Senate Budget and Fiscal Review—John Laird, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Caroline Menjivar, Chair
Senator Shannon Grove
Senator Dr. Akilah Weber Pierson

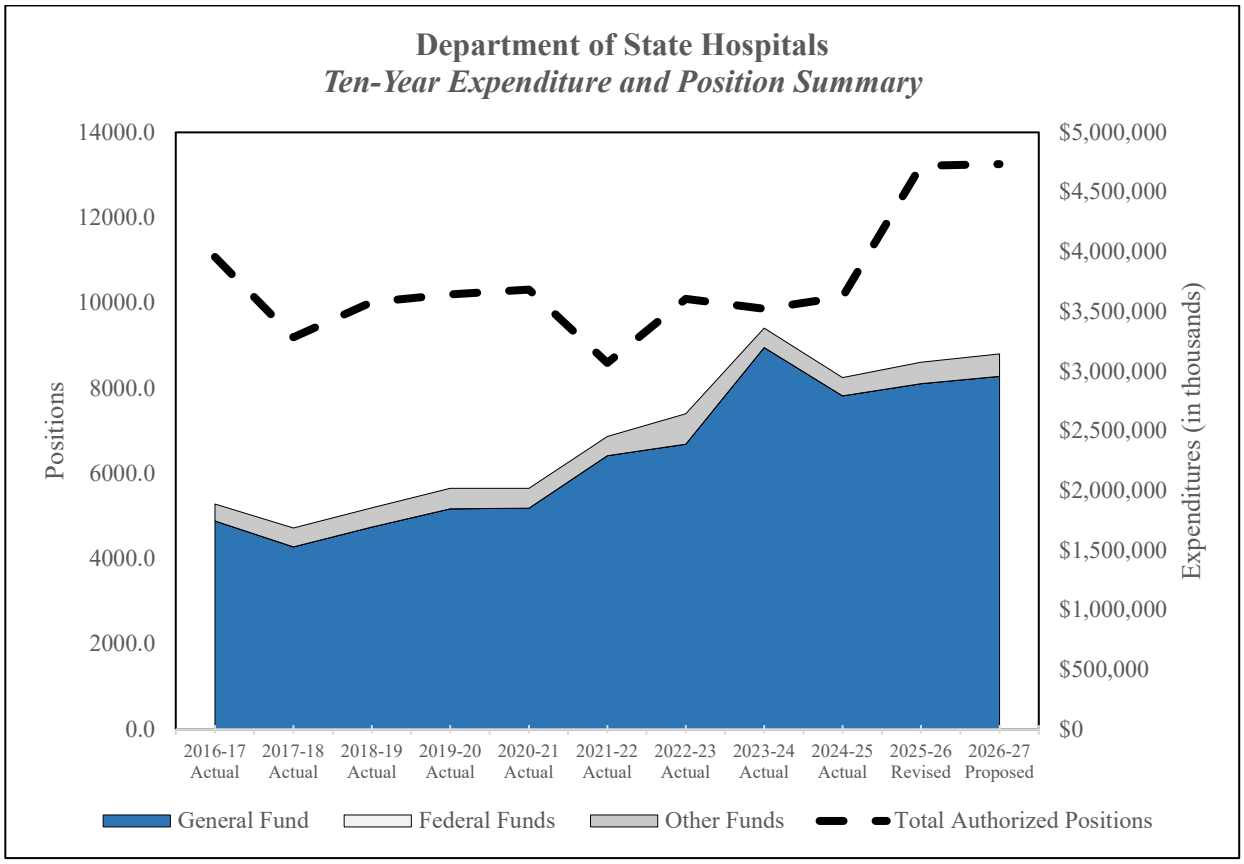
Thursday, April 30th, 2026
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultants: Nora Brackbill and Scott Ogus

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview and Program and Caseload Updates

Governor's Budget. Department of State Hospitals (DSH) requests resources to support the following program and caseload updates in its 2026-27 Governor's Budget Estimate.



Department of State Hospitals - Department Funding Summary (dollars in thousands)				
Fund Source	**2024-25 Actual**	***2025-26 Budget Act***	***2025-26 Revised***	***2026-27 Proposed***
General Fund	$2,793,776	$2,931,652	$2,894,956	$2,957,559
Federal Funds	$0	$100	$100	$100
Other Funds	$152,480	$178,748	$178,748	$186,369
Total Department Funding:	**$2,946,256**	**$3,110,500**	**$3,073,804**	**$3,144,028**
Total Authorized Positions:	**10,141.40**	**13385.5**	**13214.4**	**13255.3**
Other Funds Detail:				
CA State Lottery Education Fund (0814)	*$23*	*$21*	*$21*	*$21*
Reimbursements (0995)	*$152,457*	*$178,727*	*$178,727*	*$186,348*
CA Emergency Relief Fund (3398)	*$0*	*$0*	*$0*	*$0*

Background. Department of State Hospitals (DSH) is responsible for a total patient population of 8,317 individuals, of which 5,694 are housed in five state hospitals, 893 are on conditional release, and the remainder are in a variety of contracted programs. The majority of the population is forensic (referred through criminal justice involvement), making it the largest inpatient forensic mental health hospital system in the nation. In addition, DSH admits individuals civilly committed under the Lanterman-Petris-Short (LPS) Act. DSH is primarily funded through the General Fund and reimbursements from counties for the care of LPS patients, as shown in the table above. A table of population by commitment type and hospital is included below.

Commitment Types. The categories of individuals admitted to state hospitals for treatment are:

- *Incompetent to Stand Trial (IST)*. IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once they are able to participate in court proceedings.

- *Not Guilty by Reason of Insanity (NGI)*. NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though they may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- *Offenders with a Mental Health Disorder (OMD)*. OMD patients are parolees who meet the following six criteria for OMD classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. OMD commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- *Sexually Violent Predators (SVP)*. SVP commitments are civil commitments of individuals released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- *Lanterman-Petris-Short (LPS)*. LPS patients are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability, and require physically secure, 24-hour care. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- Coleman *Class Patients (Mentally Ill Prisoners)*. *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill

while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as an OMD.

- *Conditional Release Program (CONREP)*. CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

The table below shows the average number of patient days, by commitment type, for patients in census at the end of 2024-25.

