
ASSESSING LEVEL OF CARE GAPS IN CALIFORNIA'S BEHAVIORAL HEALTH CRISIS CONTINUUM

Introduction

California's behavioral health (BH) crisis system is marked by persistent inefficiencies and inequities, undermining effective care delivery. Too many people in crisis are sent to traditional destinations such as Emergency Departments (EDs), where they wait without receiving appropriate BH care and decompensate further (Nordstrom et al., 2019). Psychiatric patients presenting to EDs are nearly five times as likely to wait more than six hours compared to their non-psychiatric counterparts (Nolan et al., 2015). People in BH crisis waiting in EDs, termed "boarders," are more likely to be subjected to restraint or seclusion, a frequently traumatic experience (Simpson et al., 2014). Despite significant attention paid to the issue of ED boarding, Californians with a primary or secondary BH diagnosis made up 1 in 5 treat-and-release ED visits in 2021 (Health Care Access and Information, 2021).

California's BH crisis system is not meeting the needs of communities of color, and often perpetuates harm (Goldman & Vinson, 2022). While suicide deaths among white Californians have decreased, suicide deaths have increased for black and Hispanic Californians (Lund et al., 2023). People of color are at higher risk for restrictive treatment via involuntary hospitalization compared to their white counterparts (Shea et al., 2022; Simon et al., 2025). When law enforcement officials are the de facto first responders to BH crises, criminalization of mental illness is common and inequitable (Appel et al., 2020). Black and Latino Californians with BH conditions are at far higher risk of death in interactions with law enforcement compared to their white counterparts (Premkumar et al., 2021).

Californians with a primary or secondary behavioral health diagnosis made up 1 in 5 treat-and-release Emergency Department visits.

HEALTH CARE ACCESS AND INFORMATION, 2021

Addressing systemic racism will require transformative change in many aspects of the healthcare system, but building alternative destinations to jails, locked hospital wards, and EDs is an essential component of an equitable crisis continuum of care that heals rather than traumatizes (California Health and Human Services, 2023). California has shown recent political and financial commitment to transforming our BH system through the policies and investments (detailed below), but a lack of comprehensive data collection leaves us with a murky picture of the current capacity of alternative destinations. This policy analysis assesses remaining gaps in California's BH crisis system by comparing capacity across levels of care following recent statewide investment and offers recommendations for targeted investment to build a more equitable and person-centered system of care.

Transforming Behavioral Health Care in California: Recent Policies, Investment, and Evaluation

The 2025 Guidelines for a BH Coordinated System of Crisis Care lays out a national framework for crisis system best practices, including “someone to contact, someone to respond, and a safe place for help” (Substance Abuse and Mental Health Services Administration (SAMHSA), 2025). California has committed to transforming its BH crisis system by investing in each of these system components in the form of 988 call centers, mobile crisis teams (MCTs), community paramedics, and clinical infrastructure at multiple levels of care. While 988 is a critical universal service, it is beyond the scope of this analysis.

Someone to Respond

Mobile Crisis Teams. At the state level, California has implemented two parallel approaches to first responders: MCTs and community paramedics. MCTs, among other crisis services, first received state funding through SB 82, the Investment in Mental Health Wellness Act of 2013 (Savill et al., 2023). These pilot programs demonstrated promising benefits – diverting people in BH crises from the ED, decreasing law enforcement involvement in crisis response, and reaching diverse populations – but require further scaling to ensure 24/7 service availability and sustainable funding. The California budget established the Behavioral Health Continuum Infrastructure Program (BHCIP) to provide \$1.8 billion in funding for crisis infrastructure, including funding for Crisis Care Mobile Units (California Health and Human Services, n.d.). BHCIP Round 1 provided over \$163 million to support MCTs. The addition of mobile crisis services as a covered Medi-Cal benefit in 2023 through federal funding via American Rescue Plan Act is a critical step towards sustainability (Gulley et al., 2022).

