **ensuring those pieces operate not as isolated programs, but as a system** capable of meeting people where they are, when they need it most.

Appendix A — Methods

Data Sources

This paper draws from several sources: publicly available data characterizing California's behavioral health crisis care system and the population it serves, published policy papers and peer-reviewed research, and 20 semi-structured key informant interviews conducted between December 2025 and April 2026.

Public data sources include California-specific policy and administrative documentation, federal guidance on behavioral health crisis systems, and population health and administrative datasets used to characterize demand, access barriers, and demographic disparities. These sources span recent years, generally 2020 through 2025, reflecting the period of significant state investment in crisis infrastructure described in Section 1.

The primary source for this paper's findings is 20 semi-structured interviews conducted with leadership from 17 organizations: 10 community-based behavioral health organizations (CBOs) providing direct crisis continuum services, and 10 industry, advocacy, and subject-matter-expert organizations engaged with California's crisis system at a policy or systems level. In all, 31 voices are represented across these interviews.

Interview Procedures

Organizations were identified based on active provision of crisis care continuum services or substantive engagement with crisis system policy, then invited to participate in a one-hour video-conference interview. Potential respondents within each organization were organizational leadership (C-suite and executive leadership) and program leadership (directors of crisis services and program-level overseers). They were selected to capture strategic and operational perspectives on crisis service delivery.

Each interview was preceded by a brief background questionnaire covering organization type, primary service area, geography, and funding structure. This survey was used to characterize the sample; it is not a source of findings.

Interviews were recorded and transcribed via Microsoft Teams.

Two versions of the interview protocol were used, one for CBO respondents and one for industry/advocacy respondents, reflecting their different perspectives of the same system. The protocols covered four shared topic areas: funding and reimbursement, service delivery and workforce, partnerships and system integration, and challenges and lessons learned.

Participants were informed about the nature of the interview (questions and how the information would be used) and that their responses were confidential (unless asked for permission to use their name along with a quote, etc.).

Coding and Analysis

Interview transcripts were converted into a structured dataset and coded using a 47-code codebook spanning six domains: System Structure, Financing, Workforce, Integration, System Meaning, and System Forces. Appendix B provides the coding framework, including definitions and meaning for each code.

The unit of analysis was the interview (regardless of how many people participated in the interview from the organization). Coding was conducted using a large language model (LLM), applying the full codebook consistently across all transcripts. There is a growing body of literature supporting the use of LLMs to accurately code qualitative data.[39,40,41,42,43,44] To establish the reliability of this process in the current study, a subset of 52 responses (25%) was manually coded; inter-rater reliability was high (85%, 0.81 Kappa).

Analysis included code frequency and interview-level prevalence (the percentage of the 20 interviews in which a given code appeared at least once), and divergence testing between CBO and Industry/Advocacy respondents using Fisher's exact test, appropriate for the small cell counts produced by a sample of this size. Full results, including all 45 codes that appeared in the dataset and their associated significance tests, are provided in Appendix C.

Limitations

This study's findings should be read with several limitations in mind.

First, the sample size (n=20, 10 per group) limits the statistical power of the CBO/Industry divergence analysis; only three of the forty-seven codes demonstrated statistical significance ($p<0.05$). Several differences between the two groups discussed in this paper, such as divergence on law enforcement's role and on structural inequity, did not meet statistical significance and should be understood as descriptive patterns.

Second, coding was conducted primarily through an LLM. While a manually coded subset showed high agreement with this approach, there may be some risk of systematic coding bias. As discussed earlier, the use of LLMs in qualitative analysis is an emerging methodology supported by a growing body of research.[39,40,41,42,43,44]

Third, this study's findings reflect the perspectives of organizational and program leadership and policy stakeholders. It does not include the perspectives of clients, families, or other individuals with lived experience of using crisis services. The system-level and operational picture this paper describes may differ from how the same system is experienced by the people it is meant to serve. These perspectives are not addressed by this study's design. Going forward, it is essential to include these voices.