Commitment Type	Average Patient Days
Coleman/CDCR	198.3
Incompetent to Stand Trial (IST)	156.8
Lanterman-Petris Short (LPS)	2,073.8
Mentally Disordered Sex Offender (MDSO)	3,687.6
Not Guilty by Reason of Insanity (NGI)	3,990.5
Offender with Mental Health Disorder (OMD) PC 2962	304.0
OMD PC 2972	2,807.3
Sexually Violent Predators (SVP)	4,205.3

State Hospitals. The five state hospitals operated by DSH are:

- *DSH-Atascadero*. DSH-Atascadero opened in 1954 on the Central Coast in San Luis Obispo County, and is a forensic mental health hospital with a secure perimeter. It has an all-male population consisting primarily of OMD, *Coleman*, IST, and NGI commitments. The proposed budget includes $384 million and 2,196.4 positions for DSH-Atascadero. As of November 1, 2025, the vacancy rate at DSH-Atascadero was 20.0 percent.

- *DSH-Coalinga.* DSH-Coalinga opened in 2005 in the Central Valley in Fresno County, and is a forensic mental health hospital with a secure perimeter. It has an all-male population primarily consisting of SVPs, OMD, and *Coleman* patients. CDCR provides perimeter security and transportation. The proposed budget includes $434 million and 2,444.2 positions for DSH-Coalinga. As of November 1, 2025, the vacancy rate at DSH-Coalinga was 17.8 percent.

- *DSH-Metropolitan*. DSH-Metropolitan opened in 1916 in Norwalk in Los Angeles County, and has an open-style campus with a secure perimeter. Due to concerns from the community, DSH-Metropolitan does not accept patients charged with murder or a sex crime, or at high risk for escape. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI, and recently completed a project to increase its secure bed capacity. The proposed budget includes $277 million and 2,195.6 positions for DSH-Metropolitan. As of November 1, 2025, the vacancy rate at DSH-Metropolitan was 15.2 percent.

- *DSH-Napa*. DSH-Napa is the first state hospital, and opened in 1875. Most of the hospital is a forensic mental health hospital, with an open-style campus with a secure perimeter. DSH-Napa primarily serves LPS, IST, OMD, and NGI patients. The proposed budget includes $422 million

and 2,568.2 positions for DSH-Napa. As of November 1, 2025, the vacancy rate at DSH-Napa was 18.5 percent.

- *DSH-Patton*. DSH-Patton opened in 1893 in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an open-style campus with a secure perimeter. Due to concerns from the community, CDCR provides perimeter security and transportation. DSH-Patton primarily serves LPS, IST, OMD, and NGI patients. The proposed budget includes $457 million and 2,525.1 positions for DSH-Patton. As of November 1, 2025, the vacancy rate at DSH-Patton was 8.4 percent.

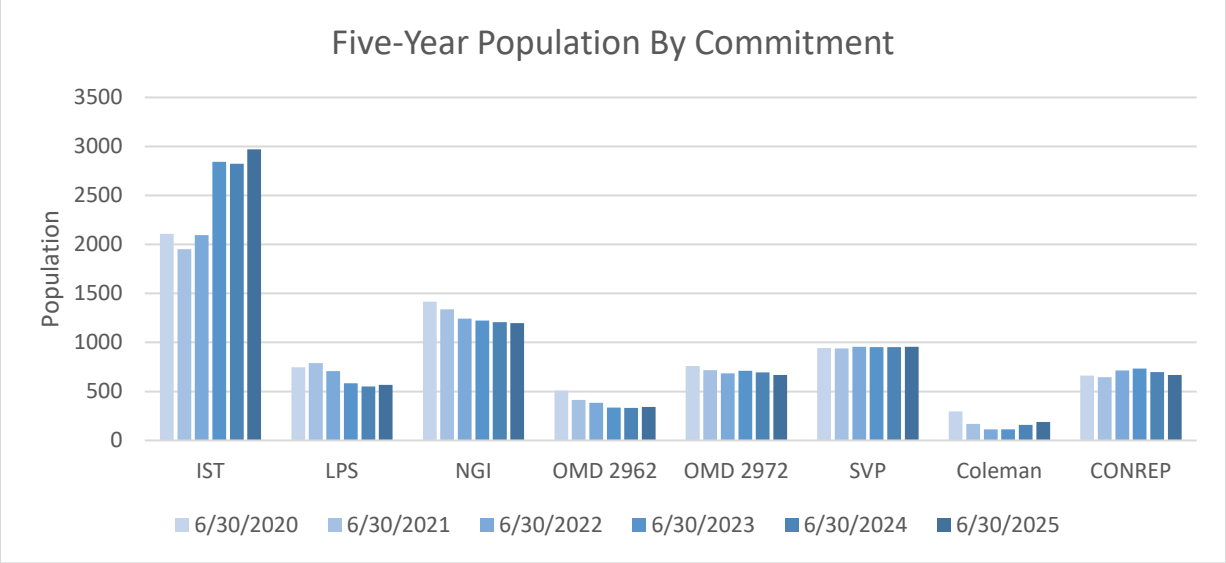
Staffing and Vacancy Rates. Across the five state hospitals, the total vacancy rate was 15.9 percent as of November 1, 2025, a decrease from 20.1 percent on November 1, 2024. The Administration noted that this can be contributed to both increased hiring and retention, and to the elimination of vacant positions pursuant to Control Section 4.12 of the Budget Act of 2024.

Contracted Programs. In addition to the five state hospitals, DSH provides services through contracted Jail-Based Competency Treatment, Community-Inpatient Facilities, Conditional Release Program, Community-Based Restoration, and pretrial felony mental health diversion programs.

Population. The population by commitment and placement are shown in the table below.