Community Paramedics. While 988 and MCTs embody the vision for a modern BH crisis system, many Californians still rely on 911, often appropriately in cases involving issues requiring physical health assessment. For these cases, California has implemented a community paramedicine triage to alternative destination programs in five locations (AB 1544). Paramedics dispatched via 911 are trained to screen individuals presenting with BH issues for medical stability and transport them to specified alternative destinations, including crisis stabilization units and sobering centers (J. M. Coffman & Blash, 2023). Studies from California (Glomb et al., 2023; Trivedi et al., 2019), North Carolina (Creed et al., 2018; Henderson et al., 2020), Colorado (Ross et al., 2013), and New Mexico (Cheney et al., 2008) show that triaging people to alternative destinations is safe. An evaluation of California’s alternative destination program diverted individuals from EDs with faster ambulance offload times than the ED (J. M. Coffman & Blash, 2023). Overall, the existing literature indicates that alternative destination programs are safe and an effective option for ED diversion.

A Safe Place for Help

Prior Estimates of Alternative Destination Capacity. Regardless of who is responding to a BH crisis, there must be a place to take those needing further stabilization. SAMHSA calls for an environment in which BH needs can be addressed, crises resolved, and linkage to appropriate ongoing care established (Substance Abuse and Mental Health Services Administration

(SAMHSA, 2025). Alternative destinations such as crisis stabilization units may meet this need more efficiently than the ED, but no prior work focuses on which facilities are best suited to be alternative destinations or their capacity. Instead, we must examine at prior work that considers the entire BH continuum of care.

Prior estimates of statewide capacity across the BH continuum shows shortages at all levels of care. A 2021 RAND evaluation found significant shortages of adult psychiatric beds. Acute¹ bed capacity was 19.5 per 100,000 residents, short of the 26.0 needed (Mcbain et al., 2021). Subacute² bed capacity ranged from 7.4 – 31.8 per 100,000, depending on region, compared to a need of 24.6. Community residential³ capacity had 12.7 beds per 100,000, falling short of the 22.3 required.

Given the significant regional variation, recommendations include prioritizing areas with high absolute bed shortages (urban centers like San Francisco) and relative shortages (rural regions like the San Joaquin Valley). Importantly, this study notes the inconsistent and limited nature of available data, recommending state-wide data collection and dissemination on psychiatric bed capacity and patient characteristics.

California's Department of Health Care Services (DHCS) commissioned an evaluation of the capacity of the BH continuum of care, which echoed the finding of shortages across the continuum (CA DHCS, 2022). This report relied on survey responses from county behavioral health leaders, state agency licensure and certification registries, and SAMHSA's Treatment Locator. They compared current capacity with recommended supply from the Crisis Resource Need (CRN) Calculator (described in further detail in methods), finding that 36% of counties lack mobile crisis capacity, 43% of counties have no crisis stabilization beds, 83% of counties have no crisis respite services, 52% of counties have no residential crisis beds, and 41% of counties have no inpatient units. Many counties that do have services at the respective level of care do not have sufficient capacity.

In addition to funding MCTs, BHCIP supports infrastructure development to expand California's BH crisis system capacity (California Health and Human Services, n.d.). Funding rounds 3 and 5 provided \$518.5 million to expand inpatient, residential and outpatient capacity and \$430 million for crisis-specific services at inpatient, residential, and outpatient levels of care. The California Legislative Analyst's Office (LAO) released a progress report on BHCIP-funded infrastructure, noting that most of the funding was awarded to acute, subacute, and residential facilities, with less awarded to outpatient facilities, including crisis stabilization units (Petek, 2025). Additionally, areas with the largest shortages in acute inpatient beds, such as the southern San Joaquin Valley, have not received funding, while areas with sufficient acute capacity (Los Angeles) have received further investment. Optimizing funding allocation is challenging given California has shortages at most levels of care; however, funding restrictive acute inpatient facilities and better-resourced counties raises concerns.