Finally, these findings are specific to California's policy, financing, and governance context. While comparative material from other states is presented in Section 3, the structural conditions and gaps described in this paper do not generalize beyond California.

Appendix B — Coding Framework and Codebook

This codebook was finalized in April 2026 based on the 20 interviews completed. The codebook spans 47 codes across six domains: System Structure, Financing, Workforce, Integration, System Meaning, and System Forces. The codebook framework was applied consistently to the complete 20-interview dataset.

Main Themes Coded

SYSTEM STRUCTURE

- Continuum Completeness
- Structural Fragmentation
- Rural Feasibility
- Accountability / Transparency
- Policy - Reality Gap
- Continuum Bottleneck
- Implementation Drift
- Step-Down Cliff
- Medical Clearance Bottleneck

FINANCING

- Commercial Payer Failure
- Medi-Cal Dependence
- Rate Adequacy
- Fee-for-Service Mismatch
- Sustainability Risk
- Coverage Inequity
- Administrative Burden
- Funding Fragmentation / Bucket Problem

WORKFORCE

- Capacity Limits
- Rural Staffing
- Staff Safety
- Training Gaps
- Workforce Emotional Burden
- Workforce Pipeline Mismatch
- Compensation - Mission Tension

INTEGRATION

- 988 Functioning & Accountability
- Rural Cross-System Misalignment
- Offloading Responsibility
- Governance / Shared Accountability
- Referral Gatekeeping
- Dispatch Authority Conflict
- Informal Integration (Relationship-Based)
- LE Default & Co-response dynamics

SYSTEMS MEANING

- Crisis Compensates for Upstream Failure
- Market Failure Shapes System
- Stigma Influences Design
- Structural Inequality
- Parallel System Formation
- Crisis as Access Gateway
- System Operating Beyond Design
- Access / Awareness gap
- Peer Led Model Inversion
- SUD System Exclusion

SYSTEM FORCES

- Financing as Structural Driver
- Workforce as Structural Constraint
- Operational vs Rhetorical Integration
- Upstream Prevention as Structural Necessity

SYSTEM STRUCTURE

Category	Definition	Meaning
Continuum Completeness	Whether the crisis system includes all necessary components across the full pathway (first contact → response → stabilization → follow-up).	System architecture gap.
Structural Fragmentation	Lack of coordination, disconnected services, siloed operations, or inconsistent system functioning.	Structural system breakdown.
Rural Feasibility	Constraints related to geography, low density, travel, coverage, or viability in rural settings.	Structural implementation constraint.
Accountability / Transparency	Lack of clear responsibility, visibility, oversight, or performance monitoring across or within system components.	Governance weakness.
Policy–Reality Gap	Disconnect between policy intent and operational reality.	Implementation failure.
Entry Point Fragmentation	Multiple crisis entry pathways (988, county lines, ER, law enforcement, EMS, provider lines) operate in parallel without consistent routing, coordination, or unified access architecture.	Fragmented access architecture.
Continuum Bottleneck	A specific point in the crisis pathway restricts flow (e.g., medical clearance, step-down, referral throughput, or follow-up access) despite other components existing.	Functional constraint within otherwise present continuum.
Implementation Drift	Crisis system structure or functioning has evolved away from its original policy or design intent over time.	Temporal system evolution.
Step-Down Cliff	Stabilization occurs but the transition to lower-intensity, ongoing care consistently fails; leaving individuals without follow-up, connection to outpatient services, or a supported pathway after crisis resolution.	Post-stabilization care gap; a specific and recurring break in the continuum.
Medical Clearance Bottleneck	The requirement for medical clearance (typically in an ED) before a person in behavioral health crisis can be transferred to a psychiatric or crisis facility; creating delays, ER overcrowding, and misrouting of persons who need behavioral health care.	A specific regulatory/policy barrier that systematically misroutes behavioral health crises through emergency medicine infrastructure.