DEPARTMENT OF STATE HOSPITALS POPULATION			
Department of State Hospitals 2026-27 Governor's Budget Estimate			
	July 1, 2025 Actual Census	**June 30, 2026 Projected Census**	**June 30, 2027 Projected Census**
POPULATION BY HOSPITAL			
ATASCADERO	1,042	1,112	1,112
COALINGA	1,289	1,289	1,289
METROPOLITAN	793	891	907
NAPA	1,073	1,073	1,073
PATTON	1,319	1,329	1,329
TOTAL BY HOSPITAL	**5,516**	**5,694**	**5,710**
POPULATION BY COMMITMENT - SH			
Coleman - PC 2684	190	260	260
IST - PC 1370	1,589	1,630	1,634
LPS & PC 2974	568	625	625
NGI - PC 1026	1,197	1,201	1,207
OMD - PC 2962	344	347	353
OMD - PC 2972	672	675	675
SVP - WIC 6602/6604	956	956	956
TOTAL BY COMMITMENT	**5,516**	**5,694**	**5,710**

CONTRACTED PROGRAMS			
JAIL BASED COMPETENCY TREATMENT	386	426	426
COMMUNITY BASED RESTORATION/DIVERSION	784	1,073	1,152
COMMUNITY INPATIENT FACILITIES	189	231	231
TOTAL - CONTRACTED PROGRAMS	**1,359**	**1,730**	**1,809**
CONREP PROGRAMS			
CONREP SVP	22	31	31
CONREP NON-SVP	525	637	622
CONREP FACT PROGRAM	30	60	90
CONREP STEP DOWN FACILITIES	86	165	165
TOTAL - CONREP PROGRAMS	**663**	**893**	**908**
POPULATION AND CONTRACTED TOTAL	**7,538**	**8,317**	**8,427**
Total IST Population (State Hospitals, JBCT, CBR, and CIF; excludes CONREP)	**2,948**	**3,360**	**3,442**

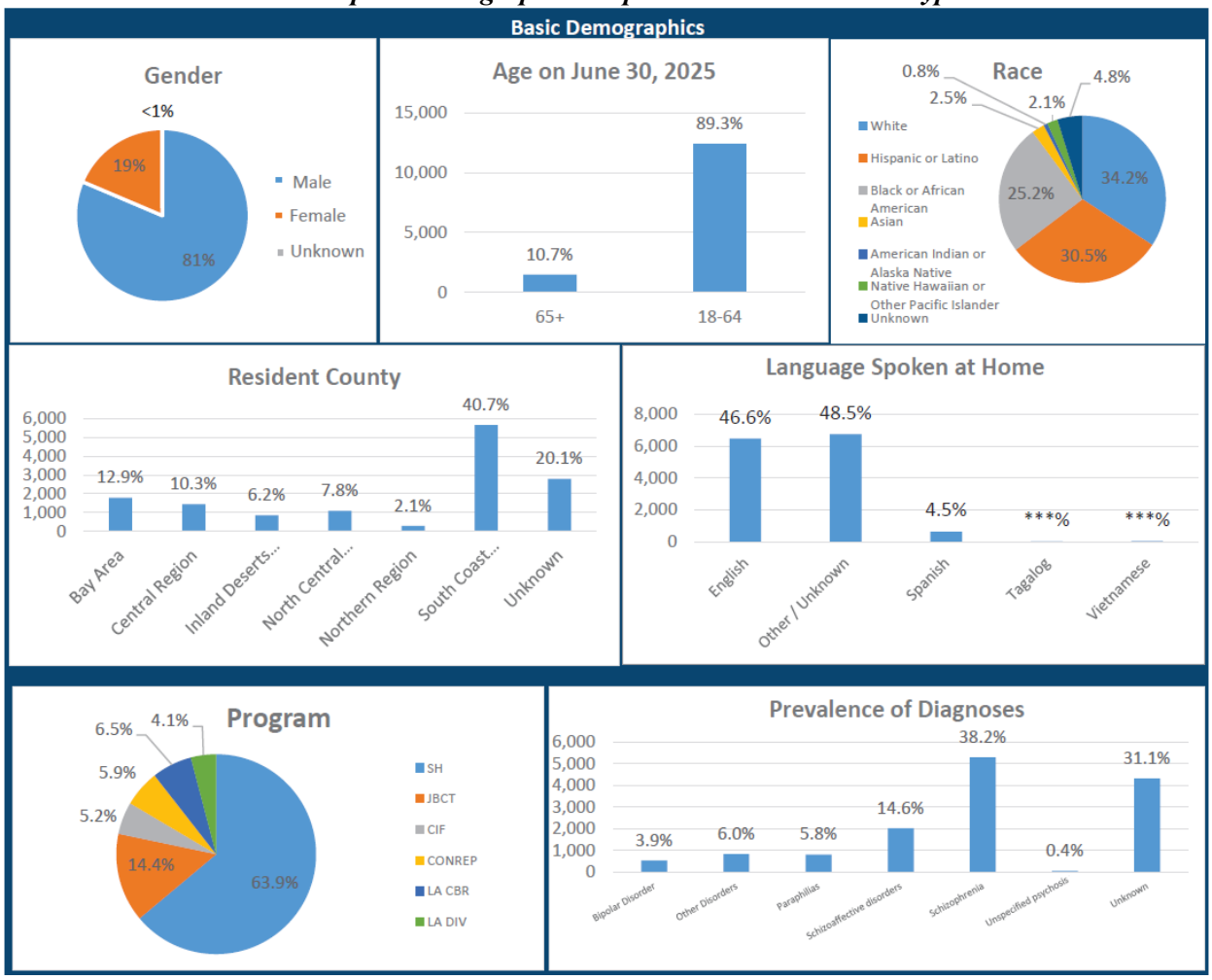


***Source**: 2026-27 Governor's Budget Estimate, Department of State Hospitals, January 2026*[1]

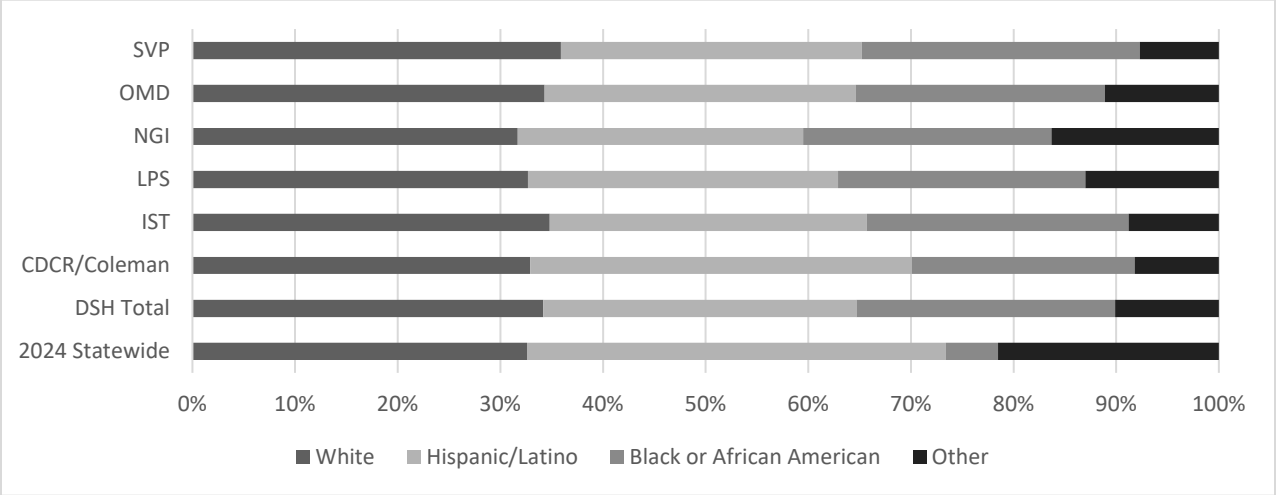
[1] https://www.dsh.ca.gov/About_Us/docs/DSH_2026-27_Governors_Budget_Estimate.pdf

