County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division

Salud Mental y Tratamiento del Uso de Sustancias

NOTICE OF PUBLIC MEETING
BEHAVIORAL HEALTH ADVISORY BOARD
SEPTEMBER 17, 2026, 3:00 PM-5:00 PM
1400 EMELINE, CONFERENCE ROOMS 206-207, SANTA CRUZ
THE PUBLIC MAY JOIN THE MEETING ON MICROSOFT TEAMS (LINK BELOW) OR CALL (831)454-2222, CONFERENCE 922 521 473#

Xaloc Cabanes Chair 1st District	Valerie Webb Member 2nd District	Michael Neidig Co-Chair 3rd District	Antonio Rivas Member 4th District	Vacant 5th District	Natalie Stott Transitional Age Youth
Kaelin Wagnermarsh Member 1st District	Dean S. Kashino Member 2nd District	Hugh McCormick Member 3rd District	Rachel Montoya Member 4th District	Jeffrey Arlt Secretary 5th District	Vacant Transitional Age Youth

Kimberly De Serpa Board of Supervisor Member	
Dr. Marni R. Sandoval Behavioral Health Director	Meg Yarnell Behavioral Health Deputy Director

Information regarding participation in the Behavioral Health Advisory Board Meeting

The public may attend the meeting at the Health Services Agency, 1400 Emeline, Conference Rooms 206-207, Santa Cruz. Individuals may click here to Join Meeting Now or may participate by telephone by calling (831)454-2222, Conference ID 922 521 473#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Behavioral Health Advisory Board website.

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

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

BEHAVIORAL HEALTH ADVISORY BOARD AGENDA

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

ID	Time	Regular Business
1	3:00-3:15	• Roll Call • Public Comment (No action or discussion will be undertaken today on any item raised during Public Comment period except that Behavioral Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each) • Board Member Announcements • *Approval of August 20, 2026 minutes** • Secretary's Report
		Presentation
2	3:15-3:35	MHCAN Update – Nina Stratton and Nick Bodsky, MHCAN Board Members
		Standing Reports
3	3:35-3:45	July and August Patients' Rights Report– George Carvalho, Patients' Rights Advocate, Advocacy Inc.
4	3:45-3:55	Board of Supervisors Report – Supervisor Kimberly De Serpa
5	3:55-4:10	Behavioral Health Director's Report – Dr. Marni R. Sandoval, Behavioral Health Director
6	4:10-4:20	Site Visit Ad Hoc Committee Update – Kaelin Wagnermarsh and Dean Kashino
		New Agenda Items
7	4:20-4:25	Revised Vision and Goals - Create Ad Hoc Committee
8	4:25-4:35	*Submission of 2026 Data Notebook Survey**
9	4:35-4:45	*Request Board authorization for BHAB to use alternative teleconferencing procedures under California Government Code § 54953.8.6**
10	4:45-4:50	Discuss Grand Jury Report
11	4:50-4:55	Discuss Behavioral Health Presentations for the Upcoming Year
	4:55-5:00	**Future Agenda Items**
	5:00	**Adjourn**

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

THE NEXT BEHAVIORAL HEALTH ADVISORY BOARD MEETING IS ON:
OCTOBER 15, 2026, 3:00PM – 5:00PM
HEALTH SERVICES AGENCY
1400 EMELINE, CONFERENCE ROOMS 206-207, SANTA CRUZ

County of Santa Cruz

HEALTH SERVICES AGENCY

BEHAVIORAL HEALTH DIVISION

Salud Mental y Tratamiento del Uso de Sustancias

MINUTES – Draft

BEHAVIORAL HEALTH ADVISORY BOARD

AUGUST 20, 2026, 3:00 PM - 5:00 PM

HEALTH SERVICES AGENCY, 1400 EMELINE, CONFERENCE ROOMS 206-207, SANTA CRUZ

MICROSOFT TEAMS (831) 454-2222, CONFERENCE 282 967 448#

Present: Antonio Rivas, Dan Barnett, Dean Kashino, Hugh McCormick, Kaelin Wagnermarsh, Michael Neidig, Rachel Montoya, Valerie Webb, Xaloc Cabanes, Supervisor De Serpa

Absent: Jeffrey Arlt, Natalie Stott

Staff: Dr. Marni Sandoval, Jane Batoon-Kurovski

I. Roll Call – Quorum present. Meeting called to order at 3:05 p.m. by Chair Xaloc Cabanes. Jeffrey Arlt joined virtually as a public member.

II. Public Comment – 1 individual addressed the BHAB in the conference room.
1 individual addressed the BHAB on Teams.

III. Board Member Announcements

- Dan Barnett announced this meeting is his last as he plans to relocate out of state.
- Mike Neidig requested to play Supervisor Koenig's video regarding the issue of reducing expenses across the public safety system. Comments included the need to make changes and to look at the public safety and justice system.

IV. Approve July 16, 2026 Minutes
Motion / Second: Antonio Rivas / Valerie Webb
Ayes: Rivas, Barnett, Kashino, McCormick, Wagnermarsh, Neidig, Montoya, Webb, De Serpa
Abstain: Cabanes
Nayes: None
Passed.

Approve July 27, 2026 Retreat Minutes
Motion / Second: Antonio Rivas / Kaelin Wagnermarsh
Ayes: Rivas, Barnett, Kashino, Wagnermarsh, Neidig, Cabanes, De Serpa
Abstain: McCormick, Montoya, Webb
Nayes: None
Passed.

V. Secretary's Report – no report.

VI. Patient's Rights Report – George Carvalho, Advocate for Advocacy, Inc.
No report. George did not attend the meeting.

VII. Board of Supervisors Report – Supervisor Kim De Serpa

- Clarified that the county has an active public defender; only individuals who are dangerous or charged with serious violent crimes remain in jail.

- New laws allow individuals with severe mental illness who cannot care for themselves or pose risks may be conserved, but funding and bed shortages limit the ability to place them in appropriate facilities.
- Clarified that the County's discretionary nonprofit funding has shifted toward equity-focused programs. Statewide budget crisis and loss of Medi-Cal for 25K residents threaten critical services. Healthcare agencies face a $200M countywide shortfall. Proposal is to allocate $1.5M to food security and reserve $2.5M for nonprofits addressing essential needs.
- BOS approved placing a half-cent sales tax measure on the November ballot to offset HR1-related funding losses, aiming to generate $25M–$27M annually to help sustain healthcare and behavioral health services.

- Other Comments / Discussion items:
  1. Board member identified the need for additional treatment, residential, step-down capacity. BH and Sheriff's Office continue working on diversion and treatment options. Future action: Explore inviting the Sheriff to a future meeting to discuss jail operations, recidivism, diversion, and system improvements.
  2. Youth Crisis Services -119 youth served through August 14, approximately 74% discharged home with follow-up services. Program continues to reduce out-of-county placements.
  3. Adult/Residential Capacity – Adult crisis residential services remain below community needs. Upcoming 16-bed residential program may reduce out-of-county placements; financial sustainability will depend on utilization and revenue.
  4. Maternal Behavioral Health – Board discussed the lack of local specialized treatment for severe postpartum psychiatric conditions. Stated that El Camino Hospital provides specialized maternal mental health services when clinically appropriate, and Nurture in Soquel has licensed therapists for postpartum issues.

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

1. Adult System of Care (ASOC) Update
   - BHSA Implementation- Implemented FSP Level 1 (ICM), completed assessments and orientations, streamlined on-call workflows, added team intro videos, and removed a redundant management layer.
   - Housing & HMIS Coordination- Partnering with housing providers to ensure HMIS documentation for all BHSA-funded placements.
   - BH Website- Modernized the BH website with an updated design and improved navigation.
   - Upcoming Program Launches- Planning ACT and FCT programs and coordinating with DHCS to implement IPS and CSC (FEP) through the Volunteer Center.
   - Bridge House Navigation Center- Bridge House opening delayed due to fire-prevention and supply issues; temporary occupancy granted, with move-in expected by next update.
2. Children's System of Care (CSOC) Update
   - Screened 227 youth and enrolled 69 into FSP Level 1; updating screening tools to prioritize youth in child welfare, probation, homelessness risk, and transition-age groups.
   - CSS enrollment into FSP was lower than expected (32 of 74 child-welfare youth); additional guidance and training will ensure presumptive eligibility is applied consistently, with expected enrollment increasing to 70–75%.
3. Substance Use Disorder Services Update
   - Integrated Care Evolution: SUDS is supporting BH's transition to fully integrated mental health and substance use care to provide seamless, comprehensive services for all clients.

- Integration Roadmap: BH leadership created a systemwide integration roadmap, with SUDS, Adult Outpatient, and BH Access jointly implementing the plan.
- Phase 1 Implementation: SUDS clinicians will embed in Adult Outpatient and Access teams, and mental health clinicians will provide brief assessments and link clients to the SUDS service array.
- Leadership Update: Sr BH Manager Casey Swank is departing at month's end; appreciation shared for her contributions and support.

IX. Site Visit Committee – Community Connections: Mike, Dean and Dan visited the site.

- Long-standing recovery center offering community engagement, career services, health support, and resilience living programs; serves about 1,000 clients, requires BH referrals, and has seen reduced Kaiser funding.
- Agency follows a recovery model with daily socialization program and a jail-based Friends Outside program which tries to link people to services. Overall impressed with agency, with questions about how Cal-AIM re-entry may affect the program.
- Facility offers recovery-focused outreach programs, including jail engagement, aimed at connecting people to community supports and helping clients develop skills and meaningful pathways based on individual interests.
- Suggestion: Encourage BHAB to attend open 12-step meetings AA, Al-Anon to learn about substance use and recovery; not appropriate as formal site visits.

X. Revised Mission Statement, Vision and Goals

- Board discussed revising its mission, vision and goals to guide future priorities.
- Proposed Ad Hoc Committees:
  1. System Efficiency
  2. Outreach
  3. Site Visit
  4. Finances
- Preferred presentations:
  - Kaelin: Heather Rodgers and Sheriff's Office
  - Valerie: Mobile Crisis Response and United Way (211)
  - Rachel: Heather Rogers and Youth Incarceration Services
  - Antonio: Farris Sabbah and PVUSD
  - Dean: Crisis Prevention /Intervention Services and MHCAN
  - Hugh: MHCAN and Heather Rogers
  - Xaloc: Sheriff's Office and Crisis Prevention/Intervention Services

XI. Grand Jury Report Update

BH response scheduled for BOS consideration on September 15th; final County responses due September 23rd. BHAB to review final public responses and consider relevant findings in future work.

XII. Future Agenda Items

- 2026 Data Notebook Survey: data will be reviewed with department before bringing the completed material to the BHAB.
- MHCAN presentation next month.

XIII. Adjournment

Meeting adjourned at 5:02pm.

Peer Tree Clubhouse

Clubhouses Save Lives

Through over 370 local Clubhouses in 31 countries around the world, Clubhouse International offers people living with mental illness opportunities for friendship, employment, housing, education and access to medical and psychiatric services in a single caring and safe environment – this social and economic inclusion reverses the alarming trends of higher suicide, hospitalization and incarceration rates associated with mental illness.

What is a Clubhouse?

A Clubhouse is a community-based service dedicated to supporting and empowering people living with mental illness, known as Clubhouse members. Based on the Clubhouse Model of psychosocial rehabilitation, each Clubhouse offers a collaborative, restorative environment where Clubhouse members can recover by gaining access to opportunities for employment, socialization, education, skill development, housing and improved wellness.

Organized around the belief that every individual has something valuable to contribute to society, Clubhouses effectively help people build self- confidence and end the social and economic isolation so often associated with mental illness.

Overview

Clubhouses are a powerful demonstration of the fact that people with mental illness can and do lead normal, productive lives. Clubhouses are local community centers that provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing, including:

- a work-ordered day in which the talents and abilities of members are recognized and utilized within the Clubhouse;
- participation in consensus-based decision-making regarding all important matters relating to the running of the Clubhouse;
- opportunities to obtain paid employment in the local labor market through a Clubhouse-created Transitional Employment Program. In addition, members participate in Clubhouse-supported and Independent programs;
- assistance in accessing community-based educational resources;
- access to crisis intervention services when needed;
- evening/weekend social and recreational events; and

- assistance in securing and sustaining safe, decent and affordable housing.

The Origin of the Term "Clubhouse"

The word “Clubhouse” derives from the original language that was used to communicate the work and vision of Fountain House, the very first Clubhouse, which was started in New York in 1948. Since its inception, Fountain House has served as the model for all subsequent Clubhouses that have been started around the world. Fountain House began when former patients of a New York psychiatric hospital began to meet together informally, as a kind of “club.” It was organized as a support system for people living with mental illness, rather than as a service or a treatment program. Communities around the world that have modeled themselves after Fountain House have embraced the term “Clubhouse,” because it clearly communicates the message of membership and belonging. This message of inclusion is at the very heart of the Clubhouse way of working.

Meaningful Relationships: The Core Ingredient

The Clubhouse environment and structures are developed in a way to ensure that there is ample opportunity for human interaction and that there is more than enough work to do.

Clubhouse staffing levels are purposefully kept low to create a perpetual need for the involvement of the members in order to accomplish their jobs. Members also need the staff and other members in order to complete the work, but even more importantly, the relationships that evolve through this work together are the key ingredient in Clubhouse rehabilitation. (Vorspan, 1986). The Clubhouse members and staff as a community are charged with prioritizing, organizing and accomplishing the tasks that are important to make the Clubhouse a success.

Relationships between members and staff develop naturally as they work together side by side carrying out the daily duties of the Clubhouse. All of the staff have generalist roles in the Clubhouse; they are involved in all of the Clubhouse activities including the daily work duties, the evening social and recreational programs, the employment programs, reach out, supported education and community support responsibilities. Members and staff share the responsibility for the successful operation of the Clubhouse. Working closely together each day, members and staff learn of each others’ strengths, talents and abilities. They also develop real and lasting friendships. Because the design of a Clubhouse is much like a typical work or business environment, relationships develop in much the same way.

The role of the staff in a Clubhouse is not to educate or treat the members. The staff are there to engage with members as colleagues in important work and to be encouraging and engaging with people who might not yet believe in themselves. Clubhouse staff are charged with being colleagues, workers, talent scouts and cheerleaders.

Patients' Rights Advocate Report
July 2026

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

TELECARE
On July 12, 2026, a client whom I represented in a certification review hearing the previous day contacted my office regarding a possible appeal hearing believed to be scheduled for 1:00 p.m. that same day. The client reported being told by his social worker that issues related to food, clothing, and shelter, including grave disability, would be discussed. I conferred with the client's social worker, who confirmed that no hearing had been scheduled for 1:00 p.m.; however, a writ of habeas corpus had been filed. I informed the client of this information and advised him that he would have the assistance of a Public Defender at that time.

On July 13, 2026, I received a voice message from a client held on a 5250 hold for intensive treatment at the Telecare psychiatric facility. The client requested a face-to-face meeting. I met with the client the following day, reviewed the history as relayed by the client, and advised him of his legal options. At the time of the meeting, the client did not wish to file a writ of habeas corpus.

Watsonville Community Hospital
On July 21, 2026, this writer received a phone call from the social worker concerning an imminent serial 5150. I placed calls to both the social worker and the client detained on a 5150 hold as a danger to self. I identified myself, explained my role, and explained the relevant points of AB 2275. The client stated that she was not informed about the second 5150 and was not aware of the ground or grounds of the hold. I advised the client of her right to be fully informed about treatment, including the use of medications. Lastly, I advised her of the right to file a writ of habeas corpus.