FINANCING

Category	Definition	Meaning
Commercial Payer Failure	Commercial/private insurance inadequately funds, covers, or participates in crisis system; through denial, underpayment, network gaps, billing dysfunction, or systematic cost-shifting to public payers.	Commercial market failure; cost absorbed by public system.
Medi-Cal Dependence	System overly reliant on Medi-Cal/public funding; creating structural fragility when Medi-Cal rules change or funding is threatened.	Financing imbalance; public system bears disproportionate risk.
Rate Adequacy	Reimbursement rates insufficient to sustain services at adequate quality or scale.	Payment insufficiency.
Fee-for-Service Mismatch	Fee-for-service payment model is structurally incompatible with crisis services, which require standing capacity regardless of volume; similar to emergency services funded as public utilities rather than per-encounter.	Financing design flaw; crisis services require capacity-based funding, not encounter-based.

FINANCING, *cont.*

Category	Definition	Meaning
Sustainability Risk	Threat to long-term viability of services or system; including grant cliff, federal funding wind-down, or mobile crisis benefit becoming optional.	Structural financing risk; active, not hypothetical.
Coverage Inequity	Differential access to crisis services based on insurance status, eligibility category, or payer rules.	Structural access inequity driven by financing.
Administrative Burden	Billing, reporting, documentation, or compliance requirements create operational strain affecting service delivery capacity.	Operational friction created by financing system.
Funding Fragmentation / Bucket Problem	Multiple funding streams (Medi-Cal, MHSA, county general fund, BHCIP, grants, commercial) each with different eligibility, rules, and administrative requirements; creating operational complexity and preventing unified service delivery.	Administrative and operational fragmentation caused by funding stream multiplicity.

WORKFORCE

Category	Definition	Meaning
Capacity Limits	Insufficient staffing to meet service demand.	Workforce volume insufficient for service need.
Rural Staffing	Workforce constraints specifically tied to geographic remoteness; including inability to recruit, compete on wages, or maintain coverage across large service areas.	Geography-linked workforce constraint.
Staff Safety	Staff safety risks, unsafe response conditions, assault risk in crisis settings.	Occupational safety concern in crisis work.
Training Gaps	Workforce lacks skills, specialized training, or clinical preparedness for crisis work.	Skills gap in the crisis workforce.
Workforce Emotional Burden	Psychological exposure, vicarious trauma, emotional load, and stress inherent in crisis work; affecting retention, safety, and workforce stability.	Structural emotional pressure on workforce.
Workforce Pipeline Mismatch	Licensing, credentialing, and educational requirements for crisis work misalign with the actual competencies needed; systematically excluding community-rooted, lived-experience workers while favoring master's-level clinicians who are less suited to or less retained in crisis roles.	Structural mismatch between workforce pipeline design and crisis work reality.
Compensation–Mission Tension	Crisis workers are motivated by mission but compensation fails to keep pace with competing options; creating a structural recruitment and retention disadvantage that cannot be solved by mission appeal alone.	Mission-based workforce sustainability is eroding as compensation gap widens.

INTEGRATION

Category	Definition	Meaning
988 Functioning & Accountability	Issues related to 988 functioning, accountability, dispatch integration, community trust, and the gap between 988's design intent and operational reality.	Accountability and trust gap in 988 design and implementation.
Cross-System Misalignment	Misalignment across hospitals, EMS, law enforcement, behavioral health, counties, and payers; preventing coordinated crisis response.	Structural misalignment across system actors.