Patient Demographics. As of June 30, 2025, the DSH population across all programs is approximately 81 percent male and 19 percent female, with 89.3 percent of the population between the ages of 18 and 64. Approximately 34 percent identify as White, 25 percent Black, and 31 percent Hispanic. The majority of the DSH population are residents of South Coast and Bay Area counties. Schizophrenia and schizoaffective disorders are the most common diagnoses, accounting for just over half of the population. The following two charts show a demographic summary for the entire population, and racial demographics by commitment type.

State Hospital Demographic Snapshot: All Commitment Types



Racial Demographics by Commitment Type



***Source**: 2026-27 Governor's Budget Estimate, Department of State Hospitals, January 2026*

Program Update – Patient-Driven Operating Expenses and Equipment. DSH uses a standardized methodology to provide funding for patient-related operating expenses and equipment (OE&E), adopted in the 2019 budget and based on the projected census and past year actual expenditures. OE&E categories include utilities, clothing, food, pharmaceuticals, and other population-driven expenses. The proposed budget includes $19 million in 2025-26 and $19.6 million in 2026-27 and ongoing for increased expenses in Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization.

The per-patient cost changes from fiscal year 2022-23 to 2024-25 are shown in the table below. The amount requested was calculated using the increase in per patient cost from 2023-24 to 2024-25 ($3,740), and adjusting for the population level.

Per-Patient Operating Expenses and Equipment Costs

	2022-23	2023-24	2024-25
Utilities	$4,987	$5,132	$5,220
Outside Hospitalization	$8,027	$11,008	$13,460
Foodstuffs	$4,469	$4,705	$4,800
Pharmaceuticals	$7,620	$8,195	$9,300
Total	$25,103	$29,040	$32,780

Program Update – Forensic Conditional Release Program (CONREP) General/Non-Sexually Violent Predator (Non-SVP) Program. The Forensic Conditional Release Program (CONREP) was established in 1986 to provide outpatient treatment to NGI, OMD, and IST patients. Courts may order patients to be released under CONREP if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released. Historically, CONREP has been primarily outpatient treatment, but has expanded to include residential placements in Statewide Transitional Residential Programs (STRPs), and Forensic Assertive Community Treatment (FACT) Programs, which are mobile teams that deliver services to clients at their residences. DSH anticipates a total contracted caseload of 862 in 2025-26 and 877 in 2026-

27. This includes 35 STRP beds, 60 FACT beds in 2025-26 growing to 90 FACT beds in 2026-27, 106 Institute for Mental Disorders (IMD) beds, and 24 Mental Health Rehabilitation Center beds.

The Governor's budget reflects one-time savings of $4.5 million in 2025-26 and $1.7 million in 2026-27 due to the closure of a FACT facility in Sacramento in June 2025, and delayed activation of a new Central CA facility in January 2027. DSH proposes to redirect these one-time savings as outlined below.

DSH proposes to redirect $1.6 million in 2025-26, and provide $2.1 million in 2026-27 and ongoing to support increased costs related with one of the IMD facilities, a 76-bed facility in Southern California operated by Golden Legacy. The recent contract renewal reflects two rate increases that are required by the Department of Health Care Services, and the addition of a full-time psychiatrist dedicated to the program.

DSH proposes to redirect $2.9 million in 2025-26 and $1.7 million in 2026-27 to address increasing cost pressures, including for labor, housing, and medical services, for CONREP providers statewide. DSH will continue monitoring these cost pressures and permanent funding will be considered as a future fiscal request.

Program Update – Contracted Patient Services, Incompetent to Stand Trial (IST) Solutions. The table below shows proposed IST resources in the Governor's budget. DSH reports one-time savings of $114 million in 2023-24 from the reversion of IST infrastructure grant funding, including reverting unobligated dollars and cancelling funding awards for 11 county projects that have not progressed. The proposed budget also reflects savings of $117.8 million in 2025-26 and $94.2 million in 2026-27, reflecting delayed activations and lower population levels for diversion and community-based restoration programs.

2026-27 Governor's Budget IST Resources (dollars in thousands)

Description	FY 2025-26	FY 2026-27	FY 2027-28 and Ongoing
Current Service Level Total	**$634,967**	**$688,722**	**$708,460**
Community Inpatient Facilities	$155,264	$235,063	$205,063
2026-27 Governor's Budget	$0	$0	$0
Re-Evaluation	$12,979	$9,109	$8,958
2026-27 Governor's Budget	$0	$0	$0
IST Solutions	$388,480	$330,135	$391,963
2026-27 Governor's Budget	($117,800)	($94,200)	$0
JBTCT	$78,244	$114,415	$102,476
2026-27 Governor's Budget	$0	$0	$0
TOTAL	**$517,167**	**$594,522**	**$708,460**

IST Waitlist and Court Compliance. DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022, which is now down to 275 as of the Governor's budget. DSH does not anticipate the waitlist to decrease further, as they received an average of 469 referrals per month in 2024-25. DSH is court-ordered to provide substantive treatment services within 28 days of a patient being transferred to DSH's responsibility, effective March 1, 2025. DSH has filed a report to the court demonstrating substantial compliance, which the court is reviewing. Of the individuals on the pending placement list, 149 are already receiving substantive treatment services through Early Access and Stabilization Services or other treatment programs, described below. The easing of pandemic-related restrictions and the

implementation of various IST solutions, including increasing bed capacity, changes to decrease the average length of stay, and implementing community-based and jail-based programs, among others, contributed to DSH reducing the IST waitlist and achieving the court-ordered timelines.