Certification Review Hearings
July 2026

1. TOTAL NUMBER CERTIFIED	39
2. TOTAL NUMBER OF HEARINGS	38
3. TOTAL NUMBER OF CONTESTED HEARINGS	11
4. NO CONTEST PROBABLE CAUSE	27
5. CONTESTED NO PROBABLE CAUSE	1
6. VOLUNTARY BEFORE CERTIFICATION HEARING	0
7. DISCHARGED BEFORE HEARING	1
8. WRITS	
9. CONTESTED PROBABLE CAUSE	10
10. NON-REGULARLY SCHEDULED HEARINGS	

Ombudsman Program & Patient Advocate Program shared 0 clients in this month (shared = skilled nursing resident (dementia) sent to behavioral health unit or mental health client placed in skilled nursing care at Telecare (Santa Cruz Psychiatric Health Facility))

Riese Hearings / Capacity Hearings

Total number of Riese petitions filed by the Telecare treating psychiatrist: N/A
Total number of Riese Hearings conducted: 1
Total number of Riese Hearings lost: 1
Total number of Riese Hearings won: 0
Total number of Riese Hearings withdrawn: 0
Hours spent on conducted hearing representation: 2.0 hours
Hours spent on hearings not conducted: 0
Hours spent on all Riese hearings: 1
Riese appeals: 0

Respectfully Submitted: Davi Schill, PRA
George Carvalho, PRA

Patients' Rights Advocate Report
August 2026

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

TELECARE
On August 26, 2026, this Advocate received a call from a client held on a 5150 hold at the Crisis Stabilization Unit. The client expressed concern about the basis and circumstances of the detention and reported being on the second day of the three-day hold. I advised the client to communicate directly with the treatment team and provided rights advisement regarding the right to be fully informed about treatment and additional rights related to a potential 5250 hold.

On August 26, 2026, a client left a voice message regarding detention at the CSP. The client disputed being a danger to self or others and stated that the detention was unjust. This Advocate returned the call, explained the 5150-detention process, advised the client of the right to be fully informed about treatment, and encouraged the client to discuss concerns with CSP staff.

7th Ave
On August 25, 2026, a resident of the 7th Avenue Center contacted this office regarding conservatorship status and related rights. The client reported being on a program level that made the client ineligible for discharge and was uncertain about the steps needed to advance to the next level. I encouraged the client to speak with the assigned mental health worker for clarification and asked the client to follow up with this office after that conversation.
assigned to the client. I asked whether the client could speak with the worker to obtain more information. The client stated that time with the worker could be arranged, and I asked the client to return a call after that conversation.

Certification Review Hearings
August 2026

1. TOTAL NUMBER CERTIFIED	40
2. TOTAL NUMBER OF HEARINGS	38
3. TOTAL NUMBER OF CONTESTED HEARINGS	17
4. NO CONTEST PROBABLE CAUSE	21
5. CONTESTED NO PROBABLE CAUSE	4
6. VOLUNTARY BEFORE CERTIFICATION HEARING	0
7. DISCHARGED BEFORE HEARING	2
8. WRITS	0
9. CONTESTED PROBABLE CAUSE	24
10. NON-REGULARLY SCHEDULED HEARINGS	0

Ombudsman Program & Patient Advocate Program shared 0 clients this month (Shared = skilled nursing resident with dementia sent to a behavioral health unit or mental health client placed in skilled nursing care at Telecare Santa Cruz Psychiatric Health Facility)

Riese Hearings / Capacity Hearings

Total number of Riese petitions filed by the Telecare treating psychiatrist: 2
Total number of Riese Hearings conducted: 2
Total number of Riese Hearings lost: 2
Total number of Riese Hearings won: 0
Total number of Riese Hearings withdrawn: 0
Hours spent on conducted hearing representation: 2.0 hours
Hours spent on hearings not conducted: 0
Hours spent on all Riese hearings: 2
Riese appeals: 0

Respectfully Submitted: Davi Schill, PRA
George Carvalho, PRA

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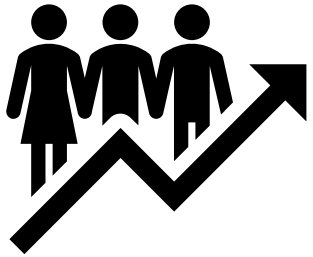
Behavioral Health Director's Report

Dr. Marni R. Sandoval

Behavioral Health Advisory Board Meeting – September 17, 2026



Adult System of Care Update

OPEN
Aug 31st!

EHR Transition

- New Electronic Health Record (EHR) system launching
- Supports state reporting requirements
- Streamlines documentation
- Reduces administrative workload
- Allows staff to spend more time directly supporting clients

Bridge House Update

- Low-barrier navigation center opened August 31
- Active outreach to individuals experiencing unsheltered homelessness
- Goal: Fill all 32 beds by end of month
- Collaborative work with community partners for resource connections and housing plans

Early Impact

- A resident shared: “Last night was the best night of sleep I have ever gotten.”
- Staff reflection: “It brought tears to my eyes. This is why we do the work we do.”

Childrens System of Care Update

Centers of Excellence Partnerships

- Parent-Child Interaction Therapy (PCIT) Center of Excellence
- Functional Family Therapy (FFT) Center of Excellence
- Advancing evidence-based practice capacity

Staff Training

- Anticipated to begin January 2027
- 11 County staff identified
- Training on PCIT or FFT

Substance Use Disorder Services Update

Strengthening System Integration
- Embedding SUDS staff into Adult System of Care and Access to Care
- Smoother client navigation and more consistent support
- Reduced stigma and improved whole-person care pathways

Preparing for SmartCare EHR Launch
- Coordinating transition to CalMHSA's new SmartCare system
- Improved client screening, tracking, and referrals
- Cross-program planning to ensure a smooth rollout

Expanding Recovery Housing
- Working to increase funding for recovery residences
- Focus on stable, supportive housing options for individuals in recovery

Leadership Transition & Continuity
- Sr BH Manager departure effective 8/28/26
- Reorganization of responsibilities to maintain momentum
- Active recruitment for new senior leader overseeing SUDS, Mobile Crisis Response, and Access to Care

Overall Division Focus
- Improving coordination
- Strengthening access
- Supporting the shift toward a unified behavioral health system

Accessing Care

Medi-Cal Members

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Mild – Moderate Level of Care

Managed Care Plan (MCP)

Central California Alliance for Health (CCAH)

How Members Access BH Care

Member in need of BH Services

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

MCP or MHP completes DHCS Screening Tool

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

Member Connected to Care

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

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

Mild – Moderate Level of Care

Managed Care Plan (MCP)

Central California Alliance for Health (CCAH)

Behavioral Health CM Referral

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

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

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

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

Specialty Mental Health & Substance Use Level of Care

Behavioral Health Plan (BHP)

Santa Cruz County Behavioral Health (SCCBH)

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

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

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

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

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

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Easy Referral to Care

Mild-Moderate

Managed Care Plan - CCAH

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

800-700-3874 x5512

Severe

County Behavioral Health Plan

Access Line

800-952-2335
(24 hour line)

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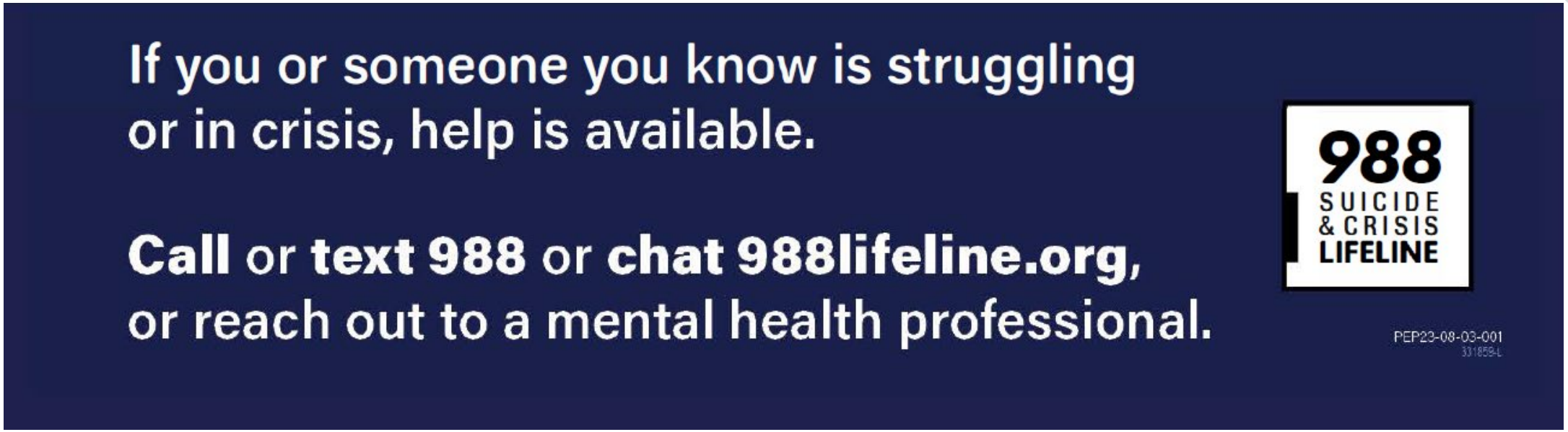
Crisis


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


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

Questions?

Thank You

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17-SEP-2026
To: Santa Cruz County Board of Supervisors
From: Santa Cruz County Behavioral Health Advisory Board
Subject: Request to Authorize Alternative Teleconferencing Procedures for the Behavioral Health Advisory Board Under Government Code 54953.8.6

Dear Chair and Members of the Board of Supervisors:
The Santa Cruz County Behavioral Health Advisory Board respectfully requests that the Board of Supervisors authorize the BHAB to conduct meetings using the alternative teleconferencing procedures available to eligible subsidiary bodies under California Government Code 54953.8.6. BHAB serves in an advisory capacity. Its role is to review, evaluate, and advise regarding the County's behavioral health system and to make recommendations to the Board of Supervisors and County Behavioral Health leadership; it does not exercise final authority over County legislation, contracts, grants, taxes, elections, or the County budget. BHAB therefore requests that the Board of Supervisors determine whether it qualifies as an "eligible subsidiary body" for purposes of Government Code 54953.8.6 and authorize use of that section, subject to review and confirmation by County Counsel.

This authorization would strengthen consistent participation by appointed BHAB members, including Transitional Age Youth members, members attending college or training programs outside Santa Cruz County, members with caregiving responsibilities, and others who may experience occasional barriers to in-person attendance. It would preserve their capacity to attend, deliberate, vote, and be counted as participating members while maintaining the public-access and transparency safeguards required by the Brown Act.

Government Code 54953.8.6 establishes a teleconferencing pathway specifically for eligible subsidiary bodies. This is distinct from the general "just cause" remote-participation process in Government Code 54953.8.3. The latter requires an individual member to state a qualifying reason and imposes frequency limitations; 54953.8.6 instead establishes meeting-level requirements for an eligible advisory body using alternative teleconferencing procedures.

Accordingly, BHAB requests that the Board of Supervisors take the following actions:
1.Determine, after consultation with County Counsel, that BHAB qualifies as an eligible subsidiary body under Government Code 54953.8.6.

2.Authorize BHAB to use the alternative teleconferencing procedures in Government Code 54953.8.6, with the required findings and periodic reconsideration or reauthorization specified by law.

3.Permit non-elected BHAB members who attend remotely under that authority to be treated as participating members for purposes of attendance, quorum, deliberation, and voting, provided that all statutory conditions and County procedures are met.

4.Direct BHAB staff, in consultation with County Counsel and the Clerk of the Board, to establish written procedures that ensure compliance with all applicable Brown Act requirements, including:
•A designated physical meeting location within Santa Cruz County that is open to the public;
•Presence of required staff at that physical location;
•Real-time audio and visual participation by remotely attending members, except where a lawful accommodation applies;
•Effective public observation and public-comment access;
•Appropriate agenda, minutes, technology, and meeting-continuity procedures.

5.Establish any reasonable local parameters necessary to ensure that the alternative teleconferencing option promotes meaningful BHAB participation while preserving public transparency, access, and orderly meeting administration.
BHAB emphasizes that this request does not seek to reduce Brown Act protections. Rather, it seeks to use the Legislature's alternative teleconferencing authority for eligible advisory bodies in a manner that preserves public access while supporting continuity, retention, and meaningful participation by appointed County residents—particularly youth and student representatives whose perspectives are important to the County's behavioral health planning and oversight.

The BHAB respectfully requests that this matter be referred to County Counsel and the appropriate County staff for preparation of a proposed resolution, findings, and implementation procedures for Board consideration.

Sincerely,
Xaloc Cabanez
Chair, Santa Cruz County Behavioral Health Advisory Board

SANTA CRUZ COUNTY
Civil Grand Jury

701 Ocean Street, Room 318-I
Santa Cruz, CA 95060
(831) 454-2099
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County Behavioral Health

Challenges Require More Urgency, Demonstration of Value, and Collaboration with the Justice System

Summary

Santa Cruz County faces growing fiscal pressure as General Fund reserves decline, and Behavioral Health continues to require more than **$18 million annually** from County reserves. Despite this significant investment, County leadership and the public lack essential financial, operational, and performance information needed to evaluate the sustainability and value of Behavioral Health services. A Board mandated financial plan—due December 2025—remains "*only 5% complete*," leaving the County without a roadmap for managing rising costs or maximizing federal funding.

A major systemwide challenge is the **lack of coordination with the jail**, which functions as one of the largest behavioral health providers in the county. More than **50% of inmates** experience moderate to severe behavioral health needs, yet the County has "*no systematic data integration or cross-referencing mechanism*" to identify individuals already served by Behavioral Health. This gap contributes to fragmented care, repeated crises, and a revolving door pattern of incarceration. Meanwhile, the County bears the full cost of jail healthcare—nearly **$12 million per year**, or about **$100 per inmate per day**—highlighting the financial stakes of poor coordination.

To ensure long term sustainability, the Grand Jury recommends completing the overdue financial plan, clarifying federal match obligations, adopting actuarial and value-based funding approaches, strengthening quality-to-cost analysis, and reassessing noncore services. Equally important is establishing integrated data systems and proactive reentry coordination with the jail to reduce recidivism, improve continuity of care, and lower long-term costs across County systems.

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Background

The Santa Cruz County General Fund Reserve is projected to drop in fiscal 2027 from $107 million to $88 million. The General Fund Reserve represents savings set aside to weather economic downturns and unanticipated emergencies. Under the Fund Balance Policy established by the Board of Supervisors, the unrestricted General Fund balance must never fall below 10% of budgeted operating expenditures.[i] The Preliminary Budget for the fiscal year 2027 presented by the County CEO indicated that the General Fund will be nearing the “policy minimum” and that balancing the budget “reduces the County’s limited reserves – from 12.5% to 10.4% - resources that will not be available in the coming years”.[ii] These trends do not bode well for our small county, and the drastic decline in reserves requires a sense of urgency in addressing all County services. One of the divisions requiring increased General Fund financing is Behavioral Health. Throughout this report, references to Behavioral Health mean the Health Services Agency, Behavioral Health Division.