Taken together, prior estimates of California's BH crisis system capacity clearly indicate shortages at all levels of care. While each captures a cross-section of the system capacity, they

1. Acute beds are "highly structured, around-the-clock medically monitored inpatient care for individuals at a heightened risk of harm to themselves or others."

2. Subacute beds include "around-the-clock inpatient care with specialized programming... with a significant ... supervision."

3. Community residential beds include those in facilities that provide "nonhospital programs in which individual live on the premises... and are provided with consistent programming to promote ... independent living skills."

examine the system with different lenses. The 2021 RAND report captures part of the crisis continuum (acute inpatient and crisis residential beds) but does not delineate which beds are dedicated to individuals in crisis. The 2022 DHCS report offers a wide-lens view of the entire BH continuum and compares available resources to CRN Calculator estimates. However, neither of these analyses account for recent BHCIP investments. The LAO report highlights the additional capacity provided by BHCIP but does not compare new capacity to CRN Calculator need estimates. This policy analysis will utilize 2022 DHCS report data, BHCIP funding award data, and the CRN Calculator to assess the remaining gaps in our BH crisis system.

Methods

This analysis will estimate: 1) optimal capacity at each level of crisis care based on CRN Calculator estimates, 2) the capacity of BH crisis services from the 2022 DHCS report, and 3) additional capacity resulting from BHCIP funding. Subtracting estimates 2) and 3) from estimate 1) will provide a rough final estimate of remaining shortages at each level of care. The facility type, county, number of beds, and projected individuals served annually from BHCIP rounds 1, 3, 4, and 5 as well as Bond round 1 were obtained from BHCIP Data Dashboards (California Health and Human Services, n.d.). Licensure data for many of facilities is publicly available, but most California BH license categories⁴ are so broad that license type does not provide meaningful data for crisis-specific care (CA DHCS, 2022).

Data Quality Issues and Estimate Limitations

The conclusions of this analysis are limited by the poor quality and inconsistency of data – constraints significant enough to warrant early acknowledgment. Both the 2021 RAND and 2022 DHCS reports highlight the absence of a standardized statewide method for data collection, requiring triangulation across disparate sources to estimate crisis system capacity. Terminology to describe clinical services offered and levels of care are inconsistent across data sources. Aligning data required mapping facility types to common definitions without clear consensus. For example, crisis stabilization unit (CSU) is a broad term that is often used interchangeably with BH urgent care. DHCS reports CSU slots while BHCIP separates CSUs and urgent care without defining these terms. Moreover, there are no standardized statewide metrics to assess clinical quality, staffing, protocols, or accessibility. It remains unclear whether facilities are low barrier, equipped for varying levels of crisis acuity, restricted by eligibility, or will be integrated into first responder systems as alternative destinations to the ED. Given these limitations, this analysis compares the relative capacity of crisis services across levels of care and regions, rather than attempting precise county-level estimates. Regions are based on BHCIP grantee regions and include a category of “balance of state,” including many less populous counties with large variation in local context (CA DHCS, n.d.).

Crisis Resource Need Calculator and Interpretation of Results

Recovery International and the National Association of State Mental Health Program Directors developed the CRN Calculator to estimate needed capacity at four levels of care for a given

geography. It uses population size and average inpatient length of stay inputs but does not consider capacity of other areas of the continuum, workforce availability, and other local factors. We used the default settings for the calculator. The four levels of care include: mobile crisis teams⁵, crisis receiving chairs⁶, short-term crisis beds⁷, and acute inpatient beds.

Gaps in capacity are categorized into five levels: “Shortage” represents less than 50% of the estimated teams, chairs or beds based on the CRN Calculator, “Near Shortage” is 50-70% of needed resources, “Approaching Demand” is 70-90% of needed resources, “Appears to Meet Demand” is 90-110% of needed resources, and “Exceeds Demand” is more than 110% of needed resources. Due to lack of expert consensus on this issue, we selected bounds for these categories that we found reasonable.