IST Population. DSH experienced two-percent decreases from 2023-24 to 2024-25 in IST patients admitted and served. This reflects small decreases in the IST inpatient population, and increase in the IST outpatient population, as shown in the charts below.

IST Inpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[4]	5,045	4,710	-7%
Patients Served[5]	7,149	6,784	-5%
Average Daily Census	2,233	2,146	-4%

IST Outpatient Data	FY 2023-24	FY 2024-25	Percent Change from Prior FY
Patient Admissions[10]	718	940	31%
Patients Served[11]	1,421	1,608	13%
Average Daily Census	673	832	24%

DSH's IST population is being affected by two recent policy changes: SB 1323 (Menjivar), Chapter 646, Statutes of 2024 and Proposition 36 (2024). SB 1323 provides judges with the authority to determine if restoration of competency is in the interest of justice and if not, to provide longer-term, more comprehensive treatment options with an emphasis on mental health diversion. This may result in fewer felony IST referrals to DSH, as IST individuals are diverted down other pathways. On the other hand, Proposition 36 (2024) changed some misdemeanor drug and theft charges into felonies, which may increase felony IST referrals to DSH. DSH noted that they are continuing to monitor the impact of these policy changes on IST referrals.

Contracted Programs. Some of the contracted programs that contributed to DSH's compliance include:

- *Community Inpatient Facility (CIF)*. DSH currently contracts with five CIF programs for a total of 197 beds throughout California. DSH executed contracts to create a 40-bed program in Fresno County, which activated in March 2026, and a 198-bed program in San Bernardino County, which is anticipated to be activated by Spring 2027.

- *Early Access to Stabilization Services (EASS).* DSH operates 57 EASS programs statewide, which provides treatment and stabilization to individuals deemed IST on felony charges in jail. EASS programs have served a total of 9,234 patients.

- *Community-Based Restoration (CBR) and Felony IST Diversion*. DSH is in the process of developing CBR and Felony IST Diversion programs. As of June 30, 2025, the original 29-county pilot DSH Diversion program ended. As of November 2025, 21 counties have executed contracts with DSH to establish permanent programs and serve up to 1,634 IST patients per year, and six counties have submitted Letters of Intent to establish permanent programs to serve an additional 193 IST patients per year.

- *Jail-Based Competency Treatment (JBCT).* DSH contracts with county sheriffs' departments to operate 433 JBCT beds across 24 counties. JBCT programs provide restoration of competency treatment services to lower acuity IST patients while they are in county jail.

IST Infrastructure Grants. The 2022-23 Budget Act included limited-term infrastructure funding for counties to expand the number of beds available to patients receiving services through a CBR or Diversion program. The 2025-26 Budget Act included a reversion of $232.5 million from 2022-23 that was unspent. The 2026-27 Governor's Budget reflects additional one-time savings of $114 million from fiscal year 2023-24 related to unobligated dollars or funds awarded for 11 county projects that had not progressed. DSH reported that counties had difficulties finding sites and providers, and were dealing with competing behavioral health priorities. Four projects in Butte, Contra Costa, Los Angeles, and San Diego have retained funding. One is completed and the other three are moving forward, for a total of $41.2 million and 439 beds.

Growth Cap. The 2022 budget package also established a county growth cap on IST referrals. If counties exceed the cap, a penalty is assessed, which is returned to the county to be used for upstream efforts to reduce future IST referrals. The number of counties and total penalties are summarized in the table below. DSH reports that most counties are using their funds to focus on post-booking strategies targeting individuals who would be most likely to contribute to their IST population. These include expanding diversion and CARE Court options, hiring dedicated clinicians and doing in-jail pre-IST engagement, funding contingency management and incentives, and/or helping with reentry planning.

County IST Referral Grown Cap Penalties

Fiscal Year	# of Counties Subject to Penalty	Total Assessed (in millions)
2022-23	11	$22.4
2023-24	20	$27.8
2024-25*	18	$26.0

*2024-25 total reflects the initial amount assessed and is subject to update in accordance with any new data received from the counties through the dispute process.

Re-Evaluation Services. DSH also re-evaluates patients who have been placed on the IST waitlist to identify individuals already returned to competency through treatment in jail and/or identify candidates for diversion, involuntary medication orders (IMOs), or other programs or approaches. As of the 2026-27 Governor's budget, DSH has completed a total of 11,094 evaluations, of which 7,262 (65.5 percent) were found not competent and continued competency restoration treatment, 3,610 (32.5 percent) were found restored to competency, and 161 (1.5 percent) were found unlikely to be restored to competency. In addition, less than one percent each were found not competent and returned to the committing court, or were found competent and continued treatment to maintain competency. The 2025-26 Budget Act redirected $6 million in savings from IST solutions to support 23.0 positions (authority only) in 2025-26 and ongoing. 22 of the positions supported the Re-Evaluation Services for Felony IST Program, and one position was to support data collection related to Felony Mental Health Diversion.

April Finance Letter Adjustments. The Administration proposed provisional budget bill language in the April Finance Letters allowing the Department of State Hospitals to shift expenditure authority between

schedules, to provide DSH with flexibility to operate programs. The April Finance Letters also contained a technical correction to the expenditure and encumbrance period for litigation risk special repair project funding, which was not updated in the Governor's proposed budget.

Subcommittee Recommendation—Hold Open.

Questions. The Subcommittee requests DSH respond to the following:

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

2. Please provide a brief overview of each of the program and caseload updates referenced in this item.

3. Please provide an update on the IST population, including progress made in meeting court orders in *Stiavetti v. Clendenin*, and the impact of recent policy changes, including SB 1323 (Menjivar), Chapter 646, Statutes of 2024 and Proposition 36 (2024).

4. Please provide an implementation update on the new system for allocating beds to counties for the LPS and IST Non-Restorable and Maximum Term populations.

Issue 2: Electrical Infrastructure Upgrades at Napa and Patton State Hospitals

Budget Change Proposal – Governor's Budget. The proposed budget includes $9 million one-time General Fund for two electrical infrastructure upgrade projects, including $7.3 million to continue a project at DSH-Napa and $1.8 million to begin a new project at DSH-Patton.

Background. The five state hospitals comprise more than 6.6 million square feet on 1,726 acres of land, and opened an average of 97 years ago. The Administration's proposed five-year infrastructure plan includes $512.3 million ($234.6 million General Fund and $277.8 million Public Buildings Construction Fund) to (1) address electrical, water, and utility plant deficiencies at Atascadero, Metropolitan, Napa, and Patton State Hospitals; (2) provide a skilled nursing facility at Coalinga to address the needs of the aging population; and (3) construct patient housing at Patton.