Behavioral Health is largely funded by federal and state revenues. When those funding streams are insufficient the County becomes the payor of last resort, using County General Funds. For the fiscal period ending June 2026, the budgeted contribution from the County General Fund for Behavioral Health is over $18 million, which is the result of $162 million in revenues less $180 million in expenses. The preliminary County General Fund budget request for the fiscal year beginning in July 2026 is also over $18 million.[iii] Behavioral Health is also one of the largest expenditures for the County, representing 22% of the $844 million in General Fund expenditures.

As it confronts decisions concerning Behavioral Health funding, County leadership and the public need better information about the performance of the department. While some measures (as mandated by state and federal regulations) are in place, the Grand Jury did not find sufficient information on cost benchmarks, alignment on quality targets, and federal “match” funding requirements. Exacerbating these concerns is a lack of urgency by County leadership in presenting reports or moving forward on initiatives that might help improve our collective understanding of behavioral health financing.

Behavioral Health costs are embedded in many areas outside the single department, and solutions require an integrated approach, including addressing the resources in our jail system. While Santa Cruz leadership has a history of interdepartmental and inter-agency cooperation, some solutions might require giving up something to support the broader goals. Improvements in behavioral health delivery will also have impacts outside of County government, such as hospitals and paramedic services.

Methodology

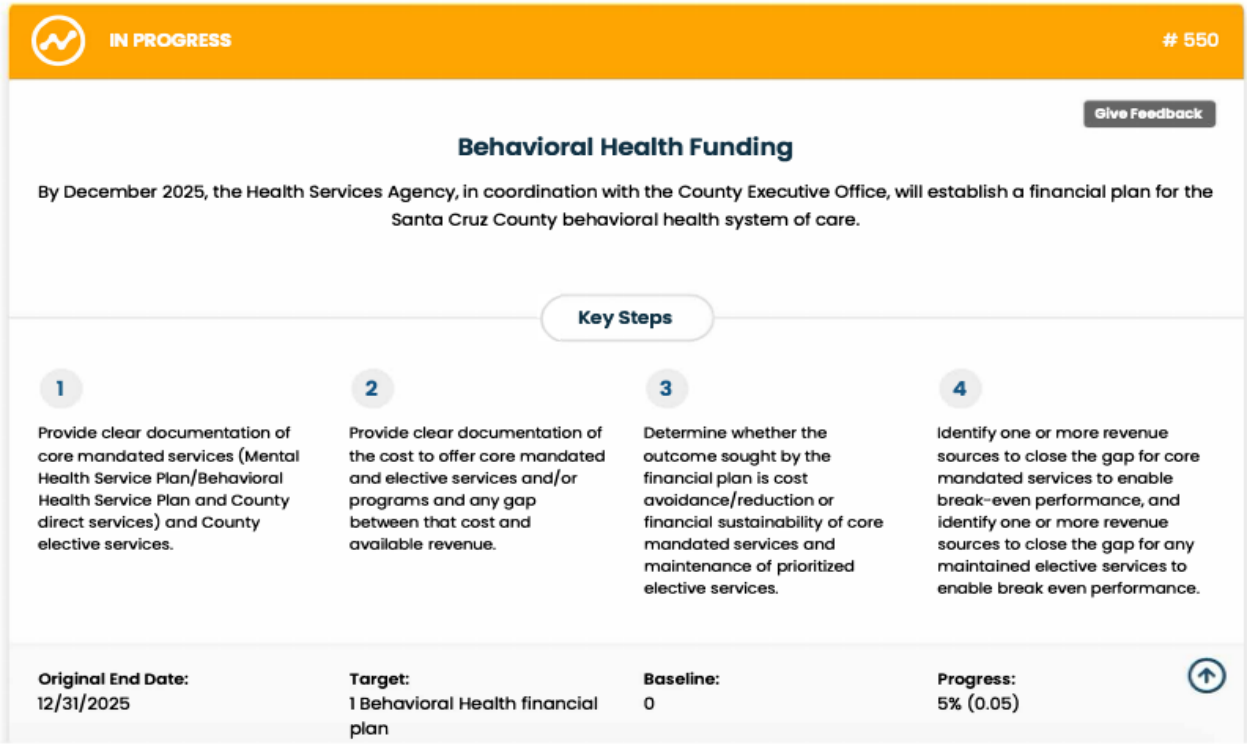
The Grand Jury conducted interviews with several department leaders for the County and the Sheriff's Office. The Grand Jury consulted the County Operations Plan, including updates presented to the Board of Supervisors. Other materials included information obtained from the California Department of Health Services and public information on various County websites.

Throughout our work, we appreciated that everyone was very transparent with information. Furthermore, it is very evident that everyone in local government is committed to treating people experiencing behavioral health issues with dignity. Santa Cruz is fortunate to have such dedicated individuals at all levels of government.

Analysis

Lack of Urgency in Providing Behavioral Health Financing Information

County Behavioral Health has not demonstrated urgency in authoring a report requested by the Board of Supervisors as part of the May 2025 Operations Plan. The status of the plan, which was due on December 31, 2025, is as follows as of April 2026.



Interviews with County leadership during January – April 2026 indicate that unclear role definitions, insufficient project management, and limited cross-department communication have contributed to delays. Addressing these governance deficiencies will require strengthened internal structures, clearer lines of responsibility, and enhanced monitoring to ensure timely completion of mandated tasks. During the Grand Jury interviews, the responses for the delay in the report reflected the following themes:

1. Many other competing priorities due to new federal and state legislation.

2. Turnover of senior leadership in the Health Services Agency and County Executive office.
3. Preparing the report is “not my job”, and that project is “owned by another department”.

Without the plan, the County lacks a cohesive roadmap to address service gaps, establish fiscal safeguards, or define priority investments. The lack of a plan contributes to inconsistent decision-making and limited ability to respond proactively to emerging challenges.

The 2024-2025 Santa Cruz Civil Grand Jury recommended that a monthly update should be provided to the Board of Supervisors on Operations Plan #550.[iv] The response from the County of Santa Cruz in September 2025 to this request was that monthly updates would not be provided and “HSA’s Behavioral Health Division is actively engaged in this effort, and progress will be reported through the County’s established Operational Plan reporting process, as defined by the County Executive Office. Adding a separate monthly reporting requirement would divert limited staff resources and place additional administrative burdens on an already under-resourced system, potentially detracting from the core work of service delivery and system improvement.”

Is $18 million of General Fund support not enough, or is it too much?

For the fiscal period 2025-2026 the Behavioral Health department will require $18 million from the General Fund reserves to cover the costs not reimbursed from federal and state payments. Aside from the financial plan mentioned earlier, County leadership and the public should have a clear understanding of “what they are getting” when General Funds are needed.

Below is an excerpt of the Behavioral Health budget as of May 2, 2026, from the County’s OpenGov Budget Tool:

Santa Cruz County					
FY 2026-27 Proposed Budget - Types					
Download generated on 05/02/2026					
Departments Filter	Behavioral Health				
		2024-25 Actuals	2025-26 Adopted Budget	2025-26 Estimated Actuals	2026-27 Proposed Budget
Revenues		**$ 136,754,915**	**$ 162,464,552**	**$ 162,012,291**	**$ 166,859,803**
Revenues	Intergovernmental Revenues	$ 122,987,862	$ 148,755,501	$ 148,383,804	$ 157,371,323
Revenues	Charges for Services	$ 12,660,481	$ 13,147,747	$ 13,167,183	$ 9,027,176
Revenues	Use Of Money and Property	$ 908,470	$ 240,000	$ 240,000	$ 240,000
Revenues	Miscellaneous Revenues	$ 149,322	$ 219,434	$ 119,434	$ 119,434
Revenues	Fines, Forfeitures & Assessments	$ 48,780	$ 101,870	$ 101,870	$ 101,870
Expenses		**$ 146,988,786**	**$ 180,747,239**	**$ 180,294,979**	**$ 185,554,379**
Expenses	Services and Supplies	$ 80,487,971	$ 107,048,882	$ 102,245,177	$ 122,004,570
Expenses	Salaries and Employee Benefits	$ 41,385,028	$ 42,585,406	$ 43,015,723	$ 46,543,637
Expenses	Other Charges	$ 18,488,978	$ 18,084,480	$ 18,817,083	$ 18,367,953
Expenses	Intrafund Transfers	$ 4,840,136	$ 11,246,046	$ 14,429,590	$ (3,848,499)
Expenses	Services and Suplies-ISF	$ 1,763,314	$ 1,385,406	$ 1,385,406	$ 2,089,699
Expenses	Other Financing Uses	$ -	$ 397,019	$ 402,000	$ 397,019
Expenses	Fixed Assets	$ 23,358	$ -	$ -	$ -
Revenues Less Expenses		**$ (10,233,870)**	**$ (18,282,687)**	**$ (18,282,688)**	**$ (18,694,576)**

Funding streams (intergovernmental revenues) for Behavioral Health include Medi-Cal reimbursements, Realignment allocations, Behavioral Health Services Act revenues, federal block grants, and state general fund allocations[v] Each funding source has its own administrative burdens and compliance expectations, while demanding sophisticated fiscal oversight.

Many of these funding streams are in jeopardy as the County has estimated that up to 30,000 individuals may lose health coverage in the coming year due to a variety of federal and state regulations, including stricter eligibility requirements. Irrespective of whether someone has health insurance, the County is required by law to provide services for those experiencing severe behavioral conditions or substance use disorders.

Some of the funding sources through federal programs have “matching” requirements, where other funds are needed to receive the federal funds. In Grand Jury interviews with County leadership, there was a consensus that General Funds might be required to maximize federal payments, but it was unclear if it was the entire $18 million from the General Fund, or something different.

In considering the “too little or too much” question, some might argue that the annual County General Fund contribution of $18 million represents only 10% of the total operating costs of the Behavioral Health department, as federal, state and other

sources totaling $166 million support the total operating costs of $185 million. Another view might consider the annual operating costs of $185 million spread over the population of the county, resulting in a per-capita cost of about $672. The costs mentioned do not include Health Services Administration costs of another $29 million, some of which are probably directed to supporting the Behavioral Health functions.

This $18 million subsidy reflects a persistent mismatch between service delivery costs and available reimbursements. Contributing factors include the absence of insurer-like financial modeling, inadequate forecasting tools, changes in Medi-Cal, and limited capacity to anticipate fluctuations in service utilization.

Below is a summary of Federal and State Funding in the 2025-2026 budget.

Table 1: Summary of Federal and State Funding

Federal Funding Requiring a "Match"

County G/L Number	County G/L Description	Budget for 2025-2026
40622	Short / Doyle Fed M/Cal	$28,214,804
40624	Short / Doyle Medical Fed	$32,865,136
	Total Federal Client Revenues (Requiring State and Local Funding)	$61,083,940

State and Local Funding to Apply Against the Federal Funding "Match" Requirement

County G/L Number	County G/L Description	Budget for 2025-2026
40471	Motor Vehicle HSA Alignment	$1,610,059
40626	Short / Doyle Mental Health	$19,380,577
40690	Other Health Aid	$5,048,894
40902	AB 118 Local Rev FD PROG	$26,831,252
	Total State and Local Funding	$52,870,782

The Grand Jury's understanding of the County's obligation for federal matching, based on several interviews: The difference between $61 million of federal funding and $52 million of state funding (about $9 million) needs to be provided by the County. The Grand Jury was told that the County fulfils this obligation through the General Fund (where costs exceed the federal and state reimbursements for the specifically funded programs).

The explanation does not reconcile to the $18 million of General Funds needed to fund all the costs in the budget, and this is likely due to costs that are not eligible for the federal match. To have a clear view of the required County financial obligations for federal funds, it is essential that the funding requirement for matching funds that may be needed from the General Fund is clarified in a manner that is easily understandable by policy makers and the public.

Responsibilities of County Behavioral Health

County Behavioral Health agencies in California operate within one of the nation's most complex regulatory and service-delivery environments. Their role extends far beyond providing clinical interventions, encompassing systemwide oversight, fiscal administration, public health responsibilities, and extensive coordination across multiple departments and community partners. Counties are responsible for delivering services ranging from early intervention and crisis stabilization to long-term psychiatric care and substance use disorder treatment. An example of the complexity in funding is shown here: Behavioral Health Funding by Setting

Santa Cruz County acts as both an "insurer" and "provider" of Behavioral Health services:

- Insurer: Most of the costs of operating Behavioral Health ($122 million of the $185 million) are in services. This largely reflects the procurement of care from many providers, both inside and outside of the County. In this scenario, the County is responsible to pay the costs of approved care irrespective of whether they are covered through federal and state funds.
- Provider: The next largest costs ($46 million of $185 million) are Salaries and Benefits, reflecting the 241 FTE's that are providing care or case management to approximately 5,000 individuals served by Behavioral Health each year.

In its role as an insurer, the County should have systems in place to understand the frequency of care, severity of care, and processes to ensure timely care is rendered in the proper setting. Examples found by the Grand Jury where the insurance function could be better managed include:

- Most insurance costs follow the Pareto Principle, meaning that 80% of the costs arise from 20% of the beneficiaries. The Grand Jury found that Behavioral Health has resisted implementing a tool to manage some of the highest cost beneficiaries, despite recommendations from outside regulators. It is unclear if the County is moving forward on a "Level of Care" (LOC) tool[vi] which will help provide case managers with information on the most effective pathways for high-cost patients. The delayed adoption of the LOC tool has impeded efforts to

standardize clinical decision-making and efficiently allocate resources. Without appropriate LOC assessments, individuals may receive services that are insufficient or excessively intensive, undermining both quality and cost-effectiveness.

- The 2024-2025 Grand Jury previously issued a report where the management of high-cost beneficiaries was identified by outside regulators as an area needing improvement, even when compared to other counties[vii] That same data reveals that the number of high-cost beneficiaries receiving Targeted Case Management in Santa Cruz County declined from 80% to 66% over a 4-year period ending in 2023. [viii]
    - Adjacent counties (Monterey, Santa Clara, and San Mateo) also saw declines in the percent of high-cost beneficiaries receiving Targeted Case Management over this period, but it is worth noting that all had a higher percentage than Santa Cruz. Monterey County for example declined from 97% to 90%.
    - The same 2023 data from 14 mid-sized counties reveals a range of 38% to 90%.
- The Grand Jury found that the budgeting process does not apply actuarial tools to understand utilization and cost. In prior Grand Jury reports, recommendations to partner with the Central California Alliance for Health (CCAH) on actuarial services have not been implemented. As background, CCAH is a County Organized Health system Medi-Cal HMO. CCAH is financially responsible for the overall healthcare of Medi-Cal beneficiaries, including “mild to moderate” behavioral healthcare[ix]. Partnering with CCAH to coordinate on the key drivers of health for the County’s “moderate to severe” behavioral health patients might yield important findings to reduce costs or increase quality. CCAH has access to a significant database, analytic staffing, and financial resources to partner with County Behavioral Health in addressing the behavioral healthcare continuum. Many studies have found that severe behavioral health is linked to other health conditions.
- Alongside partnering with CCAH, the Health Services Agency (HSA) should consider redeploying existing analytical staff to support behavioral health data needs. Currently, the HSA possesses significant administrative and data resources across its divisions. This includes 18 full-time equivalents (FTEs) within Public Health—split between Vital Statistics and Healthy Communities—and 11 administrative FTEs within Behavioral Health.[x] Furthermore, the agency’s central Administration and Accounting function comprises 53 FTEs. While these personnel are active contributors to their current roles, their presence suggests that HSA could potentially absorb behavioral health analytics internally without requesting new funding.