Estimates of California’s Current BH Crisis System Capacity

Overall, we found that BHCIP funding has expanded the capacity of the BH crisis system at the mobile crisis and inpatient levels of care, but shortages at the levels of crisis stabilization and short-term crisis residential care remain. Additionally, investment and implementation at the mobile crisis and inpatient levels varies substantially by region. Table 1 shows the DHCS only estimate of system capacity (prior to investments) and Table 2 shows the combined DHCS and BHCIP estimate of system capacity (accounting for recent investments). The precise numbers for level of care estimates are available in the appendix but should be interpreted in the context of the significant limitations mentioned above.

TABLE 1. CALIFORNIA’S BEHAVIORAL HEALTH CRISIS SYSTEM CAPACITY: DHCS 2022 ESTIMATE.

County	Mobile Crisis Teams	Crisis Receiving Chairs	Short-Term Crisis Beds	Acute Inpatient Beds
STATEWIDE	Approaching Demand	Near Shortage	Shortage	Appears to Meet Demand
BAY AREA	Near Shortage	Approaching Demand	Shortage	Appears to Meet Demand
CENTRAL COAST	Approaching Demand	Exceeds Demand	Shortage	Shortage
LOS ANGELES	Exceeds Demand	Shortage	Shortage	Exceeds Demand
SACRAMENTO AREA	Approaching Demand	Exceeds Demand	Exceeds Demand	Exceeds Demand
SAN JOAQUIN VALLEY	Shortage	Shortage	Shortage	Near Shortage
SOUTHERN CALIFORNIA	Shortage	Shortage	Shortage	Appears to Meet Demand
BALANCE OF STATE	Exceeds Demand	Exceeds Demand	Shortage	Shortage

4. See appendix for further detail on license types. Subacute beds include “around-the-clock inpatient care with specialized programming... with a significant ... supervision.”

5. MCTs are defined as services that “offer community-based intervention to individuals in need wherever they are; must include a licensed and/or credentialed clinician and respond where person is.”

6. Crisis receiving chairs are defined as services that “operate as a ‘no wrong door’ facility and accept all referrals; generally, lengths of stay must be 23 hours or less; tend to be staffed with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community.”

7. Short-term crisis beds are defined as services that “offer services to individuals who are unable to be stabilized at crisis receiving facilities; this care can also be called sub-acute care, crisis residential, crisis respite, or short-term stabilization; lengths of stay are generally 2-5 days.”

TABLE 2. CALIFORNIA'S BEHAVIORAL HEALTH CRISIS SYSTEM CAPACITY: DHCS + BHCIP ESTIMATE.

County	Mobile Crisis Teams	Crisis Receiving Chairs	Short-Term Crisis Beds	Acute Inpatient Beds
STATEWIDE	Appears to Meet Demand	Near Shortage	Shortage	Exceeds Demand
BAY AREA	Exceeds Demand	Approaching Demand	Near Shortage	Exceeds Demand
CENTRAL COAST	Exceeds Demand	Exceeds Demand	Shortage	Appears to Meet Demand
LOS ANGELES	Appears to Meet Demand	Shortage	Shortage	Exceeds Demand
SACRAMENTO AREA	Near Shortage	Exceeds Demand	Exceeds Demand	Exceeds Demand
SAN JOAQUIN VALLEY	Approaching Demand	Approaching Demand	Shortage	Approaching Demand
SOUTHERN CALIFORNIA	Near Shortage	Shortage	Shortage	Exceeds Demand
BALANCE OF STATE	Exceeds Demand	Exceeds Demand	Shortage	Approaching Demand