INTEGRATION, *cont.*

Category	Definition	Meaning
Offloading Responsibility	One system shifting responsibility for crisis response to another; often toward crisis providers, counties, or emergency rooms.	Responsibility transfer without resource transfer.
Governance / Shared Accountability	Need for shared system ownership, coordination structures, or governance mechanisms across entities.	Governance gap.
Referral Gatekeeping	Access to crisis services controlled, restricted, or filtered by centralized triage, counties, or institutional rules.	Structural access control.
Dispatch Authority Conflict	Disagreement or tension regarding which entity controls crisis dispatch (988 vs county vs provider).	Governance conflict affecting response architecture.
Informal Integration (Relationship-Based Functioning)	Coordination across systems occurs through informal relationships rather than formal agreements, governance structures, or contracts.	Informal functioning substituting for formal system design.
Law Enforcement Default & Co-Response Dynamics	The role of law enforcement in crisis response; including default routing to police, co-response models, conditions for effective vs. harmful law enforcement involvement, and racial disparities in how law enforcement crisis response is experienced.	Law enforcement involvement as both a system design feature and an equity issue.

SYSTEM MEANING

Category	Definition	Meaning
Crisis Compensates for Upstream Failure	Crisis system absorbs failures in prevention, early care, or outpatient services; functioning as a catch-all for a system that doesn't invest sufficiently upstream.	Structural burden transfer from upstream to crisis.
Market Failure Shapes System	System structure reflects financing distortions; commercial market failures shift costs and design decisions in ways that harm system function.	Market logic is incompatible with crisis system needs.
Stigma Influences Design	Behavioral health stigma shapes policy, funding, system design, or public perception of crisis services.	Stigma as a structural determinant of system design.
Structural Inequity	System produces unequal access, response quality, or outcomes across populations; including by race/ethnicity, language, geography, insurance status, or immigration status.	Equity failure; system produces differential outcomes by population.
Parallel System Formation	Crisis system evolving separate from mainstream health care; developing its own funding, governance, and operational logic outside the broader health system.	System fragmentation at the macro level.
Crisis as Access Gateway	Crisis system functions as an entry point into broader care rather than solely as a stabilization mechanism.	Role expansion of crisis system beyond stabilization.
System Operating Beyond Design	Crisis system absorbing roles beyond intended design; including social stabilization, housing interface, system navigation, and upstream prevention functions.	System strain and adaptive behavior beyond designed function.
Access / Awareness Gap	Crisis services, programs, or lines exist but are underutilized due to lack of awareness among public, partners, or systems.	Underutilization due to awareness failure.

SYSTEM MEANING, *cont.*

Category	Definition	Meaning
Peer-Led Model Inversion	The claim that the current crisis response model; clinician-led with peer support as an add-on; should be inverted: peer support specialists should be the primary relationship, with clinicians providing backstop supervision and clinical expertise. Includes evidence for peer-led models and advocacy for resourcing peer support as core, not supplemental.	Model design claim: peer support is the primary therapeutic mechanism in crisis, not a supplement to clinical care.
SUD System Exclusion	The crisis system is designed around a mental health model that systematically excludes or inadequately serves substance use disorder crises; including drug-induced psychosis, withdrawal, and overdose. SUD is treated as an add-on rather than a co-equal partner in crisis system design.	Structural design exclusion of SUD from crisis system.

SYSTEM FORCES

Category	Definition	Meaning
Financing as Structural Driver	Financing structure is described as a primary force shaping system behavior, stability, or failure; not just a funding issue but a structural determinant of how the crisis continuum operates, expands, or destabilizes.	Financing is a structural determinant of system function.
Workforce as Structural Constraint	Workforce limitations are framed as an ongoing structural feature; not a temporary shortage; linking workforce capacity to system feasibility, scalability, or design.	Workforce capacity is a structural system limit.
Operational vs Rhetorical Integration	Distinction between how integrated the crisis system is described in policy/narrative versus how it actually functions in practice. Integration exists conceptually but not operationally.	Integration is conceptual rather than functional.
Upstream Prevention as Structural Necessity	The argument that upstream prevention, early intervention, and mild-to-moderate care are not nice-to-haves but structural prerequisites for a functioning crisis system; and that without upstream investment, the crisis system will always be overwhelmed regardless of its design.	Upstream prevention is a structural prerequisite, not a supplement.