- CCAH transitioned the management and coordination of “mild to moderate” behavioral healthcare from Carelon in July 2025. Reviews have not been developed to ensure that appropriate referrals to the County (and associated payment streams) for “moderate to severe” patients are in place. Disruptions in care from changes in providers can cause cases to become more severe.
- Monterey County Behavioral Health produces an annual report entitled “Data Driven Decisions”[xi] which summarizes all the different programs, clients served, service types, primary diagnosis and program goals over an extended period. Information from this report can help understand the frequency, causes, and severity of the population.

Quality Improvement (QI) Work Plan & Outcomes

The Department of Health Care Services (DHCS) enforces behavioral health accountability through performance metrics, financial reporting, and strict licensing. It holds County Behavioral Health Plans accountable to the Behavioral Health Accountability Sets (BHAS)[xii] ensuring plans meet minimum performance levels for access, quality (QI), and equitable care. Santa Cruz Behavioral Health reports this and other QI metrics on a quarterly basis, but the metrics are not linked to targeted financial goals. Without connecting quality outcomes to cost implications—such as reductions in hospitalizations or justice system involvement—the County is unable to fully demonstrate the fiscal benefits of improved service delivery. As a result, quality improvement activities may be undervalued or insufficiently prioritized during budget deliberations.

Expanding the QI framework to incorporate cost modeling, risk assessment, and long-term financial projections would strengthen the County’s ability to evaluate the effectiveness of its interventions. Additionally, integrating QI outcomes with strategic planning would promote alignment across departments and ensure that quality improvement efforts directly support system sustainability.

In its role as provider of services, the County needs to efficiently deliver care via appropriate staffing and coordination. The County’s Quality Improvement Work Plan demonstrates a commitment to continually enhancing service quality, operational consistency, and beneficiary experience[xiii] During the 2024–2025 reporting period, the County tracked 18 quality indicators, meeting 12, partially meeting one, and not meeting five. These metrics provide insight into specific aspects of performance, including timeliness, documentation accuracy, and cultural competence, but do not indicate financial implications.

The Quality Improvement Work plan is published quarterly. For the period ending December 2025, the dashboard identified 7 goal areas[xiv] The progress is summarized as: 3 goals on track (green), 3 goals in progress (yellow), and 1 goal needing attention (red).

- One of the quality initiative goals involving CCAH concerning coordination of care has been deferred (red). It was reported that "staff are attending Central California Alliance for Health led broad community effort to align goals and select an IT vendor for Closed-Loop Referral (CLR) functionality"[xv]
- A more detailed goal concerns documentation of direct service to patients and is broken into various program categories. These goals are important to achieve, as state and federal funding is associated with a higher amount of documented time spent providing patient care. In aggregate, the goals are an annual improvement of 5% from prior periods. Unfortunately, a 5% improvement is well below the long-term goals to sustain federal and state funding. As examples:
    - Federally Qualified Health Center Medication Support for Adults by physicians and nurse practitioners is achieving improvement at 34 contacts per week, but the long-term goal for financial sustainability is 40 per week. It is the understanding of the Grand Jury that federal and state regulators review patient contact statistics to inform network adequacy and funding. Under CalAIM, reimbursement is tied directly to face-to-face minutes spent with the patient.
    - Measurements concerning the percentage of time worked performing billable services have been below targets (yellow), requiring a larger effort to achieve the long-term goals.
- Targeted Case Management documentation was present in only 40% of the cases examined for children, and 70% of the adult cases reviewed.

Quality metrics reported by the County lack associated financial analyses, limiting the ability to evaluate the cost-effectiveness of meeting or failing to meet performance goals. For instance, improving aftercare timeliness following psychiatric discharge may significantly reduce hospital readmission rates and crisis events—both of which carry substantial financial implications. Without quantifying these impacts, the County is unable to fully understand the value of these quality improvements.

Value in Healthcare: A Framework for Funding Decisions

A value-based care framework provides a foundational tool for evaluating behavioral health services by emphasizing the relationship between quality outcomes and the total cost of delivering care. This framework encourages decision-makers to look beyond

immediate expenditures and consider the broader impact of investments on health outcomes, system sustainability, and cross-department efficiencies.

$$\text{Value} = \text{Quality} / \text{Cost}$$

Quality in behavioral health includes dimensions such as clinical effectiveness, patient safety, equitable access, cultural responsiveness, and client experience. Cost encompasses direct service delivery expenses, administrative overhead, crisis-related expenditures, and long-term cost consequences to systems such as housing, criminal justice, and emergency medical services.

By adopting a value-based approach in considering General Fund allotments, the County can make more informed decisions about where to invest resources, which interventions produce the greatest measurable impact, and which services may require redesign or reinvestment. This framework also promotes transparency and supports the development of funding models that incentivize improved outcomes and long-term sustainability.

Value-Based Funding: Benefits and Implications

As the Board of Supervisors and the public consider the question of how much General Fund support should be directed to Behavioral Health, the Grand Jury suggests (as a starting point) adopting value statements in each of the Division's Quality Initiatives demonstrating both quality and cost measurements. Value-based funding offers significant benefits for enhancing system sustainability, strengthening accountability, and maximizing the impact of public investments. By linking funding decisions to measurable outcomes, the County can ensure that limited resources are directed toward interventions that produce demonstrable improvements in clinical outcomes, equity, and community well-being.

This funding model enhances transparency by providing clear connections between performance outcomes and financial impacts. Such clarity enables the Board of Supervisors and the public to better understand the return on investment for behavioral health services, reinforcing trust in the system and supporting more informed policy decisions.

Value-based funding also promotes collaboration across systems by highlighting the shared benefits of effective behavioral health interventions. Improvements in behavioral health outcomes can reduce costs and burdens across housing, justice, and emergency response systems. Recognizing these interdependencies creates opportunities for co-investment, shared accountability, and integrated programming that amplifies impact across multiple public sectors.

System Conversion as an Opportunity

Successfully adapting to a value-based funding approach will require investment in administrative capacity, clearer communication channels, improved data infrastructure, and strengthened internal alignment. Without these improvements, the County may struggle to meet regulatory demands while providing high-quality services during periods of heightened policy change. County Behavioral Health is converting its antiquated clinical information system to a service that is used by many counties in California (SmartCare). It is hoped that once implemented, improved processes for both the insurer and provider roles will assist in demonstrating value.

The Cost of Distractions

Operational alignment is essential in a system that serves as both a clinical provider and a risk-bearing entity. Yet Santa Cruz County has struggled to implement key components of its strategic framework, partially due to the resources spent on non-core services.

During our interviews, there were several comments that the Health Services Agency has taken on a lot of projects that might not be core to the primary mission. These projects may provide for one-time funding, but the ongoing obligations once the funding runs out can be problematic. By its own admission, the Health Services Agency stated this as part of its budget overview for 2026-2027.

> ***Extensive Non-Core Services:*** *HSA provides several services beyond core mandated programs to address local needs and service gaps. These discretionary services include administrative support functions, community wellness and prevention initiatives, health education and outreach efforts, pilot and grant-funded projects, workforce development activities, and community-based partnerships that are not fully reimbursable through state or federal funding.*
>
> *While these services support important community outcomes and help address gaps in the safety net, they often rely on limited or unstable funding sources. As costs increase and revenues remain constrained, sustaining these non-core services becomes more challenging and may require reevaluation of service levels or funding strategies in future budgets.*

The Grand Jury believes that Health Services Agency leadership should prioritize the identification and associated costs of these non-core services, especially as they relate to Behavioral Health. Upon the development of the list, a timeline should be established for swift elimination of each identified non-core service. To prevent further “scope

creep," the Health Services Agency needs to develop a policy concerning future non-core services before any financial obligations are made. Resources that are freed up can be redirected to completing the Financial Plan for Santa Cruz County Behavioral Health System of Care that was mentioned earlier in this document that was due on December 31, 2025.

Strategic Planning, Service Gaps & Performance Metrics

A Behavioral Health Services Integrated Plan is a mandatory, three-year prospective spending and planning document required by the state of California under the Behavioral Health Services Act (BHSA). It outlines exactly how counties will fund, deliver, and track mental health and substance use programs using various local, state, and federal funding streams. The most current version for 2026-2029 is nearing completion for Santa Cruz. The plan identifies various service gaps but does not provide sufficient analytical depth to support targeted policy interventions. Notably, the plan cites lower utilization of specialty mental health services compared to statewide averages but does not explore contributing factors such as demographic patterns, cultural barriers, or the role of jail-based services in overall utilization statistics.

During a recent meeting of the Board of Supervisors, the County Strategic Plan update included an initiative calling for a "50% increase in step-down beds[xvi] As part of the analysis (and supporting a value-based approach) the Grand Jury recommends a demonstration of how the increase in beds improves quality or cost before moving forward on additional funding.

Developing a comprehensive evaluation system that ties service gaps and quality metrics to financial data would enable the County to identify high-impact strategies, quantify return on investment, and make more informed decisions regarding resource allocation.

Greater Coordination and Accountability with the Justice System

The total funding complexity of behavioral health is further heightened by the County's responsibility to deliver care in detention settings, where constitutional mandates require timely and appropriate behavioral health services for incarcerated individuals. The County lacks a reliable method for determining how many individuals in the jail have previously been served by County Behavioral Health. Aside from daily multidisciplinary care conferences, there is no systematic data integration or cross-referencing mechanism that automatically identifies overlap between the jail population and Behavioral Health caseloads. This gap limits the County's ability to plan services, track outcomes, forecast demand, allocate resources, and measure the systemwide impact of behavioral health interventions.

The situation is exacerbated by a perceived revolving-door pattern among many individuals with behavioral health needs who are repeatedly incarcerated, released, and then returned to custody. Each cycle creates disruptions in treatment continuity, medication management, and follow-up care, increasing both clinical risk and long-term costs. Because Medi-Cal coverage is suspended during incarceration, individuals often reenter the community without immediate access to coverage, services, or care coordination, resulting in missed treatment opportunities and measurable impacts on public safety and community health.

Many people in County leadership roles frequently state that the jail is the largest mental health facility in the county. As part of the Department of Healthcare Services Justice Involved initiative,[xvii] it has been reported that:

- 66% of Californians in jails or prisons have moderate or high behavioral health or substance use treatment needs.
- Incarcerated individuals with an active mental health case rose by 63% over the past decade.

Over the past year, the county jail housed an average of 331 individuals. Each month, the facility processes over 550 bookings and 217 formal admissions. According to Grand Jury interviews with Sheriff's Office leadership, more than 50% of these inmates suffer from moderate-to-severe behavioral health conditions—a population that qualifies for County Behavioral Health services. Furthermorea stark one third of the inmate population are chronic recidivists with 43 or more bookings. Altering these trends demands deep, systemic collaboration across county departments.

Financially, the jail's role as a major behavioral health provider is further strained by the fact that incarcerated individuals are suspended from Medi-Cal coverage (or any other forms of health insurance) while in custody. As a result, the County bears full responsibility for all medical and behavioral health costs incurred during incarceration. The costs of providing healthcare in the jail are nearly $12 million per year. To put the $12 million in perspective, the annual amount translates to $100 per jailed inmate per day of health services. Admittedly, some of the services are for non-behavioral health issues, but it highlights the "shadow cost" for behavioral health.

This report is not intended to examine the cost or quality of healthcare in the Jail. Over 2 years ago the Sheriff's office contracted with Naphcare, and all reports seem to indicate the services have vastly improved compared to the prior contractor. The Grand Jury observed that the Naphcare personnel were very forthcoming with information during our tour of the jail facilities.

While there is a “warm handoff” to County Behavioral Health upon the jail release, many interviews revealed that there needs to be something more proactive. The current “warm handoff” results in missed appointments at County Behavioral Health and jail recidivism. California, through the CalAIM Jails Involved Initiative, is requiring each county to have a program in place by September 30, 2026.[xviii] One of the goals of the program is to have an incarcerated person enrolled in Medi-Cal within 90 days of release from the jail. The goals and results of the program should be carefully tracked in Santa Cruz, with regular reports to the Board of Supervisors.

The Sheriff’s Office and County Behavioral Health operate a Focused Intervention Team (FIT). There are over 5 FTE’s devoted to the program, which is capped at no more than 30 clients. The grand jury appreciates that the FIT team has begun tracking important statistics beginning in September 2025. When the FIT team was established, one of the goals was to reduce recidivism by addressing root causes. The premise was that if the focused intervention was successful, there would be a decrease in the resources consumed for emergency services and the criminal justice system. This analysis needs to be completed in light of the CalAIM Jails Involved Initiative program and other reforms to the behavioral health system.

The Sheriff’s Office also staffs a behavioral health crisis response unit. This is another example where the County is providing behavioral health services that are not recorded under the Behavioral Health Division but are incurred more broadly.

The Sheriff has also mentioned in several venues that the current jail does not adequately address the medical needs of an aging population with severe behavioral health and substance use disorders[xix] Across the United States, newer jail facilities incorporate specialized housing units with improved sightlines, sensory-reduced spaces, dedicated treatment rooms, and enhanced staffing configurations conducive to stabilizing individuals experiencing psychiatric symptoms. Santa Cruz County’s facility, by contrast, faces significant limitations in its ability to provide a therapeutic environment, contributing to challenges in managing safety risks, treatment consistency, and crisis episodes. The current main jail, constructed in 1981, reflects an era when mental illness was not as prevalent within incarcerated populations.

As alternative space options are considered for incarcerated individuals requiring care, the Grand Jury observed that there are several areas where physical space appears to be under-utilized in the county and could be redeployed to support behavioral health at a lower cost than building something from the ground up. Examples include the Rountree campus, Emeline campus, Juvenile Hall, and other county owned assets. Intra-agency and regional efforts should also be explored, as Santa Cruz is not unique in the region. As an example, the counties of Santa Cruz, Monterey, and San Benito

could collaborate on an under-utilized physical asset that resides within the school systems, health facilities or other government owned property.

Conclusion

Systemwide Challenges Require Macro Perspective

Santa Cruz County's Behavioral Health system is at a critical juncture. Rising costs, declining reserves, and increasing service demands require a more disciplined, transparent, and value-driven approach to planning and oversight. The Grand Jury concludes that the County must urgently complete the long-delayed financial plan, clarify its federal matching obligations, and adopt actuarial and data-driven tools that support proactive management of high-cost beneficiaries. The County's Quality Improvement efforts demonstrate commitment, but performance metrics must be tied to financial outcomes to fully understand the value of services. A value-based framework—where quality and cost are evaluated together—would allow the County to better demonstrate return on investment and make more informed decisions about resource allocation.

Coordination with the justice system remains an important, but not singular, component of County Behavioral Health system improvement. While the jail population includes many individuals with behavioral health needs, the primary challenge is the absence of integrated systems to track service histories, plan care transitions, and understand broader utilization patterns. Addressing this gap would improve continuity of care and reduce avoidable costs, but it should be viewed as part of a broader effort to modernize Behavioral Health operations.

Ultimately, the Grand Jury concludes that Santa Cruz County must adopt a more integrated, value-based, and analytically grounded approach to Behavioral Health. By strengthening internal processes, improving data systems, and focusing on core responsibilities, the County can deliver higher-quality care while safeguarding limited public resources. The path forward requires urgency, discipline, and sustained collaboration across departments.

Findings, Recommendations and Required Responses

Finding 1: The County Executive Office and County Behavioral Health did not complete the requested financial plan (Operations Plan #550) by December 31, 2025, depriving the Board of Supervisors and the public of critical information needed to make informed decisions about program sustainability, resource allocation, and performance expectations.