Mobile Crisis Teams

We found that the statewide number of MCTs is sufficient to meet the estimate provided by the CRN Calculator, an increase from the DHCS data showing that MCT capacity was approaching demand. However, this statewide estimate masks regional disparities: Sacramento area and Southern California are nearing MCT shortages. Counties included in the “Balance of State” category include many with populations so small that the CRN Calculator estimated a need of zero MCTs. This is an important consideration when interpreting the finding that capacity exceeds demand: having a single MCT in one of these areas would exceed demand. This highlights the pitfalls of applying a generalized formula via the CRN Calculator to counties with diverse local needs. Deliberate decision-making tailored to local contexts is critical to understand whether services such as MCTs are the appropriate resource.

Implementation barriers are also an issue for mobile crisis capacity: the BHCIP Round 1 data dashboard notes that 91% (48/53) of county grantees are currently providing services and the remaining counties are experiencing workforce challenges preventing them from hiring mobile crisis staff. Moreover, staff turnover and burnout can impede service delivery even for established teams. While the dashboard does not identify these counties, rural counties in California are known to face significant BH workforce issues (J. Coffman & Peterson, 2023).

Crisis Receiving Chairs

The combined DHCS and BHCIP estimate shows that California continues to have a near shortage of crisis receiving chairs, suggesting that BHCIP investments have not yet improved crisis stabilization capacity at the state level. Shortages persist in Los Angeles and Southern California and while the Bay Area is approaching demand, this level remains unchanged with BHCIP investment. These findings echo the 2025 LAO report highlighting the lack of BHCIP funding for outpatient care, including crisis stabilization services. However based on our estimates, one region of improvement from the Bond Round 1 awards is in the Joaquin Valley which is now approaching demand.

Short-Term Crisis Beds

This estimate of both DHCS and BHCIP capacity shows a shortage of short-term crisis beds at the state level; this suggests no improvement from BHCIP above DHCS estimates alone. The Central Coast, Los Angeles, San Joaquin Valley, Southern CA, and the Balance of State counties all show shortages, with the Bay Area nearing a shortage. Only the Sacramento area has a sufficient supply of short-term crisis beds, primarily due to the notable availability of peer respite services. Peer respite is a critical component of the crisis continuum, especially as a step-down option from inpatient care, but may not be appropriate for more acute BH crises. Thus, Sacramento may still benefit from further investment in higher intensity crisis beds.

An important caveat is that this analysis only includes SRP crisis beds, peer respite beds, and beds at LPS-designed MHRCs in this level of care. If we include all SRP and MHRC beds, statewide capacity would meet demand for this level of care. While beds in SRPs and MHRCs could be potential pools from which to expand this bed supply, the 2021 RAND study shows an existing shortage of beds for the long-term rehabilitation purposes for which they are intended (Mcbain et al., 2021). Repurposing these beds for crises would likely exacerbate shortages in other parts of the BH care continuum. Practically, it is unlikely that these general beds are currently being used for short-term crisis capacity.

Acute Inpatient Beds

Our estimates show a sufficient supply of acute inpatient beds statewide with most regions across the state meeting or exceeding demand, while the San Joaquin Valley is nearing demand – suggesting that BHCIP has effectively added inpatient bed supply compared to the older 2021 RAND estimate. This differs from the conclusion of the 2025 LAO report that compares RAND and BHCIP capacity, which notes a substantial remaining shortage of inpatient beds. This may in part be due to the definition of “inpatient” level of care, which includes both acute and subacute beds. As discussed above, many general subacute beds may be not equipped to accept individuals in crisis.