Appendix C — Charts and Frequency Tables

Appendix B presented the coding framework applied to the interview data. This appendix presents the quantitative results of that coding: how often each code appeared across the 20 interviews, where CBO and Industry/Advocacy respondents converged or diverged, and which of those divergences are statistically distinguishable from chance given the sample size. The figures and table below provide the full quantitative basis for the findings described in Sections 2 through 5 of the paper.

Examining the top 20 codes across the interviews

% of interviews where code appeared (n=20 interviews)

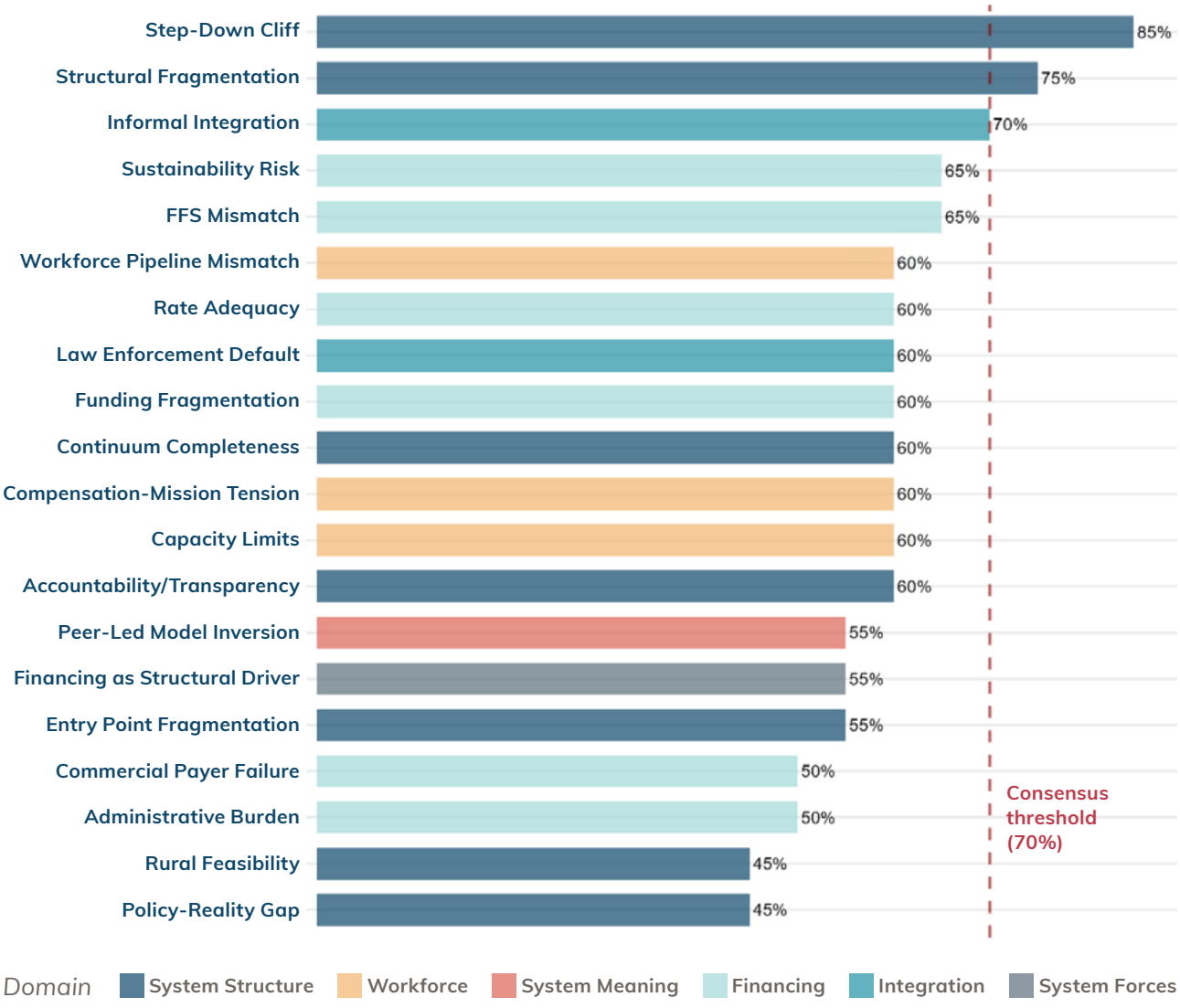


Figure C.1. Code prevalence with a 70% consensus threshold marked. Only Step-Down Cliff, Structural Fragmentation, and Informal Integration crossed this threshold, indicating near-universal agreement across both respondent groups on these three findings.