The Governor's budget proposes $9 million General Fund for the design phases of electrical infrastructure upgrade projects at Napa and Patton State Hospitals. These are the two oldest state hospitals, opened in 1875 and 1893, respectively. Their electrical power systems are decades old, and in need of replacement and upgrades. Upgrading these systems will facilitate ongoing maintenance, help manage peak loads (such as during heatwaves), and provide emergency generator capacity for use during power outages.

Napa Electrical Infrastructure Upgrade. The 2025 Budget Act included $2.8 million one-time General Fund for the preliminary plans phase of this project, which includes upgrading the electrical distribution infrastructure and installing emergency generators. The proposed 2026-27 budget includes $7.27 million in General Fund for the working drawings phase of this project.

Total project costs are estimated at $95.1 million. This is an increase of around $6 million from last year's estimate, which the Administration attributed to omitted overheard costs of $4.6 million and inflation. This includes preliminary plans ($2.8 million), working drawings ($7.3 million), and construction ($85.0 million). The current project schedule estimates preliminary plans will be completed in April 2027. Working drawings are scheduled to begin then and be completed in May 2028. Construction is scheduled to begin in October 2028 and be completed in February 2032.

Patton Electrical Infrastructure Upgrade. This project would upgrade distribution infrastructure, replace obsolete panels and wiring, and install emergency generators to provide auxiliary power at Patton State Hospital and support future campus improvements, including the patient housing project in the five-year plan. The proposed budget includes $1.8 million in General Fund for the preliminary plans phase of this project.

Total project costs are estimated at $61.7 million which includes preliminary plans ($1.8 million), working drawings ($3.4 million), and construction ($56.5 million). The current project schedule estimates preliminary plans to commence July 2026 and be completed in June 2027. Working drawings are scheduled to begin in July 2027 and be completed in April 2029. Construction is scheduled to begin in May 2029 and be completed in March 2032.

Subcommittee Staff Recommendation—Hold Open.

Questions. The Subcommittee requests the Administration respond to the following:

1. Please provide a brief overview of these proposals, and why funding is required this year.

2. Please describe DSH's long-term infrastructure plans for its facilities.

Issue 3: Transitional Housing (SB 380)

Budget Change Proposal – Governor's Budget. The proposed budget includes $469,000 one-time General Fund and two limited-term positions in 2026-27 to conduct an analysis and report to the Legislature on the feasibility of establishing transitional housing facilities for the Conditional Release Program (CONREP) - Sexually Violent Predators (SVP) program, pursuant to SB 380 (Jones), Chapter 581, Statutes of 2025.

Background. SVP commitments are civil commitments of individuals who have completed their prison sentences and are being released, and meet certain criteria under the Sexually Violent Predator Act. These criteria include being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. As a civil commitment, the person must be released from custody once they are no longer deemed a threat to public safety. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

DSH's Conditional Release Program (CONREP) provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing is held to determine if the patient will continue in the program, be sent back to DSH, or be released. The program is available to SVPs with additional requirements, such as 24-hour supervision, intensive treatment, mandated sex offender risk assessments, and GPS tracking, among others.

As of July 1, 2025, there were 22 individuals in the CONREP-SVP program. DSH projects a caseload of 31 persons designated as SVP to be conditionally released into the community as of June 30, 2027. About 5.5 percent of SVP patients at DSH have been granted conditional release. Of these participants, as of December 2025, about 30 percent had their conditional release revoked to ensure community safety, but no participant has perpetrated a sexual contact offense while in CONREP-SVP[2]. In addition, about 43 percent of CONREP-SVP participants have been unconditionally released by the courts from the program.

However, finding suitable community placements for SVPs in their county of domicile is difficult. The average timeframe from petition to placement has increased to 25 months (up from 22 months as of the 2025-26 Governor's budget). Placements are not allowed within a quarter mile of any school, including homeschools, if the person being placed has had child victims. Proximity to other sites including playgrounds, victims and family, and treatment is also considered.

DSH contracts with a provider to vet viable homes for rent, including a site analysis, after which potential placement locations are submitted to DSH for review. After DSH review, a local housing committee is convened where local partners can provide feedback on the potential sites, pursuant to SB 1034 (Atkins), Chapter 880, Statutes of 2022. If a site passes these reviews, the court orders DSH to provide a minimum 30-day notification to local law enforcement and to the public, and public input is collected. Finally, the court holds a hearing to consider public feedback and approve or deny the placement location.

[2] https://www.dsh.ca.gov/Treatment/docs/SVP-Conrep_Fact_Sheet.pdf

SB 380 requires DSH to conduct an analysis on the feasibility of establishing transitional housing facilities as an additional placement option for the CONREP-SVP program and submit a report of the results by January 1, 2027. The required report is consistent with recommendations from the State Auditor in a 2024 report on CONREP-SVP.[3] DSH is requesting $417,000 for two limited-term positions for the 2026-27 fiscal year, including one psychologist for clinical review and expertise, and one health program specialist for project management and analysis. DSH is also requesting $52,000 in operating expenses and equipment, including $20,000 for travel to program sites and to meet with subject matter experts, both within California and out of state.

Subcommittee Staff Comment— This proposal is consistent with the fiscal impact estimated during the policy process.

Subcommittee Staff Recommendation—Hold Open.

Questions. The Subcommittee requests the Administration respond to the following:

1. Please provide an overview of this proposal.

[3] https://www.auditor.ca.gov/reports/2023-130/#recommendations

Issue 4: Dental Care Initiative

Budget Change Proposal – Governor's Budget. The proposed budget includes four permanent positions and $3.9 million General Fund in 2026-27 and $1.1 million General Fund in 2027-28 and ongoing to support dental health services for patients at DSH-Metropolitan and DSH-Patton.

Background. According to DSH, patients residing in state hospitals often exhibit complex medical, psychiatric and cognitive conditions that place them at elevated risk for poor oral health outcomes. Many are unable to maintain routine dental hygiene due to the nature of their illnesses, medication side effects, limited mobility and behavioral challenges.