Discussion and Recommendations to Address Gaps in California's BH Crisis System

This policy analysis assessed remaining gaps at four levels of BH crisis care in California using the CRN Calculator, 2022 DHCS capacity estimates, and new capacity through BHCIP investment. Our findings suggest that BHCIP funding improved capacity for MCTs to meet demand, but implementation is likely impeded by local challenges (like workforce issues) and regional contexts are critical to understanding whether current services are sufficient and appropriate. A statewide shortage of short-term crisis beds and near shortage of crisis receiving chairs remains, with little improvement from pre-BHCIP capacity. While BHCIP investment may have exceeded the demand for inpatient beds in some areas, regions such as the San Joaquin Valley that were identified in the 2021 RAND study as having inpatient bed shortages were not yet resolved by BHCIP awards. This finding must be qualified with the caveat that regional barriers to building capacity at specific levels of care may be driving investment in adjacent levels. For example, a lack of subacute beds in Los Angeles may result in an excess of inpatient beds to address this bottleneck. Overall, this analysis suggests that state-level policymakers may want to reconsider how they prioritize future funds to address gaps in our BH crisis system.

Future Policy Opportunities

Both state- and county-level policymakers have an opportunity to act on these findings with the recent passage of Proposition 1 in 2024, which funds \$4.4 billion in state bonds to further expand the BH continuum, including crisis services (CA DHCS, n.d., p. 1). These funds are estimated to fund 6,800 residential beds and 26,700 outpatient slots. The Round 2 Request for Applications (RFA) prioritizing unmet needs in the BH system will close in September 2025. This RFA specifies crisis stabilization facilities as a target level of care for funding; our findings suggest that broadening this target to include crisis residential facilities may help address remaining gaps.

California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative offers another timely opportunity to act on these findings. The BH-CONNECT initiative has five arms, one of which is a workforce initiative that aims to bolster California's BH workforce through training and resources (CA DHCS, 2025). While MCTs were the primary level of care noted to have a hiring issue due to BH workforce shortages, other levels of care are also likely to be affected by workforce issues. County-level policy makers should leverage the loan repayment, BH training scholarships, recruitment/retention bonuses, and community-based provider training programs to staff MCTs in rural areas and increase sustainability at other levels of care.

Data Collection Recommendations

This attempt to quantify statewide system capacity highlights the acute need for standardized data collection. Many state-funded programs have data reporting requirements, and standardizing requirements with a common unit of beds/chairs available through a program or facility is a potential first step. Alternatively, adapting the CRN Calculator categories and formula to California's unique licensing system may provide clarity on how to classify SRP and MHRC beds. We used estimates that encompass facilities that may or may not appropriately function as alternative destinations for ED diversion as there is a dearth of data available on which are utilized in practice and which have effective outcomes. Future efforts should identify the facilities that are equipped to receive individuals diverted from the ED. The Roadmap to an Ideal Crisis system specifies metrics that crisis systems should strive to track and meet including "timely, safe, accessible, least restrictive, effective, person- and family-centered" care (Minkoff et al., 2021). Policymakers should build a system with the technical capacity to track these metrics, ensuring that California's investments truly transform our BH crisis continuum into an equitable and compassionate system of care.

From Infrastructure to Impact

California's commitment to expanding the behavioral health crisis continuum through BHCIP and Proposition 1 represents a historic opportunity to close longstanding gaps in access, geography, and equity. But the success of these investments hinges not only on building new facilities – it depends equally on ensuring that these facilities operate at the capacity, clinical acuity, staffing levels, and accessibility standards required to function as true alternatives to the ED, jails, and locked units.

Across all levels of care, implementation challenges surfaced in this analysis point to a critical truth: capacity on paper does not necessarily translate into capacity in practice. Workforce shortages prevent mobile crisis teams from launching; facilities labeled as "crisis receiving" may be restricted by eligibility criteria; newly funded beds may sit idle due to delays in hiring, licensing, or integration with 988/911 systems; and counties vary dramatically in their ability to operationalize new bricks-and-mortar resources.

To safeguard the intent of ongoing state investments, California must pair capital expansion with operational accountability mechanisms that ensure facilities are not only open but fully functioning, staffed, integrated into first responder pathways, and capable of meeting the clinical needs of people in crisis.