Examining where CBOs and Industry/Advocacy groups diverge in themes

Divergence = absolute difference in application rates

✳ Fisher's exact p<0.05

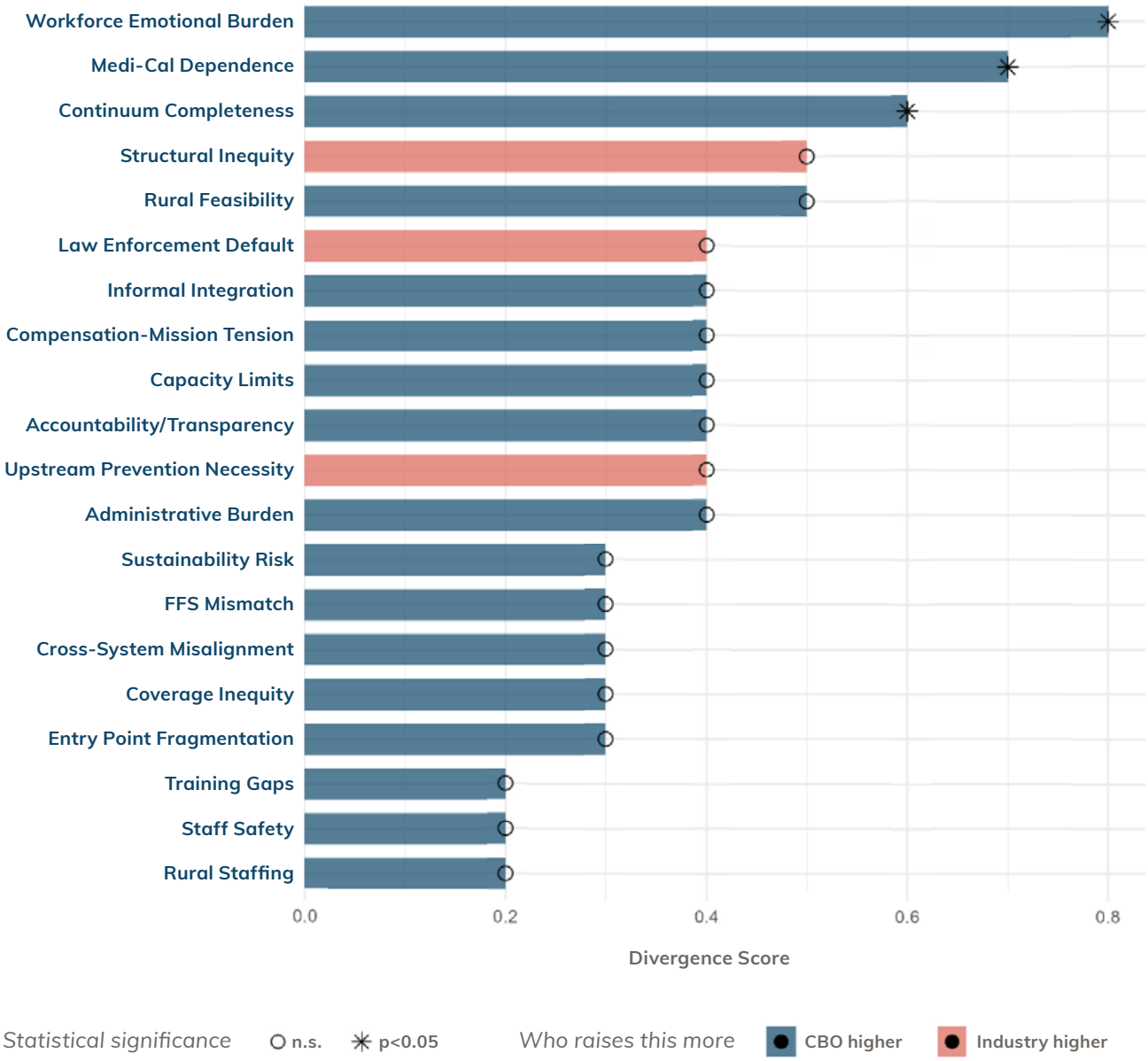


Figure C.2. The 20 codes with the largest absolute difference in prevalence between CBO and Industry/Advocacy respondents. Asterisks mark the three codes that reach statistical significance by Fisher's exact test (Workforce Emotional Burden, Medi-Cal Dependence, and Continuum Completeness); all other divergences shown, including Law Enforcement Default and Structural Inequity, are directionally real but do not reach significance given the sample size.

Overall code frequencies and by group

Table C.1. Full code frequency and CBO/Industry divergence analysis for all 45 codes that appeared in the dataset (two codes, Implementation Drift and Operational vs. Rhetorical Integration, were never used and were omitted). Prevalence is reported as the count and percentage of interviews (out of 20 total, 10 per group) in which each code appeared at least once. Fisher's exact test was used to assess whether CBO and Industry/Advocacy prevalence rates differ; only three codes reach statistical significance at the $p < 0.05$ threshold.

Domain	Code	Code Name	Prevalence (n/20)	CBO (n/10)	Industry/ Advocacy (n/10)	Fisher's p	Significant (p<0.05)
System Structure	1.1	Continuum Completeness	12 (60.0%)	9 (90%)	3 (30%)	0.02	Yes
System Structure	1.2	Structural Fragmentation	15 (75.0%)	8 (80%)	7 (70%)	1.00	No
System Structure	1.3	Rural Feasibility	9 (45.0%)	7 (70%)	2 (20%)	0.07	No