DSH is requesting $865,000 ongoing for two dental hygienists for DSH-Patton and one licensed dentist and one dental hygienist for DSH-Metropolitan. As shown in the table below, currently each of the five state hospitals has a Chief Dentist and between four and ten other dental staff (including dentists, hygienists, and assistants). DSH-Metropolitan has the fewest staff (five) and the fewest dentists (two, including the Chief Dentist), despite serving the most patients (2,268). DSH-Patton serves the second-most patients (2,203), but its staff of seven does not include any dental hygienists.

Dental staffing and patients served by each hospital in 2023-24

Location	Patients Served	Total Dental Staff	Chief Dentist	Dentist	Dental Hygienist	Dental Assistant	Office Technician
Atascadero	1,876	6	1	2	0	3	0
Coalinga	1,466	11	1	2	1	5	2
Metropolitan	2,268	5	1	1	1	2	0
Napa	1,697	10	1	3	1	5	0
Patton	2,203	7	1	2	0	4	0

DSH's goal is to provide patients with two cleanings per year (although some patients refuse cleanings or may not stay long enough for two cleanings). Generally, DSH hospitals provide at least one to two cleanings per year for patients who do not refuse treatment. However, at DSH-Metro and Patton this is difficult to achieve due to the resource levels and turnover among the IST population. DSH estimates that each hygienist can perform five cleanings per day, which comes out to 1260 per year, so two hygienists can cover a population of roughly 1,300 with two cleanings per year.

The remainder of the proposed resources are for associated equipment and a modular trailer to expand the DSH-Patton dental clinic. Specifically, the proposal includes $322,000 one-time and $269,000 ongoing for operating expenses and equipment, and $2.5 million one-time for construction costs.

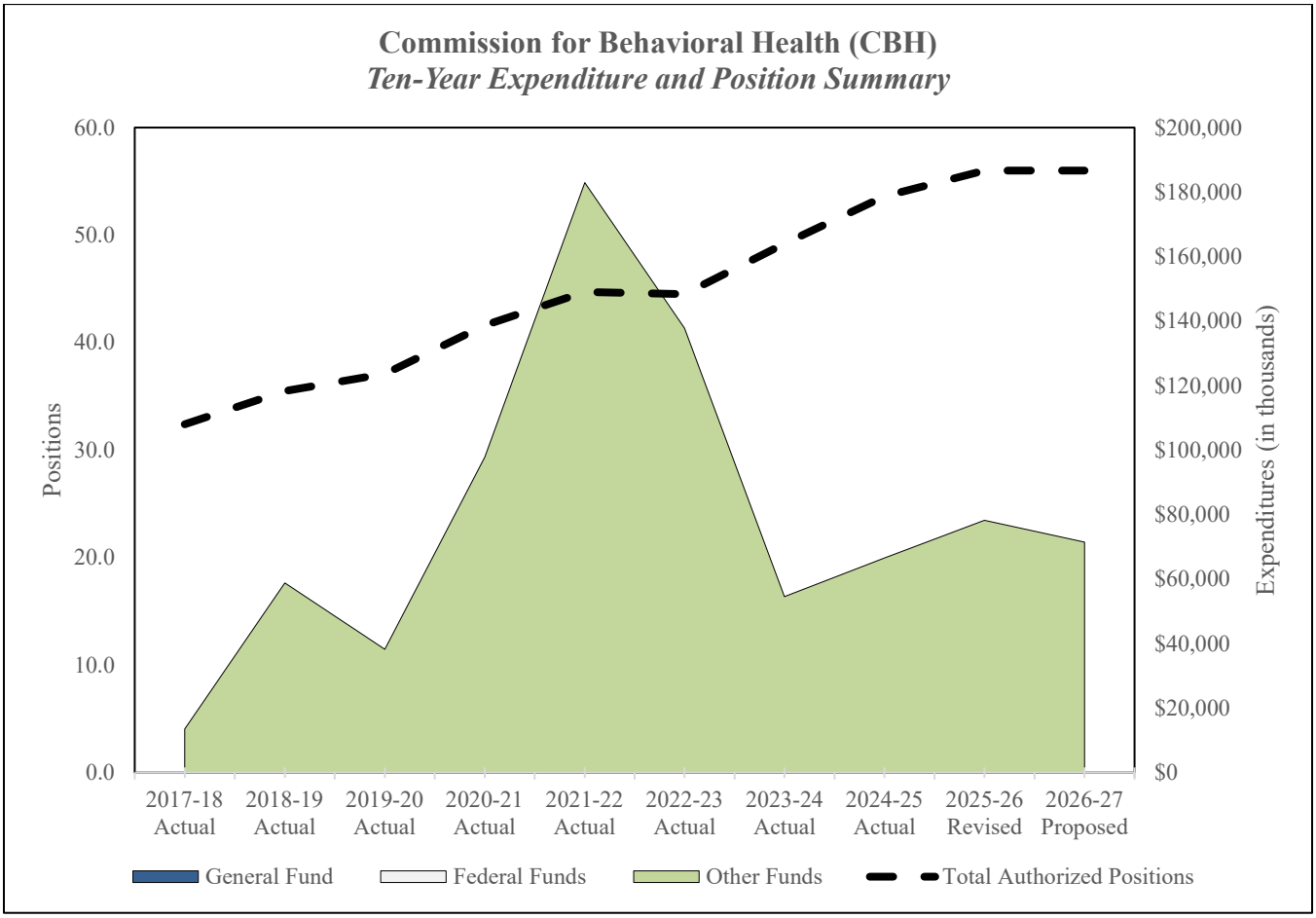
Subcommittee Staff Recommendation—Hold Open.

Questions. The Subcommittee requests the Administration respond to the following:

1. Please provide an overview of this proposal.

4560 COMMISSION FOR BEHAVIORAL HEALTH

Issue 5: Overview



Commission for Behavioral Health - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2024-25 Actual***	***2025-26 Budget Act***	***2025-26 Revised***	***2026-27 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$66,559	$112,161	$78,251	$71,440
Total Department Funding:	**$66,559**	**$112,161**	**$78,251**	**$71,440**
Total Authorized Positions:	**53.6**	**59.0**	**56**	**56**
Other Funds Detail:				
Reimbursements (0995)	*$0*	*$15,000*	*$0*	*$0*
Behavioral Health Services Fund (3085)	*$66,559*	*$97,161*	*$78,251*	*$71,440*

Behavioral Health Services Act. The Behavioral Health Services Act (BHSA), originally established by voters in Proposition 63 in 2004, and updated by voters in Proposition 1 in 2024, imposes a one percent income tax on personal income in excess of $1 million to expand behavioral health services for individuals with, and at risk of, serious behavioral health issues, and their families. The BHSA prioritizes services for people with the most significant needs, supports both mental health and substance use disorder treatment, expands housing interventions, develops the behavioral health workforce, and enhances oversight, transparency, and accountability at the state and local levels.