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APPENDIX

APPENDIX

Data Source Alignment and Assumptions

The CRN Calculator, DHCS report, and BHCIP all use the same unit for capacity at the first level of care: mobile crisis teams. However, BHCIP funds can be used to enhance existing teams, thus adding DHCS and BHCIP team estimates would likely overcount the available teams. Instead, we use the data from the BHCIP Round 1 Data Dashboard as the total estimate. This approach may result in undercounting the number of teams as there are likely teams that exist but did not receive additional BHCIP funding. The DHCS report quantifies the crisis stabilization slots per county and BHCIP projects the number of individuals served annually at crisis stabilization units, BH urgent cares, and sobering centers. These BHCIP projections were divided by 365 to estimate the number of individuals served daily to approximately align with DHCS crisis stabilization slots.

Short-term crisis beds represent the most variable category in terms of settings. Crisis beds in Social Rehabilitation Program (SRP) facilities, peer respite beds, and beds in Mental Health Rehabilitation Centers (MHRCs) with Lanterman-Petris-Short (LPS) Designation were included in the short-term crisis bed estimate. LPS-designed MHRCs were included because these facilities are equipped to accept individuals placed on 5150 holds, representing sufficient staffing and service intensity to care for people in crisis. Acute inpatient beds are one level of care for which licensing is representative of the crisis system component: for both DHCS and BHCIP data, beds were included from facilities licensed as psychiatric general acute care, acute psychiatric hospitals, and psychiatric health facilities. This mirrors the California Hospital Association Psychiatric Bed Report definitions of inpatient beds (Lowe, 2018).

CALIFORNIA'S BEHAVIORAL HEALTH CRISIS SYSTEM CAPACITY: DHCS 2022 ESTIMATE.

County	Mobile Crisis Teams	Crisis Receiving Chairs	Short-Term Crisis Beds	Acute Inpatient Beds
STATEWIDE	86.87%	54.00%	20.05%	107.51%
BAY AREA	53.33%	75.59%	45.18%	105.96%
CENTRAL COAST	78.95%	138.55%	40.00%	40.93%
LOS ANGELES	234.25%*	36.04%	5.08%	148.30%
SACRAMENTO AREA	70.83%*	113.04%	131.36%	131.11%
SAN JOAQUIN VALLEY	42.11%	49.79%	0.00%	58.72%
SOUTHERN CALIFORNIA	40.69%	18.66%	0.00%	101.26%
BALANCE OF STATE	173.33%	200.00%	0.00%	46.93%

**CALIFORNIA'S BEHAVIORAL HEALTH CRISIS SYSTEM CAPACITY: DHCS +
BHCIP ESTIMATE.**

County	Mobile Crisis Teams	Crisis Receiving Chairs	Short-Term Crisis Beds	Acute Inpatient Beds
STATEWIDE	102.53%	68.73%	33.08%	129.27%
BAY AREA	138.33%	89.90%	66.94%	118.52%
CENTRAL COAST	184.21%	157.42%	40.00%	93.95%
LOS ANGELES	101.37%*	48.62%	27.75%	179.31%
SACRAMENTO AREA	54.17%*	139.41%	153.39%	144.72%
SAN JOAQUIN VALLEY	78.95%	70.23%	6.06%	87.83%
SOUTHERN CALIFORNIA	67.59%	28.08%	1.40%	115.49%
BALANCE OF STATE	362.50%**	237.90%**	15.52%	78.21%

*These tables show a decrease in MCT availability due to the method of quantifying MCTs described in the “Data Source Alignment and Assumptions” appendix section. Our findings likely undercount the availability of teams; however, even this potential underestimation shows that the state is meeting MCT demand, with some regional variation. A higher level of MCT capacity would only strengthen our conclusion that BHCIP investment has significantly increased MCT capacity.