Recommendation 1: The Grand Jury recommends that the Board of Supervisors direct the County Executive Office and County Behavioral Health to complete the financial plan report no later than September 30, 2026.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 2: The County Executive Office and County Behavioral Health do not have an aligned understanding of baseline requirements for Federal funding, resulting in allocations from the General Fund that might be more than needed.

Recommendation 2: The Grand Jury recommends that the Board of Supervisors direct the County Executive Office and County Behavioral Health to complete a report to the Board of Supervisors on the minimum County funding requirements for meeting federal and state matching fund requirements for behavioral health services by December 31, 2026.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 3: County Behavioral Health has not implemented a Level of Care (LOC) tool, resulting in missed opportunities to efficiently manage high-cost beneficiaries.

Recommendation 3: The Grand Jury recommends that the Board of Supervisors directs County Behavioral Health, in conjunction with its system conversion to SmartCare, to implement the LOC tool within 90 days after the go-live of the SmartCare system, as recommended in the 2023-2024 External Quality Review for the California Department of Healthcare Services.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 4: County Behavioral Health has not applied actuarial tools concerning the utilization and severity of the Medi-Cal population receiving behavioral health services, resulting in an inability to plan for its key cost drivers.

Recommendation 4: The Grand Jury recommends that the Board of Supervisors direct County Behavioral Health publish a report that summarizes the utilization and costs of the assigned Medi-Cal population for the fiscal year ending June 2026 by

December 31, 2027. The report can be used as a tool to identify targeted improvements for the 2027-2028 fiscal period.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 5: County Behavioral Health has not applied financial measurements to Quality Improvement Initiatives, resulting in an inability to make informed decisions about where to invest resources, which interventions produce the greatest measurable impact, and which services may require redesign.

Recommendation 5: The Grand Jury recommends that the Board of Supervisors direct County Behavioral Health to apply targeted financial measurements that demonstrate potential reductions in costs and/or increases in revenues for each of its Quality Initiatives beginning with the reporting period ending on December 31,2026.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 6: Santa Cruz County has not implemented the CalAIM Justice Involved Reentry System, potentially resulting in the loss of Care Management services through Medi-Cal and costly gaps in care as people transition from the justice system.

Recommendation 6: The Grand Jury recommends that the Board of Supervisors direct County Behavioral Health, in collaboration with the Santa Cruz County Sheriff to prepare a report no later than December 31, 2026 to the County Board of Supervisors summarizing the steps taken to support the implementation of the CalAIM Justice Involved Reentry Program (which has a state mandated implementation date of September 30, 2026). The report shall provide a summary of key metrics that will be measured and regularly reported on to demonstrate program effectiveness or areas of opportunity.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 7: County Behavioral Health has several projects that are not essential to core services, resulting in expenditure of resources that might be better directed to addressing more urgent core priorities.

Recommendation 7: The Grand Jury recommends that the Board of Supervisors direct County Behavioral Health to prepare a report to the County Executive Officer that identifies non-core projects, the associated costs, and the earliest timeframe for elimination of the non-core service by December 31, 2026.

Required Respondent: Santa Cruz County Board of Supervisors

Finding 8: A review on the outcomes of the Sheriff's Office Focused Intervention Team has not been completed, resulting in a lack of knowledge on whether the program has achieved the goals concerning recidivism or a reduction in emergency resources.

Recommendation 8: The Grand Jury recommends that the Sheriff produce a report to the County Board of Supervisors summarizing the progress of the Focused intervention Team in achieving its stated goals concerning recidivism and impact on emergency services by December 31, 2026. The report shall also include a discussion of future resource deployment of the FIT considering the CALAim Justice Involved Reentry program.

Required Respondent: Sheriff, Santa Cruz County

Finding 9: The current jail facilities are not physically designed to address the incarcerated population experiencing severe behavioral health and/or substance used disorder illness, resulting in ineffective treatment and recidivism.

Recommendation 9: The Grand Jury recommends that the Sheriff, in collaboration with County Behavioral Health produce a report concerning the current condition of the jails where the physical space may be deficient in the treatment of incarcerated individuals experiencing severe behavioral health issues by March 31, 2027. The report should include:

a. A list of the current physical space deficiencies
b. An estimate on the number of inmates who might be served on a typical day.
c. A discussion on how County Behavioral Health might collaborate on the use of a facility.
d. An estimate of the potential benefits of the facility (such as reduced recidivism or reduction in high-cost cases for County Behavioral Health).
e. A discussion on potential sites that are currently operated by local government agencies that might be repurposed.
f. A discussion on potential alternative sources of capital funding (if needed) such as Medi-Cal Managed Care initiatives or Housing for Health initiatives.

Required Respondent: Sheriff, Santa Cruz County

Finding 10: Incarcerated individuals who may have been patients seen through County Behavioral Health experience gaps in treatment plans, resulting in resource duplication.

Recommendation 10: The Grand Jury recommends that the Board of Supervisors direct County Behavioral Health, in collaboration with the Sheriff, to author a report to the County Board of Supervisors concerning the identification of the barriers

preventing the ongoing mutual sharing of clinical data between the jail and County Behavioral Health and possible solutions, by March 31, 2027

Required Respondent: Santa Cruz County Board of Supervisors

Commendation

County Health Services and Sheriff's office leadership, staff and associated service providers are dedicated individuals who are devoted to the principles of compassionate care.

Endnotes

[i] County of Santa Cruz Fund Balance Policy
https://santacruzcountyca.gov/Portals/0/County/auditor/Fund%20Balance%20Policy.pdf

[ii] Santa Cruz County Budget Strategic Initiatives Budget Message from CEO April 30, 2026, https://santacruzcountyca.gov/VisionSantaCruz/Budget/BudgetMessage.aspx

[iii] Santa Cruz County Budget Tool
https://santacruzcountyca.opengov.com/transparency#/176758/accountType=revenuesVersusExpenses&embed=n&breakdown=types&currentYearAmount=cumulative&currentYearPeriod=years&graph=bar&legendSort=desc&proration=true&saved_view=818442&selection=56F38E4CB566CC009DA3B2DE96A16DEC&projections=null&projectionType=null&highlighting=null&highlightingVariance=null&year=2027&selectedDataSetIndex=null&fiscl_start=earliest&fiscal_end=latest

[iv] Santa Cruz County Required Response to the 2024-2025 Grand Jury Report" The Challenges Facing the Management of High-Cost Beneficiaries in the Health Services Agency"
https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2025_final/2025-6a_Measure_BoS_RequiredResponse.pdf

v Understanding County Behavioral Health in California
https://vimeo.com/1153687589/dbd437084b?fl=pl&fe=sh

[vi] 2023-2024 Medi-Cal Specialty Behavioral Health External Quality Review
https://www.santacruzhealth.org/Portals/7/Pdfs/QI/2024/Santa%20Cruz%20MHP%20FY%202023-24%20Final%20Report-26958112.pdf

[vii] Santa Cruz County Required Response to the 2024-2025 Grand Jury Report" The Challenges Facing the Management of High-Cost Beneficiaries in the Health Services Agency"

https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2025_final/2025-6a_Measure_BoS_RequiredResponse.pdf

[viii] California Department of Health Care Services High-Cost Beneficiaries Receiving Targeted Case Management Dashboard Tool
https://behavioralhealth-data.dhcs.ca.gov/pages/9894cbb6f6644b569ddd60d5287ef3ce

[ix] Behavioral Health Integration in Medi-Cal
https://www.chcs.org/resource/behavioral-health-integration-in-medi-cal-a-blueprint-for-california/

[x] Health Services Agency Staffing by Service
https://www2.santacruzcountyca.gov/CAO/StrategicPlan/Budget/2026-27/dept/24

[xi] Monterey County Behavioral Health Plan Data Driven Decisions
https://www.countyofmonterey.gov/home/showpublisheddocument/143886/639019929902500000

[xii] Department of Healthcare Services Behavioral Health Accountability Set
https://www.dhcs.ca.gov/wp-content/uploads/2026/05/Behavioral-Health-Accountability-MY-2026-RY-2027.pdf

[xiii] Santa Cruz County Behavioral Health QI Workplan FY 24-25 Evaluation
https://www.santacruzhealth.org/Portals/7/Pdfs/BH/FY24%20-25%20QI%20Work%20Plan%20Evaluation_8_1_2025-1245345252.pdf

[xiv] Santa Cruz Behavioral Health QI Work Plan FY 2025-2026
https://www.santacruzhealth.org/Portals/7/Pdfs/BH/FY25%20-26%20QI%20Work%20Plan%20Goals%20and%20Exec%20Summary_FINAL_10_2025.pdf

[xv] Santa Cruz Behavioral Health QI Work Plan FY 2025-2026
https://www.santacruzhealth.org/Portals/7/Pdfs/BH/FY25%20-26%20QI%20Work%20Plan%20Goals%20and%20Exec%20Summary_FINAL_10_2025.pdf

[xvi] County of Santa Cruz Strategic Plan 2026-2032 Presented in May 2026
https://santacruzcountyca.primegov.com/viewer/preview?id=0&type=8&uid=f2dc216f-dc05-44e2-82fc-bfe5dbe57d34

[xvii] Fact Sheet: Transformation of Medi-Cal: Justice Involved
https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CalAIM-JI-a11y.pdf

[xviii] Department of Healthcare Services Justice Involved Reentry Initiative
justice-involved-reentry-initiative

[xix] Santa Cruz Local" Santa Cruz County Sheriff Eyes New Mental Health Jail Facility https://santacruzlocal.org/2025/12/11/sheriff-eyes-new-mental-health-jail/

Data Notebook 2026

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

The California Behavioral Health Planning Council (Council) is under federal and state mandate to review, evaluate and advocate for an accessible and effective behavioral health system. This system includes both mental health and substance use treatment services designed for individuals across the lifespan. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness and/or substance use disorders.

For general information, you may contact the following email address or telephone number:
DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or you may contact us by postal mail at:

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California Behavioral Health Planning Council
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For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2026 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2026 Data Notebook, please use the following link and fill out the survey online by **October 12, 2026**:

https://www.surveymonkey.com/r/DN2026

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CBHPC 2026 Data Notebook

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions (local boards) are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. Planning Council staff analyze these responses to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data,
- To communicate their findings to the Planning Council,
- To serve as an educational resource on behavioral health data and information,
- To obtain the opinions and thoughts of local board members, and
- To identify successes, unmet needs, and make recommendations.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local boards to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify critical issues in their community. This work informs county and state leadership about behavioral health programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council provides our annual 'Overview Report, which is a compilation of information from all the local boards and commissions who completed

[1] W.I.C. 5604.2, regarding mandated reporting roles of Behavioral Health Boards and Commissions in California.

their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions (CALBHBC). The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to the Substance Abuse and Mental Health Services Administration (SAMHSA)[3].

Background and Brief History:

The 2016 Data Notebook focused on the behavioral health needs of children and youth in California. It compiled a wide range of existing data from multiple sources to highlight the needs for mental health services and access to substance use treatment. The Data Notebook also addressed services for youth in crisis, early intervention in psychosis, and full-service partnerships available to children and youth. In addition, it reviewed the continuum of care for foster youth and children and their needs for behavioral health services. Our goal in 2016 was to provide this information to the local mental health/behavioral health boards and gather their feedback through discussion questions, including those related to foster care and other areas needing improvement.

The California Behavioral Health Planning Council first examined the role and potential of Behavioral Health Services for Children and Youth in their 2017 Overview Report on the findings of the 2016 Data Notebook Project[4]. That report identified models such as full-service partnerships that are one type of wrap-around service provision that promotes a "whatever it takes approach." This model emphasized the importance of these services in promoting trauma-informed, recovery-oriented systems of care, particularly for individual youth or family members who may not engage readily with some formal treatment environments.

More than a decade later, this year's Data Notebook serves as a follow-up to that foundational work, revisiting the specific parts of Children and Youth Behavioral Health Services, particularly the programs and services intended for foster youth, including older transitional-aged youth often referred to as non-minor foster youth.

In 2012, several programs began shifting how services for foster youth were delivered through California's Continuum of Care Reform (CCR). These changes were

[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Behavioral Health Boards and Commissions website.
[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.
[4] See the 2017 Overview Report on the 2016 Data Notebook on Children and Youth, posted on the website of the California Behavioral Health Planning Council, CBHPC-Data-Notebook and CBHPC Reports specifically for 2017.

subsequently enacted into law through Assembly Bill (AB) 403 in 2015 and reached statewide implementation that took effect on January 1, 2017.

Over the past decade, policy changes, evolving community needs, and ongoing local program development have led to significant changes in foster care services. Some of these changes were part of the Continuum of Care Reform. Alongside the Continuum of Care Reform, legislative initiatives, such as AB 2083 (2018) strengthened the requirement for of trauma-informed care[5] across the foster care system. This includes the training of therapists, administrators, prospective foster parents, social workers, and others.

The core values of these programs have remained consistent. However, their structure, scope, and funding have evolved significantly due to changes in federal and state legislation, especially those that established Families First programs and services.

Our present goal, in 2026, is to focus on the behavioral health needs of foster youth and children. The current Data Notebook project and survey seek to increase understanding of how behavioral health services are provided to foster youth and how those services are coordinated with local departments of social services and with contracted agencies and service providers.

USA Today reported[6] in 2018 that when the president signed the new bipartisan federal spending bill, he also approved a major overhaul of the foster care system. These changes were urgently needed, based on the data available. As a result of these new laws[7], children at imminent risk of being removed from their homes and placed in foster care are now eligible to receive services and support to help stabilize and strengthen their family. These services may include mental health services, substance use treatment, parenting classes or coaching, and other supportive approaches. For a full

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[5] Informative resources about Foster Youth and their needs, with links to specific trauma-informed therapies designed for the specific age-ranges of youth and children, may be found at this website; California Association of Local Behavioral Health Boards and Commissions website. These resources are well-written and are intended for the general public and for families, clients, and other stakeholders.

[6] When Trump signed spending bill, he signed into law a huge overhaul of foster care. By Teresa Wiltz, Pew/Stateline, published May 5, 2018. https://www.usatoday.com/story/news/nation/2018/05/05/foster-care-family-first-prevention-services-act-trump/573560002/

[7] Report of the California Legislative Analyst's Office, 2026. A large part of the material that follows in this section is based on material in that report and on general information found on the webpages of the California Department of Social Services (www.cdss.ca.gov).

list of commonly used evidence-based practices for these prevention services, please see the 2026 Legislative Analyst Report[8].

The term *imminent risk of foster care* is defined by the states as a child or family who qualifies for federal Title IV-E funding for prevention services. The Family First Prevention Services Act (FFPSA), passed in 2018, required changes to update child welfare practices so the state could claim Title IV-E funding for certain evidence-based prevention services. California began implementing FFPSA in 2021-2022 through the Family First Prevention Services Program.

As a result, the state's child welfare system now emphasizes prevention services to decrease risks for maltreatment and prevent the need for child removal and foster care placement. These services and supports are especially important when a child's removal is being considered primarily because of a family's financial instability or poverty.[9]

It is important to note that children and youth in Medicaid-eligible families with a demonstrated medical need (or court-ordered need) qualify for most, if not all, of these prevention services. Many of these supports already exist through county social services agencies and county behavioral health departments. The key change is that these services can now be funded through Title IV-E of the Social Security Act specifically to prevent or reduce the need for foster care placement.