System Structure	1.4	Accountability / Transparency	12 (60.0%)	8 (80%)	4 (40%)	0.17	No
System Structure	1.5	Policy-Reality Gap	9 (45.0%)	4 (40%)	5 (50%)	1.00	No
System Structure	1.6	Entry Point Fragmentation	11 (55.0%)	7 (70%)	4 (40%)	0.37	No
System Structure	1.7	Continuum Bottleneck	7 (35.0%)	3 (30%)	4 (40%)	1.00	No
System Structure	1.9	Step-Down Cliff	17 (85.0%)	8 (80%)	9 (90%)	1.00	No
System Structure	1.10	Medical Clearance Bottleneck	5 (25.0%)	3 (30%)	2 (20%)	1.00	No
Financing	2.1	Commercial Payer Failure	10 (50.0%)	6 (60%)	4 (40%)	0.66	No
Financing	2.2	Medi-Cal Dependence	9 (45.0%)	8 (80%)	1 (10%)	0.01	Yes
Financing	2.3	Rate Adequacy	12 (60.0%)	7 (70%)	5 (50%)	0.65	No
Financing	2.4	Fee-for-Service Mismatch	13 (65.0%)	8 (80%)	5 (50%)	0.35	No
Financing	2.5	Sustainability Risk	13 (65.0%)	8 (80%)	5 (50%)	0.35	No
Financing	2.6	Coverage Inequity	9 (45.0%)	6 (60%)	3 (30%)	0.37	No
Financing	2.7	Administrative Burden	10 (50.0%)	7 (70%)	3 (30%)	0.18	No
Financing	2.8	Funding Fragmentation	12 (60.0%)	7 (70%)	5 (50%)	0.65	No
Workforce	3.1	Capacity Limits	12 (60.0%)	8 (80%)	4 (40%)	0.17	No
Workforce	3.2	Rural Staffing	2 (10.0%)	2 (20%)	0 (0%)	0.47	No
Workforce	3.3	Staff Safety	2 (10.0%)	2 (20%)	0 (0%)	0.47	No
Workforce	3.4	Training Gaps	8 (40.0%)	5 (50%)	3 (30%)	0.65	No
Workforce	3.5	Workforce Emotional Burden	8 (40.0%)	8 (80%)	0 (0%)	<0.001	Yes
Workforce	3.6	Workforce Pipeline Mismatch	12 (60.0%)	7 (70%)	5 (50%)	0.65	No
Workforce	3.7	Compensation-Mission Tension	12 (60.0%)	8 (80%)	4 (40%)	0.17	No
Integration	4.1	988 Functioning & Accountability	7 (35.0%)	3 (30%)	4 (40%)	1.00	No