**The CRN Calculator relies on only two inputs: population size and average acute inpatient length of stay. Counties included in the “Balance of State” category have such small populations that the CRN Calculator produces estimates with very small numbers. For example, 12 counties in this group have an estimated need of 0 mobile crisis teams. Thus, small increases in the number of teams or chairs available represent a larger proportion of the total, leading to large percentages.

California Counties Included in Regions

- *Bay Area:* Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
- *Central Coast:* Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz
- *Sacramento Area:* El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba
- *San Joaquin Valley:* Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
- *Southern California:* Imperial, Orange, Riverside, San Bernardino, San Diego, Ventura
- *Balance of State:* Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne

California Psychiatric Licensure Categories

License	Licensing Department	Description	Source
1. Acute Psychiatric Hospital	CDPH	"24-h inpatient care for mentally disordered, or incompetent patients. APH facilities provide medical, nursing, rehabilitative, pharmacy and dietary services under Section 1250 of the Health & Safety Code. Under OSHPD jurisdiction."	Department of Health Care Access and Information (HCAI). Advisory Guide Series: Acute Psychiatric Hospitals. Section 1: Behavioral Health Facility Types. URL below.
2. Psychiatric Health Facility	DHCS	"24-hour inpatient care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the WIC. Care includes, but is not limited to psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings."	California Department of Health Care Services (DHCS). Mental Health Licensing Branch. Psychiatric Health Facility. URL below.
3. Psychiatric Beds within General Acute Care Hospitals	CDPH	"Acute psychiatric, developmentally disabled or drug abuse patients receiving 24-hour medical care (T22 §70006. Acute Psychiatric Care Bed Classification)."	Department of Health Care Access and Information (HCAI). Licensed Bed Classification and Designations Trends: Data Dictionary. URL below.
4. Mental Health Rehabilitation Center	DHCS	"24-hour program which provides intensive support and rehabilitative services designed to assist persons with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning."	California Department of Health Care Services (DHCS). Mental Health Licensing Branch. Mental Health Rehabilitation Center. URL below.

California Psychiatric Licensure Categories (continued)

License	Licensing Department	Description	Source
5. Social Rehabilitation Program (SRP)	CDSS + DHCS	"SRPs provide a wide range of alternatives to acute psychiatric hospitalization and institutional care based on the principles of community-based treatment. Community-based treatment includes a high level of care provided in a homelike setting, individual and group counseling, psychiatric services, pre-vocational and vocational assistance, community participation, and linkages to other community services."	California Department of Health Care Services (DHCS). Mental Health Program Certification Section. Social Rehabilitation Programs. URL below.
6. LPS Designation	DHCS	"Mental health treatment facilities that are designated by the county for evaluation and treatment, and licensed as a health facility as defined in subdivision (a) or (b) of Section 1250 or 1250.2 of the Health and Safety Code or certified by DHCS to provide mental health treatment. A designated facility may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and certified crisis stabilization units."	California Department of Health Care Services (DHCS). LPS Designated Facilities. URL below.
Source links: https://hcai.ca.gov/wp-content/uploads/2025/02/A4_Acute_Psychiatric_Hospitals_Advisory_Guide-02-07-2025-A.pdf#:~:text=Acute%20Psychiatric%20Hospital%20(APH)%20%E2%80%933,and%20Title%2022%20Section%2071000. https://www.dhcs.ca.gov/provgovpart/Pages/Psychiatric-Health-Facilities.aspx https://data.chhs.ca.gov/dataset/licensed-bed-classification-and-designations-trends https://www.dhcs.ca.gov/provgovpart/Pages/Mental-Health-Rehabilitation-Centers.aspx https://www.dhcs.ca.gov/services/MH/Pages/Mental-Health-Program-Certification-Section.aspx#:~:text=Social%20Rehabilitation%20Programs%20(SRP)%20are,linkages%20to%20other%20community%20services. https://www.dhcs.ca.gov/provgovpart/Pages/County-LPS-Facilities.aspx			