This shift helps reduce the likelihood that children will need trauma-informed treatment and other therapies that often become necessary after removal of a child. When a child is removed, they lose not only their home, but also their school, siblings, pets, and the community connections that may have supported them. Preventing removal whenever safely possible helps avoid these additional layers of disruption.

Part of California's foster care reforms were driven by legislation such as Senate Bill 163, which addresses early learning, childcare, behavioral health treatment for autism, and Wraparound services for foster youth. This bill made changes across several state codes, including the California Education Code, Government Code, Health and Safety Code, and the Welfare and Institutions Code.

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[8]Information contained in the recent report by the California Legislative Analyst's Office, 2026.
[9] Efforts by the Child Welfare Council (CWC) Mandated Reporting Advisory Committee (MRAC) work to help mandated reporters decide when a child is in true danger of abuse or neglect vs. family being in poverty. An outline of this committee's recent work may be referenced at : https://www.caltrin.org/wp-content/uploads/2026/06/MRAC-Meeting_05-21-2026_Main-Deck_Final.pdf

In brief, SB163 is the California version of the 'Families First' programs mandated by the federal government that implements the federal requirements in our state. This bill also laid the groundwork for changes in financing[10] of services provided by child welfare contracting organizations to provide a more sustainable model to cover essential costs.

In summary, SB 163 is California's version of the federal "Families First" initiative, implementing federal requirements at the state level. The bill also laid the groundwork for updating how child welfare partner organizations are financed, creating a more sustainable model to support essential program costs. In addition, SB 163 helped launch the Tiered Rate Structure (TRS), which restructures funding for child-welfare-serving organizations, so reimbursement aligns with the intensity and level of care provided. The legislation also contributed to the establishment of the Center of Excellence (COE), which is responsible for defining and supporting high-fidelity Wraparound services statewide. The COE's role is to create one clear, consistent definition of Wraparound in California and replace the 58 different county versions that exist today to ensure quality and fidelity across programs.

Two main themes emerged during the Planning Council's Performance Outcomes Committee discussions: (a) the importance of high-fidelity Wraparound Services, and (b) the need for reform that strengthen the funding of foster care related services.

Financial reforms include improved resources to support the agencies responsible for foster home placements (including kinship care), and/or arranging formal guardianship or adoption. This financial reform is often referred to as changes in the T*iered Rate Structure (TRS)* which focuses on ensuring adequate funding for a child or youth's individual needs including situations where complex medical care requires specialized authorization and coverage through Medicaid.

As we consider these service and financing reforms, it is also essential to understand several foundational features of California's foster care system that directly affect how these changes are implemented. Many definitions and legal processes are complex, especially when funding responsibilities, jurisdiction, and public-school enrollment intersect. Additional challenges emerge when a child must be transferred to another county to access treatment or therapeutic resources unavailable locally. Under California's "presumptive transfer" policy, that receiving county becomes financially responsible for the youth's behavioral health services. We should also recognize the practical challenges that come with presumptive transfer. Youth are often placed

[10] This bill launched the 'Tiered Rate Structure' (TRS) for child welfare serving organizations, that would provide cover costs for care of a child or youth at various levels ('tiers') depending on the acuity of their needs, per assessment by designated diagnostic tools (e.g. 'CANS'), and perhaps by other supplemental information depending on the circumstances.

outside their home county because the specialized services they need are not available locally. Although presumptive transfer is intended to ensure continuity of behavioral health care across county lines, it can lead to administrative delays, funding disagreements, and coordination difficulties between counties. These issues often cause lengthy delays in reimbursing providers for services they have already delivered. These are barriers that providers cannot control but that significantly affect both service delivery and financial stability. Further complications can arise when reunification with the family of origin is the intended goal, adding yet another layer of coordination across counties and service systems.

CBHPC 2026 Data Notebook: Focus on Foster Youth and their Needs for Behavioral Health, Social Services, and Support for Complex Medical Needs

What is a Foster Youth/Child?

The term "foster youth" refers to a child or youth who has been removed from their home due to abuse or neglect and is under the jurisdiction of the superior court. This includes children for whom a petition has been filed under the applicable sections of California's Welfare and Institutions Code, designating them as dependents of the court under WIC § 300 (see Appendix A[11] for the full legal text and criteria). In addition, some non-minor[12] foster youth may continue to receive support as they transition into adulthood through supervised independent living, financial assistance, and/or housing services, as outlined in California WIC §16522.1(a)(1) (see Appendix B)[13].

Additional legal codes are outlined in Appendix C[14], including those that establish the court's authority over juveniles, as well as statutes that apply to youth involved in serious and/or violent offenses (Appendix D)[15]. It is hoped that this information may provide some clarity about provisions distinguishing youth under the foster care system in contrast to those juveniles that are under other provisions of the court's authority.

What is the prevalence of children and youth in foster care?

[11] See Appendix A: The legal description of W.I.C. section 300.
[12] Non-minor foster youth also include nonminor dependents (NMDs) participating in extended foster care under AB 12. Depending on their individual circumstances, needs, and the availability of placement options, NMDs may reside in a variety of settings. Some youth may be placed in transitional housing programs, such as THP-Plus Foster Care (THP+FC), which provide both housing and supportive services to help youth develop the skills needed for successful adulthood. Other eligible youth may reside in a Supervised Independent Living Placement (SILP), the least restrictive placement option within extended foster care, which allows NMDs to live independently in an approved residence while continuing to receive foster care benefits, case management, and supportive services.
[13] Appendix B: The legal description of W.I.C. section 16522.1.
[14] Appendix C: The Legal description of W.I.C. sections 700 & 701.
[15] Appendix D: Legal description of W.I.C. 707.

California has the largest number of children and youth in foster care of any state in the nation. In fiscal year 2024, California had 38,490 foster youth and children. In 2023, the rate at which children entered foster care was 4.5 per 1,000 children, which was very close to the national average of 4.6 per 1,000. To put this in context, California has approximately 8.73 million residents under the age of 18, representing about 22% of the state's total population. In 2026, the state's total population was estimated at approximately 39.9 million.

What is the process?

A report is made to either law enforcement or the local social services hotline alleging that a child or youth is experiencing or is at serious risk of abuse, neglect, abandonment, or unsafe living conditions. Once the situation is reviewed by a Superior Court judge, the judge may issue an order placing the youth under the care and supervision of the state. This typically results in the child entering the foster care system and being removed from their home. Child welfare workers do not act independently; they carry out these actions as an extension of the Superior Court's authority.

Youth in foster care may be placed with relatives (kinship care), foster families, group homes, or in Short-Term Residential Therapeutic Programs (STRTPs). Placement decisions depend on the youth's individual circumstances, level of need, and the resources available within their county, tribe, or state.

There are different pathways[16] into the foster care system when a child may be experiencing, or at risk of experiencing, maltreatment. Not all individuals or families go through a court or judicial proceeding. They may avoid the trauma and stress of court, especially if they voluntarily seek services that support and strengthen families. However, issues may arise with financial resources, and financial responsibility, or lack of resource availability due to an insufficient number of local providers.

(a) Reports by Mandated Reporters:
A mandated reporter (or another individual concerned about a child's safety or well-being) makes a report to a child abuse hotline or law enforcement. More recently, policymakers and stakeholders have emphasized the importance of ensuring that reports based solely on poverty-related circumstances are diverted to community-based supports rather than entering the child welfare system whenever safely appropriate. That approach is promoted by advocates that include the California Alliance through its participation in the Mandated Reporter Advisory Committee (MRAC).[17]

[16] Implementing California's Child Welfare Services Program, January 28, 2026, The Legislative Analyst's Office (the California Legislature's Nonpartisan Fiscal and Policy Advisor" https://LAO.ca.gov/Publications/Report/5106#Background.
[17] See Report linked in preceding footnote (16).

The local child welfare agency or tribe assesses the report and determines whether further investigation, voluntary services, or other interventions are warranted. If a case is opened, the agency may also determine whether the child and family are candidates for Title IV-E prevention services. If it is determined that the child can safely remain at home with supportive services, the family may be referred to the county's Differential Response Program (in participating counties), connected to community-based prevention services, or participate in voluntary or court-ordered Family Maintenance Services.

If, at any point, it is determined that the child cannot safely remain at home, the local child welfare agency may petition the juvenile court and facilitate an out-of-home placement. Depending on the child's needs, this may include placement with relatives, resource families, Foster Family Agency (FFA)-certified homes, or other family-based settings. Foster family agencies play a critical role in recruiting, certifying, training, and supporting resource families, particularly for children and youth with higher or more specialized needs.

For youth requiring a higher level of behavioral health treatment and supervision, placement may occur in a Short-Term Residential Therapeutic Program (STRTP). These programs provide intensive, trauma-informed residential treatment and are intended to serve youth whose needs cannot be safely met in a family-based setting at that time. These residential programs are interconnected with family foster agencies (FFAs) and other parts of the continuum of care. Family foster agencies may help support youth as they transition from residential treatment back into family-based placements.

(b) Community Pathway to Services:

A family is referred to, or independently seeks, supports/services from a trusted community organization, such as a family resource center.

The local child welfare agency or tribe determines whether the child/family are candidates for Title IV-E prevention services. If it is determined that the child can remain safely at home, then the county’s contracted community organization(s) will facilitate services to stabilize and strengthen the family. The community organization will be responsible for monitoring the child’s safety. If at any point it is determined that the child cannot remain safely at home, the local child welfare agency will facilitate a foster placement and/or take other steps necessary to ensure the child’s safety.

Who are the populations at risk of being placed in foster care?

When a child is at imminent risk of being placed in foster care, or children cannot remain safely with their parents, the state provides temporary out-of-home placements through the foster care system. During this time, services may be provided to parents with the goal of safely reunifying the child with their family. If reunification is not possible, the state assists in establishing a permanent placement, such as adoption or guardianship. Prevention services are intended to support and strengthen families so that removal can be avoided or significantly reduced whenever safely possible.

> Children and youth who qualify for Title IV-E prevention services are those determined to be at "imminent risk" of entering or re-entering foster care, as well as their parents or kin caregivers. Pregnant or parenting foster youth are automatically eligible for prevention services and do not require an individual assessment.
>
> California's state plan for implementing the federal Families First Prevention Services Act expands the definition of potential candidates for prevention services to include ten additional groups:
>
> - Youth and families receiving voluntary or court-ordered Family Maintenance services
> - Probation youth
> - Youth whose guardianship or adoption is at risk of disruption
> - Youth who are subject to a maltreatment allegation and investigation but for whom the court does not pursue a case
> - Youth with a sibling in foster care
> - Homeless or runaway youth
> - Substance-exposed newborns
> - Youth who were victims of commercial sexual exploitation
> - Youth exposed to domestic violence
> - Youth whose caretakers experience substance use disorder."[18]

Some populations experience greater risk than others, particularly when examining the types of reports made in California and their impact on Black and Brown families.[19] California's child welfare system receives more than 400,000 reports each year. Nearly

[18] "Implementing California's Child Welfare Services Program for Prevention, January 28, 2026, The Legislative Analyst's Office (the California Legislature's Nonpartisan Fiscal and Policy Advisor" https://LAO.ca.gov/Publications/Report/5106#Background.
[19] This information is from a Legislative Analyst (LA) report on AB 2085 implementation.

90% of those reports are unsubstantiated, with many reflecting families struggling with poverty rather than abuse or neglect.

- Black and Brown families bear the greatest burden, with a disproportionate number of families of color being investigated by child protective services before reaching adulthood.

As a result, child welfare agencies spend enormous capacity investigating families who need support, not intervention.

What resources comprise the continuum of care and housing for foster youth?

In 2025, California had 30,945 licensed foster homes. These homes, often referred to as *resource families,* represent only one part of the broader Children's Continuum of Care. Resource families and other foster care providers go through a formal licensing and approval process, described in detail in the California Department of Social Services (CDSS) *Roadmap for Facility Licensing*[20]. Additional licensed foster care providers and related facilities can be found on the CDSS Children's Residential Program webpage, which maintains the full list of approved programs, facilities, and agencies. The following list summarizes facilities and agencies licensed to provide (or supervise) foster care, Kincare, guardianship, and/or adoption:

- Community Crisis Homes (CCH)
- Community Treatment Facility (CTF)
- Enhanced Behavioral Support Homes (EBSH)
- Foster Family Agency (FFA)
- Group Home
- Group Home for Children with Special Health Care Needs (GHCSHN)
- Short-Term Residential Therapeutic Program (STRTP)
- Small Family Home (SFH)
- Temporary Shelter Care Facilities (TSCF)
- Transitional Shelter Care Facilitates (TrSCF)
- Transitional Housing Placement Provider (THPP)
- Youth Homelessness Prevention Center (YHPC).

[20] The Community Care Licensing Division (CCLD) has step-by-step resources to guide applicants through the licensing process. Help is available for Child Care Program, Children's Residential Program [PDF], and Home Care Services applicants. Access a general license overview guide on the CCLD webpage [PDF].

Wrap-Around Services for Foster Youth in California's Public Behavioral Health and Social Services Systems

Wraparound Services for foster youth represent an essential model within California's public behavioral health landscape. These community-based programs are designed to support foster youth and children and their families living with trauma, serious emotional disorders, and/or serious mental illness, and/or substance use disorders by offering accessible, voluntary, and person-centered services. The California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) coordinate within the state of California's Health and Human Services Agency. Such inter-agency cooperation is essential for the Child Welfare Wraparound Immediate Needs (WIN) program which is financed under the Tiered Rate Structure (TRS) and the Department of Health Care Services Medi-Cal High Fidelity Wraparound (HFW) program.

The wraparound services model draws from principles of peer and parent partner supports, empowerment, wellness, and a "whatever it takes" approach. These principles also will help provide effective services under High Fidelity Wrap. In part, the goal is to ensure California provides supportive services to individual youth and their families to prevent removing children from family homes. But there is also the goal of encouraging family reunification when removal has been necessary for the safety of the child. High Fidelity Wrap can enable families to pursue recovery by engaging in services that promote better parenting skills, stability, resilience, and social connection, and thereby ensure that families have the services and tools to remain together.

This year, the California Behavioral Health Planning Council (CBHPC) has focused the Data Notebook on *Foster Youth and Their Needs for Behavioral Health, Social Services, and Support for Complex Medical Needs*. In alignment with this goal, the document highlights areas where additional support is needed to ensure that programs are stable, sustainable, and financially viable. Key efforts include: (a) the launch of the High-Fidelity Wraparound services model, (b) revisions to the Tiered Rate Structure (TRS) to better align funding with each youth's assessed needs, and (c) the forthcoming implementation of "Wraparound Immediate Needs" resources. Together, these initiatives strengthen the continuum of care available to foster youth and their families. This focus is particularly timely given recent policy and funding shifts under state legislation such as SB 163, the Behavioral Health Services Act (BHSA), and broader Behavioral Health Transformation efforts.

As counties adjust to new mandates and evolving resource allocations, concerns have grown that Wraparound services and other essential supports for foster youth may face

reductions or even loss of funding despite their alignment with statewide goals of equity, prevention, and community-based care. There is an urgent need for additional financial support, as current program funding is insufficient to adequately sustain foster families, therapeutic service providers, and foster family agencies. These organizations assist families in caring for youth who have experienced trauma, often repeated or complex trauma, which contributes to intensive service needs.