Domain	Code	Code Name	Prevalence (n/20)	CBO (n/10)	Industry/ Advocacy (n/10)	Fisher's p	Significant (p<0.05)
Integration	4.2	Cross-System Misalignment	7 (35.0%)	5 (50%)	2 (20%)	0.35	No
Integration	4.3	Offloading Responsibility	2 (10.0%)	1 (10%)	1 (10%)	1.00	No
Integration	4.4	Governance / Shared Accountability	2 (10.0%)	1 (10%)	1 (10%)	1.00	No
Integration	4.5	Referral Gatekeeping	2 (10.0%)	2 (20%)	0 (0%)	0.47	No
Integration	4.6	Dispatch Authority Conflict	4 (20.0%)	3 (30%)	1 (10%)	0.58	No
Integration	4.7	Informal Integration	14 (70.0%)	9 (90%)	5 (50%)	0.14	No
Integration	4.8	Law Enforcement Default	12 (60.0%)	4 (40%)	8 (80%)	0.17	No
System Meaning	5.1	Crisis Compensates Upstream	9 (45.0%)	4 (40%)	5 (50%)	1.00	No
System Meaning	5.2	Market Failure Shapes System	4 (20.0%)	1 (10%)	3 (30%)	0.58	No
System Meaning	5.3	Stigma Influences Design	4 (20.0%)	2 (20%)	2 (20%)	1.00	No
System Meaning	5.4	Structural Inequity	9 (45.0%)	2 (20%)	7 (70%)	0.07	No
System Meaning	5.5	Parallel System Formation	2 (10.0%)	0 (0%)	2 (20%)	0.47	No
System Meaning	5.6	Crisis as Access Gateway	1 (5.0%)	0 (0%)	1 (10%)	1.00	No
System Meaning	5.7	System Beyond Design	4 (20.0%)	2 (20%)	2 (20%)	1.00	No
System Meaning	5.8	Access / Awareness Gap	6 (30.0%)	4 (40%)	2 (20%)	0.63	No
System Meaning	5.9	Peer-Led Model Inversion	11 (55.0%)	5 (50%)	6 (60%)	1.00	No
System Meaning	5.10	SUD System Exclusion	2 (10.0%)	1 (10%)	1 (10%)	1.00	No
System Forces	6.1	Financing as Structural Driver	11 (55.0%)	6 (60%)	5 (50%)	1.00	No
System Forces	6.2	Workforce as Structural Constraint	3 (15.0%)	1 (10%)	2 (20%)	1.00	No
System Forces	6.4	Upstream Prevention as Necessity	8 (40.0%)	2 (20%)	6 (60%)	0.17	No

A p-value above 0.05 in the table above does not mean a divergence is unreal, only that it cannot be distinguished from chance at this sample size. Several of the divergences discussed in the body of this paper, including Law Enforcement Default and Structural Inequity, reflect consistent and substantively meaningful differences in emphasis between CBO and Industry/Advocacy respondents, even though they do not meet the threshold for statistical significance. Readers should weigh these patterns as descriptive findings from a qualitative dataset, not as confirmed statistical results.

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