At present, the financial picture remains unsustainable. For fiscal year 2025–2026, available resources fall short of what is needed to maintain a stable system of care, and projections for fiscal year 2026–2027 indicate even more serious shortfalls unless meaningful, systemwide solutions are implemented. As of Spring 2026, advocates across multiple sectors are actively engaging state leaders to highlight these concerns and urge legislative action.

Although Wraparound programs differ across counties in name, scope, staffing, and funding, most share core elements based on statutory requirements that all counties and agencies must follow beginning July 1, 2026. The current statewide goal is to deliver a high-fidelity Wraparound model. This approach has been approved by the federal Clearinghouse as an evidence-based practice, demonstrating positive outcomes for children and youth.

For the purposes of the 2026 Data Notebook Survey, we are using the following definition:

> ***Wraparound services*** *are community-based programs for foster youth and children that offer 'voluntary support services to individuals experiencing mental health and/or substance use challenges.' These programs prioritize peer support, empowerment, and self-determined approaches to recovery, often providing activities such as family education, family teams in the child welfare systems, resource navigation, to do "whatever it takes" to provide that youth or child with the resources to heal, develop, and thrive.*

2026 Data Notebook on Behavioral Health Services for Foster Youth Survey Questions

Note to Boards and Commissions: The following questions are focused upon foster youth who have been made dependents of the court (per W.I.C. 300) and are served by the local child welfare staff. These youth will have full scope Medi-Cal and often do have behavioral health needs. These questions are not typically tracked or discussed by behavioral health boards, but it is likely the Behavioral Health Plan in your county will have these responses in the Quality Assurance Program. It will be necessary for the Boards to work closely with the Behavioral Health Plan in your county that serves foster youth to provide this information to the Planning Council.

If the answer to a question is not known and is not easily obtainable by your board or county behavioral health, please feel free to skip it and answer the questions that you can. Our goal is to gather as much information as possible without requiring burdensome research.

1. **What is the name of your county?** *(Drop down menu)*
2. Does your county track the number and type of Medi-Cal Services provided to foster youth?
    a. Yes
    b. No
3. Does your county track the number and type of NON Medi-Cal Services provided to foster youth?
    a. Yes
    b. No
4. Who provides the Child and Adolescent Needs and Strengths (CANS) assessment for foster care youth in your county? (select all that apply)
    a. County Child Welfare
    b. County Behavioral Health Department
    c. Other [with text box]
5. About how often does your county Behavioral Health staff meet with staff from county child welfare services for the purposes of strategic planning and system coordination?
    a. More than once a month
    b. Once a month
    c. Once a quarter (every 3 months)
    d. Once a year
    e. Less than once a year
    f. Never

6. Does your county behavioral health department or one of your contractors work with schools to offer services and supports to foster youth with serious emotional disturbances (SED) or serious mental illness (SMI)?
    a. Yes
    b. No
7. Does your county behavioral health department provide support services for **pregnant or parenting** foster youth?
    a. Yes
    b. No
8. Does your county behavioral health department provide support services for **justice-involved** foster youth?
    a. Yes
    b. No
9. What is the unduplicated count of foster youth who received **mental health services** in your county during FY 24/25? (Please skip this question if the count is fewer than 11. If you do not have an exact count, please provide an estimate.)
    a. [Text box for numerical response]
10. Approximately what percentage of behavioral health services, including crisis services, for foster youth in your county are provided directly by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]
11. Approximately what percentage of behavioral health services, including crisis services, for foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]
12. What is the unduplicated count of foster youth who received **SUD treatment services** in your county during FY 24/25? (**Please skip this question if the count is fewer than 11**.) If you do not have an exact count, please provide an estimate.)
    a. [Text box for numerical response]
13. Approximately what percentage of outpatient substance use interventions being offered to foster youth in your county are directly provided by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]
    b. Not applicable
14. Approximately what percentage of outpatient substance use interventions being offered to foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]

b. Not applicable

15. What is the unduplicated count of foster youth who received **wraparound services** in your county in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.**) If you do not have an exact count, please provide an estimate.)
    a. [Text box for numerical response]
16. In fiscal year 24/25, how many foster youth receiving wraparound services "graduated" from the service? **(Please skip this question if the count is fewer than 11.**) If you do not have an exact count, please provide an estimate.)
    a. [with numerical response]
17. How is your county planning to provide High-Fidelity Wraparound services that are required starting July 1, 2026?
    a. High-Fidelity Wraparound services will be provided directly by county behavioral health.
    b. High-Fidelity Wraparound services will be provided by one or more contractors.
    c. High-Fidelity Wraparound services will be provided by a combination of county behavioral health and one or more contractors.
    d. Unknown
    e. Other (please describe)
18. Approximately what percentage of SB 163 wraparound services for foster youth in your county are provided directly by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]
19. Approximately what percentage of SB 163 wraparound services for foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. [Text box for numerical response]
20. What is the unduplicated count of foster youth who received **Full Service Partnership (FSP) services** in your county in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.** If you do not have an exact count, please provide an estimate.)
    a. [Text box for numerical response]
21. What is the unduplicated count of foster youth who are Med-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.** If you do not have an exact count, please provide an estimate.)
    a. [Text box for numerical response]
22. Of the foster youth who are Medi-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25, what **percentage** were seen by a clinician within 7 days of discharge? (Please submit your response as a number between 0-100, rounded to the nearest decimal)

    a. [Text box for numerical response]
23. Of the foster youth who are Medi-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25, what **percentage** were seen by a clinician within 30 days of discharge? (Please submit your response as a number between 0-100, rounded to the nearest decimal)
    a. [Text box for numerical response]
24. In the past year, has your board/commission had any agenda items focused on foster youth? If yes, what are some examples of such agenda items?
    a. Yes [with text box]
    b. No
25. What are the top 3 comments and/or recommendations you would like to make about the services for foster youth in your county?
    a. [Text box for response

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. The questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

1. What process was used to complete this Data Notebook? *(Please select all that apply)*
    a. BH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
    b. BH board completed the majority of the Data Notebook.
    c. Data Notebook placed on agenda and discussed at board meeting.
    d. BH board work group or temporary ad hoc committee worked on it.
    e. BH board partnered with county staff or director.
    f. BH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
    g. Other (please specify)
2. Does your board have designated staff to support your activities?
    a. Yes (if yes, please provide their job classification)
    b. No
3. Please provide contact information for this staff member or board liaison.
4. Please provide contact information for your board’s presiding officer (chair, etc.)

Do you have any feedback or recommendations to improve the Data Notebook for next year?

Appendix A. California Laws Pertaining to Foster Youth

Welfare and Institutions Code W.I.C. 300

DIVISION 2. CHILDREN [100 - 1500]

(Division 2 enacted by Stats. 1937, Ch. 369.)

PART 1. DELINQUENTS AND WARDS OF THE JUVENILE COURT [100 - 1459]

(Part 1 enacted by Stats. 1937, Ch. 369.)

CHAPTER 2. Juvenile Court Law [200 - 987]

(Chapter 2 repealed and added by Stats. 1961, Ch. 1616.)

ARTICLE 6. Dependent Children—Jurisdiction [300 - 304.7]

(Article 6 added by Stats. 1976, Ch. 1068.)

300.

A child who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge that person to be a dependent child of the court:

(a) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted nonaccidentally upon the child by the child's parent or guardian. For purposes of this subdivision, a court may find there is a substantial risk of serious future injury based on the manner in which a less serious injury was inflicted, a history of repeated inflictions of injuries on the child or the child's siblings, or a combination of these and other actions by the parent or guardian that indicate the child is at risk of serious physical harm. For purposes of this subdivision, "serious physical harm" does not include reasonable and age-appropriate spanking to the buttocks if there is no evidence of serious physical injury.

(b) (1) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of any of the following:

(A) The failure or inability of the child's parent or guardian to adequately supervise or protect the child.

(B) The willful or negligent failure of the child's parent or guardian to adequately supervise or protect the child from the conduct of the custodian with whom the child has been left.

(C) The willful or negligent failure of the parent or guardian to provide the child with adequate food, clothing, shelter, or medical treatment.

(D) The inability of the parent or guardian to provide regular care for the child due to the parent's or guardian's mental illness, developmental disability, or substance abuse.

(2) A child shall not be found to be a person described by this subdivision solely due to any of the following:

(A) Homelessness or the lack of an emergency shelter for the family.

(B) The failure of the child's parent or alleged parent to seek court orders for custody of the child.

(C) Indigence or other conditions of financial difficulty, including, but not limited to, poverty, the inability to provide or obtain clothing, home or property repair, or childcare.

(3) Whenever it is alleged that a child comes within the jurisdiction of the court on the basis of the parent's or guardian's willful failure to provide adequate medical treatment or specific decision to provide spiritual treatment through prayer, the court shall give deference to the parent's or guardian's medical treatment, nontreatment, or spiritual treatment through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by an accredited practitioner thereof, and shall not assume jurisdiction unless necessary to protect the child from suffering serious physical harm or illness. In making its determination, the court shall consider (1) the nature of the treatment proposed by the parent or guardian, (2) the risks to the child posed by the course of treatment or nontreatment proposed by the parent or guardian, (3) the risk, if any, of the course of treatment being proposed by the petitioning agency, and (4) the likely success of the courses of treatment or nontreatment proposed by the parent or guardian and agency. The child shall continue to be a dependent child pursuant to this subdivision only so long as is necessary to protect the child from risk of suffering serious physical harm or illness.

(4) The Legislature finds and declares that a child who is sexually trafficked, as described in Section 236.1 of the Penal Code, or who receives food or shelter in exchange for, or who is paid to perform, sexual acts described in Section 236.1 or 11165.1 of the Penal Code, and whose parent or guardian failed to, or was unable to, protect the child, is within the description of this subdivision, and that this finding is declaratory of existing law. These children shall be known as commercially sexually exploited children.

(c) The child is suffering serious emotional damage, or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care. A child shall not be found to be a person described by this subdivision if the willful

failure of the parent or guardian to provide adequate mental health treatment is based on a sincerely held religious belief and if a less intrusive judicial intervention is available.

(d) The child has been sexually abused, or there is a substantial risk that the child will be sexually abused, as defined in Section 11165.1 of the Penal Code, by the child's parent or guardian or a member of the child's household, or the parent or guardian has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.

(e) The child is under five years of age and has suffered severe physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child. For the purposes of this subdivision, "severe physical abuse" means any of the following: any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness; or the willful, prolonged failure to provide adequate food. A child shall not be removed from the physical custody of the child's parent or guardian on the basis of a finding of severe physical abuse unless the social worker has made an allegation of severe physical abuse pursuant to Section 332.

(f) The child's parent or guardian caused the death of another child through abuse or neglect.

(g) The child has been left without any provision for support; physical custody of the child has been voluntarily surrendered pursuant to Section 1255.7 of the Health and Safety Code and the child has not been reclaimed within the 14-day period specified in subdivision (g) of that section; the child's parent has been incarcerated or institutionalized and cannot arrange for the care of the child; or a relative or other adult custodian with whom the child resides or has been left is unwilling or unable to provide care or support for the child, the whereabouts of the parent are unknown, and reasonable efforts to locate the parent have been unsuccessful.

(h) The child has been freed for adoption by one or both parents for 12 months by either relinquishment or termination of parental rights or an adoption petition has not been granted.

(i) The child has been subjected to an act or acts of cruelty by the parent or guardian or a member of the child's household, or the parent or guardian has failed to adequately protect the child from an act or acts of cruelty when the parent or guardian knew or reasonably should have known that the child was in danger of being subjected to an act or acts of cruelty.

(j) The child's sibling has been abused or neglected, as defined in subdivision (a), (b), (d), (e), or (i), and there is a substantial risk that the child will be abused or neglected, as defined in those subdivisions. The court shall consider the circumstances surrounding the abuse or neglect of the sibling, the age and gender of each child, the nature of the abuse or neglect of the sibling, the mental condition of the parent or guardian, and any other factors the court considers probative in determining whether there is a substantial risk to the child.

It is the intent of the Legislature that this section not disrupt the family unnecessarily or intrude inappropriately into family life, prohibit the use of reasonable methods of parental discipline, or prescribe a particular method of parenting. Further, this section is not intended to limit the offering of voluntary services to those families in need of assistance but who do not come within the descriptions of this section. To the extent that savings accrue to the state from child welfare services funding obtained as a result of the enactment of the act that enacted this section, those savings shall be used to promote services which support family maintenance and family reunification plans, such as client transportation, out-of-home respite care, parenting training, and the provision of temporary or emergency in-home caretakers and persons teaching and demonstrating homemaking skills. The Legislature further declares that a physical disability, such as blindness or deafness, is no bar to the raising of happy and well-adjusted children and that a court's determination pursuant to this section shall center upon whether a parent's disability prevents the parent from exercising care and control. The Legislature further declares that a child whose parent has been adjudged a dependent child of the court pursuant to this section shall not be considered to be at risk of abuse or neglect solely because of the age, dependent status, or foster care status of the parent.

As used in this section, "guardian" means the legal guardian of the child.

(Amended by Stats. 2022, Ch. 832, Sec. 1. (SB 1085) Effective January 1, 2023.)

Note: A foster child under 18 years of age shall be eligible for placement in the program certified as a "Transitional Housing Placement program for minor foster children" pursuant to paragraph (1) of subdivision (a) of Section 16522.1.

Appendix B. Transitional Housing Placement Program for Minor Foster Children and Non-minor Foster Youth

California Laws about 'Aid to Families and Children' contain provisions that enable and describe supported 'Transitional Living' programs for both older minor and nonminor Foster Youth.

Welfare and Institutions Code W.I.C 11401
DIVISION 9 - PUBLIC SOCIAL SERVICES
PART 3 - AID AND MEDICAL ASSISTANCE CHAPTER 2 - California Work Opportunity and Responsibility to Kids Act
ARTICLE 5 - Aid to Families With Dependent Children—Foster Care
Section 11401.

Universal Citation:

CA Welf & Inst Code § 11401 (2025)

11401. Aid in the form of AFDC-FC shall be provided under this chapter on behalf of any child under 18 years of age, and to any nonminor dependent who meets the conditions of any of the following subdivisions:

(a) The child has been relinquished, for purposes of adoption, to a licensed adoption agency, or the department, or the parental rights of either or both of the child's parents have been terminated after an action under the Family Code has been brought by a licensed adoption agency or the department, provided that the licensed adoption agency or the department, if responsible for placement and care, provides to those children all services as required by the department to children in foster care.

(b) The child has been removed from the physical custody of the child's parent, relative, or guardian as a result of a voluntary placement agreement or a judicial determination that continuance in the home would be contrary to the child's welfare and that, if the child was placed in foster care, reasonable efforts were made, consistent with Chapter 5 (commencing with Section 16500) of Part 4, to prevent or eliminate the need for removal of the child from the child's home and to make it possible for the child to return to the child's home, and any of the following applies:

(1) The child has been adjudged a dependent child of the court on the grounds that the child is a person described by Section 300.

(2) The child has been adjudged a ward of the court on the grounds that the child is a person described by Sections 601 and 602, or the child or nonminor is under the transition jurisdiction of the juvenile court pursuant to Section 450.

(3) The child has been detained under a court order, pursuant to Section 319 or 636, that remains in effect.

(4) The child's or nonminor's dependency jurisdiction, or transition jurisdiction pursuant to Section 450, has resumed pursuant to Section 387, or subdivision (a), (e), or (f) of Section 388.

(c) The child has been voluntarily placed by the child's parent or guardian pursuant to Section 11401.1.

(d) The child is living in the home of a nonrelated legal guardian, or the nonminor is living in the home of a former nonrelated legal guardian.

(e) The child is a nonminor dependent who is placed pursuant to a mutual agreement as set forth in subdivision (u) of Section 11400, under the placement and care responsibility of the county child welfare services department, an Indian tribe that entered into an agreement pursuant to Section 10553.1, or the county probation department, or the child is a nonminor dependent reentering foster care placement pursuant to a voluntary agreement, as set forth in subdivision (z) of Section 11400.

(f) The child has been placed in foster care consistent with the federal Indian Child Welfare Act of 1978 (25 U.S.C. Sec. 1901 et seq.). Sections 11402, 11404, and 11405 shall not be construed as limiting payments to an Indian child, as defined in subdivision (b) of Section 224.1 and Section 1903 of the federal Indian Child Welfare Act of 1978, placed in accordance with that act and the provisions of Section 361.31.

(g) To be eligible for federal financial participation, the conditions described in paragraph (1), (2), (3), or (4) shall be satisfied:

(1) (A) The child meets the conditions of subdivision (b).

(B) The child has been deprived of parental support or care for any of the reasons set forth in Section 11250.

(C) The child has been removed from the home of a relative as defined in Section 233.90(c)(1) of Title 45 of the Code of Federal Regulations, as amended.

(D) The requirements of Sections 671 and 672 of Title 42 of the United States Code, as amended, have been met.

(2) (A) The child meets the requirements of subdivision (h).

(B) The requirements of Sections 671 and 672 of Title 42 of the United States Code, as amended, have been met.

(C) This paragraph shall be implemented only if federal financial participation is available for the children described in this paragraph.

(3) (A) The child has been removed from the custody of the child's parent, relative, or guardian as a result of a voluntary placement agreement or a judicial determination that continuance in the home would be contrary to the child's welfare and that, if the child was placed in foster care, reasonable efforts were made, consistent with Chapter 5 (commencing with Section 16500) of Part 4, to prevent or eliminate the need for removal of the child from the child's home and to make it possible for the child to return to the child's home, or the child is a nonminor dependent who satisfies the removal criteria in Section 472(a)(2)(A)(i) of the federal Social Security Act (42 U.S.C. Sec. 672 (a)(2)(A)(i)) and agrees to the placement and care responsibility of the placing agency by signing the voluntary reentry agreement, as set forth in subdivision (z) of Section 11400, and any of the following applies:

(i) The child has been adjudged a dependent child of the court on the grounds that the child is a person described by Section 300.

(ii) The child has been adjudged a ward of the court on the grounds that the child is a person described by Sections 601 and 602 or the child or nonminor is under the transition jurisdiction of the juvenile court, pursuant to Section 450.

(iii) The child has been detained under a court order, pursuant to Section 319 or 636, that remains in effect.

(iv) The child's or nonminor's dependency jurisdiction, or transition jurisdiction pursuant to Section 450, has resumed pursuant to Section 387, or subdivision (a), (e), or (f) of Section 388.

(B) The child has been placed in an eligible foster care placement, as set forth in Section 11402.

(C) The requirements of Sections 671 and 672 of Title 42 of the United States Code have been satisfied.

(D) This paragraph shall be implemented only if federal financial participation is available for the children described in this paragraph.

(4) With respect to a nonminor dependent, in addition to meeting the conditions specified in paragraph (1), the requirements of Section 675(8)(B) of Title 42 of the United States Code have been satisfied. With respect to a former nonminor dependent who reenters foster care placement by signing the voluntary reentry agreement, as set forth in subdivision (z) of Section 11400, the requirements for AFDC-FC eligibility of Section 672(a)(3)(A) of Title 42 of the United States Code are satisfied based on the nonminor's status as a child-only case, without regard to the parents, legal guardians, or

others in the assistance unit in the home from which the nonminor was originally removed.

(h) The child meets all of the following conditions:

(1) The child has been adjudged to be a dependent child or ward of the court on the grounds that the child is a person described in Section 300, 601, or 602.

(2) The child's parent also has been adjudged to be a dependent child or nonminor dependent of the court on the grounds that the child's parent is a person described by Section 300, 450, 601, or 602 and is receiving benefits under this chapter.

(3) The child is placed in the same licensed or approved foster care facility in which the child's parent is placed and the child's parent is receiving reunification services with respect to that child.

(Amended by Stats. 2024, Ch. 656, Sec. 28. (AB 81) Effective September 27, 2024.)

Appendix C: Foundation of the Court's Authority over Juveniles

In California, **W.I.C. 600** refers to **California Welfare and Institutions Code section 600**, which is part of the state's juvenile court jurisdiction statutes. It is the starting point for a series of sections (WIC § 600 et seq.) that define when a minor can be brought into the juvenile court system and adjudicated a **ward of the court.**

What WIC § 600 Covers

WIC § 600 sets out the general jurisdiction of the juvenile court over minors. It authorizes the court to take custody of a minor if the minor is alleged to have committed a delinquent act (such as a crime) and to determine appropriate placement or supervision. The court can order:

- The minor to live with parents or guardians under supervision
- Probation (including living with a relative, in a foster home, group home, or institution)
- Probation with camp or ranch placement
- Placement in the Department of Corrections and Rehabilitation, Division of Juvenile Justice (DJJ) for minors, or in adult facilities if tried in adult court sanbernardino.courts.ca.gov.

Related Provisions

While WIC § 600 is the general jurisdiction section, other WIC sections (like WIC § 601) define specific situations that can trigger juvenile court involvement, such as:

- Habitual truancy (four or more absences in a school year)
- Refusal to obey parental/guardian orders
- Violation of a curfew ordinance based solely on age FindLaw.

Purpose

The intent of WIC § 600 is to give the juvenile court authority to protect minors, ensure their safety, and provide appropriate care or rehabilitation when they are at risk of harm or have committed acts that would otherwise be handled in adult court.

In short: W.I.C. 600 is the foundational section of California's juvenile court jurisdiction law, authorizing the court to take custody of minors and determine their care, supervision, or placement when they are alleged to have committed delinquent acts.

California Code, Welfare and Institutions Code - WIC § 601

(a) Any minor between 12 years of age and 17 years of age, inclusive, who persistently or habitually refuses to obey the reasonable and proper orders or directions of the minor's parents, guardian, or custodian, or who is beyond the control of that person, or

who is a minor between 12 years of age and 17 years of age, inclusive, when the minor violated any ordinance of any city or county of this state establishing a curfew based solely on age is within the jurisdiction of the juvenile court which may adjudge the minor to be a ward of the court.

(b) If a minor between 12 years of age and 17 years of age, inclusive, has four or more truancies within one school year as defined in Section 48260 of the Education Code or a school attendance review board or probation officer determines that the available public and private services are insufficient or inappropriate to correct the habitual truancy of the minor, or if the minor fails to respond to directives of a school attendance review board or probation officer or to services provided, the minor is then within the jurisdiction of the juvenile court which may adjudge the minor to be a ward of the court pursuant to this section. However, it is the intent of the Legislature that a minor who is described in this subdivision, adjudged a ward of the court pursuant solely to this subdivision, or found in contempt of court for failure to comply with a court order pursuant to this subdivision, shall not be held in a secure facility and shall not be removed from the custody of the parent or guardian except for the purposes of school attendance.

(c) To the extent practically feasible, a minor who is adjudged a ward of the court pursuant to this section shall not be permitted to come into or remain in contact with any minor ordered to participate in a truancy program, or the equivalent thereof, pursuant to Section 602.

(d) Any peace officer may issue a notice to appear to a minor who is within the jurisdiction of the juvenile court pursuant to this section. Before issuing a notice to appear under this subdivision, a peace officer shall refer a minor who is within the jurisdiction of this section to a community-based resource, the probation department, a health agency, a local educational agency, or other governmental entities that may provide services.

California Code, Welfare and Institutions Code - WIC § 601.2

In the event that a parent or guardian or person in charge of a minor described in Section 48264.5 of the Education Code fails to respond to directives of the school attendance review board or to services offered on behalf of the minor, the school attendance review board shall direct that the minor be referred to the probation department or to the county welfare department under Section 300, and the school attendance review board may require the school district to file a complaint against the parent, guardian, or other person in charge of such minor as provided in Section 48291 or Section 48454 of the Education Code.

Appendix D. California W.I.C. Codes for Juvenile Serious/Violent Offenses

In California, **Welfare and Institutions Code (WIC) § 707(b)** lists the specific serious and violent offenses that can trigger a juvenile's transfer from juvenile court to adult criminal court. These are the "WIC 707(b) offenses" and are considered the most serious crimes of which a minor can be accused.

Key WIC 707(b) Offenses. The statute includes 30 or more felony-level crimes, such as:

- **Murder**
- **Arson** (inhabited structure or causing great bodily injury)
- **Robbery**
- **Rape** (with force, violence, or threat of great bodily harm)
- **Sodomy** (by force, violence, duress, menace, or threat of great bodily harm)
- **Oral copulation** (by force, violence, duress, menace, or threat of great bodily harm)
- **Sexual penetration** (by force, violence, duress, menace, or threat of great bodily harm)
- **Kidnapping** (for ransom, robbery, with bodily harm, for sexual assault, or during carjacking)
- **Attempted murder**
- **Assault with a firearm or destructive device**
- **Assault likely to cause great bodily injury**
- **Shooting into an occupied building**
- **Carjacking while armed**
- **Torture**
- **Aggravated mayhem**
- **Forcible sex offenses** (including lewd acts against children under 14)
- **Gang-related violent felonies**
- **Witness intimidation**
- **Manufacturing/selling significant quantities of certain controlled substances**
- **Violent escape from a juvenile facility causing serious injury to staff**

Transfer Process

Under **WIC § 707**, if a minor (14–17) is accused of one of these offenses, the prosecutor can move the case to adult court before jeopardy attaches. The juvenile court must

review the case, consider a probation officer's report, and decide whether the minor is "not amenable to rehabilitation" in the juvenile system.

Why It Matters

A juvenile adjudication for any WIC 707(b) offense carries **collateral consequences** that most juvenile records do not, including:

- Potential **Three Strikes liability**
- Severe restrictions on **record sealing**
- Long-term impact on employment, education, and housing legalclarity.org

In summary: If a California juvenile is charged with any offense listed in **WIC § 707(b)**, it can lead to transfer to adult court and significant lifelong consequences.

2026 Data Notebook on Behavioral Health Services for Foster Youth Survey Questions

Note to Boards and Commissions: The following questions are focused upon foster youth who have been made dependents of the court (per W.I.C. 300) and are served by the local child welfare staff. These youth will have full scope Medi-Cal and often do have behavioral health needs. These questions are not typically tracked or discussed by behavioral health boards, but it is likely the Behavioral Health Plan in your county will have these responses in the Quality Assurance Program. It will be necessary for the Boards to work closely with the Behavioral Health Plan in your county that serves foster youth to provide this information to the Planning Council.

If the answer to a question is not known and is not easily obtainable by your board or county behavioral health, please feel free to skip it and answer the questions that you can. Our goal is to gather as much information as possible without requiring burdensome research.

1. **What is the name of your county?** *(Drop down menu)* **Santa Cruz County**
2. Does your county track the number and type of Medi-Cal Services provided to foster youth?
    a. **Yes (Avatar Billable Services)**
    b. No
3. Does your county track the number and type of NON Medi-Cal Services provided to foster youth?
    a. Yes
    b. No
4. Who provides the Child and Adolescent Needs and Strengths (CANS) assessment for foster care youth in your county? (select all that apply)
    a. County Child Welfare
    b. County Behavioral Health Department
    c. Other [with text box]
5. About how often does your county Behavioral Health staff meet with staff from county child welfare services for the purposes of strategic planning and system coordination?
    a. More than once a month (Interagency Leadership Team/ILT, Interagency Placement Committee/IPC, Children's System of Care (CSOC) Partner Meeting, Child, Youth, and Family Wellbeing Cabinet, etc.)
    b. Once a month
    c. Once a quarter (every 3 months)
    d. Once a year

e. Less than once a year
f. Never

6. Does your county behavioral health department or one of your contractors work with schools to offer services and supports to foster youth with serious emotional disturbances (SED) or serious mental illness (SMI)?
   a. Yes
   b. No
7. Does your county behavioral health department provide support services for **pregnant or parenting** foster youth?
   a. Yes
   b. No
8. Does your county behavioral health department provide support services for **justice-involved** foster youth?
   a. Yes
   b. No
9. What is the unduplicated count of foster youth who received **mental health services** in your county during FY 24/25? (Please skip this question if the count is fewer than 11. If you do not have an exact count, please provide an estimate.)
   a. 89
10. Approximately what percentage of behavioral health services, including crisis services, for foster youth in your county are provided directly by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. 53
11. Approximately what percentage of behavioral health services, including crisis services, for foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. **47**
12. What is the unduplicated count of foster youth who received **SUD treatment services** in your county during FY 24/25? (**Please skip this question if the count is fewer than 11**.) If you do not have an exact count, please provide an estimate.)
    a. 11
13. Approximately what percentage of outpatient substance use interventions being offered to foster youth in your county are directly provided by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. 1
    b. Not applicable

14. Approximately what percentage of outpatient substance use interventions being offered to foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. 99
    b. Not applicable
15. What is the unduplicated count of foster youth who received **wraparound services** in your county in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.**) If you do not have an exact count, please provide an estimate.)
    a.
16. In fiscal year 24/25, how many foster youth receiving wraparound services "graduated" from the service? **(Please skip this question if the count is fewer than 11.**) If you do not have an exact count, please provide an estimate.)
    a.
17. How is your county planning to provide High-Fidelity Wraparound services that are required starting July 1, 2026?
    a. High-Fidelity Wraparound services will be provided directly by county behavioral health.
    b. High-Fidelity Wraparound services will be provided by one or more contractors.
    c. High-Fidelity Wraparound services will be provided by a combination of county behavioral health and one or more contractors.
    d. Unknown
    e. Other (please describe)
18. Approximately what percentage of SB 163 wraparound services for foster youth in your county are provided directly by **county behavioral health?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. 0
19. Approximately what percentage of SB 163 wraparound services for foster youth in your county are provided by **contractors?** (Please submit your response as a number between 0-100, rounded to the nearest whole number.)
    a. 100
20. What is the unduplicated count of foster youth who received **Full Service Partnership (FSP) services** in your county in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.** If you do not have an exact count, please provide an estimate.)
    a.
21. What is the unduplicated count of foster youth who are Med-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25? (**Please skip this question if the count is fewer than 11.** If you do not have an exact count, please provide an estimate.)

a. **27**

22. Of the foster youth who are Medi-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25, what **percentage** were seen by a clinician within 7 days of discharge? (Please submit your response as a number between 0-100, rounded to the nearest decimal)
    a. **78**
23. Of the foster youth who are Medi-Cal beneficiaries of your county who were **hospitalized for inpatient psychiatric care** in fiscal year 24/25, what **percentage** were seen by a clinician within 30 days of discharge? (Please submit your response as a number between 0-100, rounded to the nearest decimal)
    a. **96**
24. In the past year, has your board/commission had any agenda items focused on foster youth? If yes, what are some examples of such agenda items?
    a. Yes [with text box]
    b. No
25. What are the top 3 comments and/or recommendations you would like to make about the services for foster youth in your county?
    a. [Text box for response]