Commission for Behavioral Health – The Behavioral Health Services Oversight and Accountability Commission. Proposition 63 established the Mental Health Services Oversight and Accountability Commission. After the passage of Proposition 1, the commission was recast as the Behavioral Health Services Oversight and Accountability Commission, referred to as the Commission for Behavioral Health (CBH). The commission promotes transformational change in California's behavioral health system through research, evaluation and tracking outcomes, and other strategies to assess and report progress. The commission uses information and analyses to inform grant making, identify key policy issues and emerging best practices, provide technical assistance and training, promote high-quality programs, and advise the Governor and the Legislature regarding the Behavioral Health Services Act and related components of the behavioral health system.

The commission is composed of 27 members, including people with lived experience, mental health and substance use disorder professionals, county representatives, and state leaders. These members include:

Elected Officials:

- Attorney General, or designee
- Superintendent of Public Instruction, or designee
- Senator selected by the President pro Tempore of the Senate, or designee
- Assemblymember selected by the Speaker of the Assembly, or designee

23 members appointed by the Governor:

- Two persons who have or have had a substance use disorder
- Two persons who have or have had a substance use disorder.
- A family member of an adult or older adult who has or has had a mental health disorder.
- One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or cooccurring disorder.
- A family member of an adult or older adult who has or has had a substance use disorder.
- A family member of a child or youth who has or has had a mental health disorder.
- A family member of a child or youth who has or has had a substance use disorder.
- A current or former county behavioral health director.
- A physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.
- A mental health professional.
- A professional with expertise in housing and homelessness.
- A county sheriff.

- A superintendent of a school district.
- A representative of a labor organization.
- A representative of an employer with less than 500 employees.
- A representative of an employer with more than 500 employees.
- A representative of a health care service plan or insurer.
- A representative of an aging or disability organization.
- A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities.
- A representative of a children and youth organization.
- A veteran or a representative of a veteran's organization.

Innovation Partnership Fund. The BHSA allocates up to $20 million annually from the Behavioral Health Services Fund to support the Innovation Partnership Fund. BHSA requires the commission to use the fund to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorders and practices. The funded innovative programs and practices are required to improve BHSA programs and practices for underserved populations, low-income populations, communities impacted by behavioral health disparities, and other populations determined by the commission.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested CBH to respond to the following:

1. Please provide a brief overview of the Commission's mission and programs.

Issue 6: Behavioral Health Services Act – Innovation Partnership Fund

Legislative Oversight – Behavioral Health Services Act Innovation Partnership Fund. The Behavioral Health Services Act allocates up to $20 million annually from the Behavioral Health Services Fund to support the Innovation Partnership Fund. BHSA requires the commission to use the fund to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorders and practices. The funded innovative programs and practices are required to improve BHSA programs and practices for underserved populations, low-income populations, communities impacted by behavioral health disparities, and other populations determined by the commission.

In developing its framework approach to the Innovation Partnership Fund, CBH held three listening sessions and several meeting of the full commission and various committees. The commission's final approved framework includes the following definitions and requirements:

1) ***What is "Innovative"?*** – To be considered "innovative" for the purpose of the Innovation Partnership Fund, a project must:

   a. Advance new culturally competent models, tools, partnerships, or technologies not yet widely implemented in California, including adopting or scaling efforts underway in other counties
   b. Introduce or scale practical, community-centered solutions (including community-defined evidence-based practices) that increase access to behavioral health treatment and recovery supports, particularly for historically underserved populations and inclusive of harm reduction approaches
   c. Demonstrate a clear break from the status quo, not simply incremental improvements to existing programs or efforts, but a concerted deviation from those efforts
   d. Be actionable and ready for real-world implementation, not solely focused on concepts, research, or pilot testing.

2) ***Eight Core Dimensions*** – All proposals must consider the following eight core dimensions:

   a. *Equity* – Proposals should demonstrate how they will advance equity and close gaps in access, experience, and outcomes for communities historically underserved by the behavioral health system, including communities of color, LGBTQ+ individuals, people with disabilities and substance use disorders, rural residents, and other marginalized by systemic barriers.
   b. *Financial Sustainability* – Proposals should demonstrate a clear, feasible plan for long-term sustainability.
   c. *Public-Private Partnerships* – Proposals should demonstrate how they will collaborate across public, private, and community sectors with explicit benefits to the public system and demonstrating partnerships between government agencies, health systems, technology innovators, philanthropic organizations, community-based providers, and others working together toward shared impact.
   d. *Lived Experience and Community Leadership* – Proposals should demonstrate how they are designed with people with behavioral health conditions and lived experience, and meaningful engagement of individuals, families, and communities who are most directly impacted, through co-design, shared governance, continuous feedback loops, and leadership roles in implementation.

e. *Alignment with Statewide Behavioral Health Transformation Efforts* – Proposals should demonstrate how they will build upon, no duplicate, California's broader behavioral health transformation efforts, including Proposition 1, BH-CONNECT, CalAIM, DMC-ODS, and CYBHI, as well as focus on substance use disorders independently.
f. *Advance Effective Treatment Models* – Proposals should demonstrate how they will invest in new or improved ways of delivering care that address the layered challenges with complex behavioral health needs face, including strengthening county behavioral health systems with the infrastructure and partnerships necessary to coordinate care, apply evidence-based or community-defined evidence practices, to deliver person-centered, integrated, culturally responsive support.
g. *Demonstrate Agility and Quality Improvement Integration* – Proposals should demonstrate agility and a commitment to nimble, quality improvements, including building necessary infrastructure, cultivating a culture of continuous learning, and developing teams that can rapidly iterate, pivot, and operate under a continuous quality improvement philosophy.
h. *Leverage Emerging Technologies* – Proposals should demonstrate innovation, including those that leverage new technologies, improve behavioral health service delivery, bridge silos, and enable providers across the mental health and substance use systems to work together in service of whole-person care for priority populations.

Round 1 Request for Application Released in March. On March 20, 2026, CBH released a request for application (RFA) for Round 1 of funding for the Innovation Partnership Fund. The RFA identified two grant categories available for funding:

1) *Small Grants* – The program will award a minimum of eight grants of less than $500,000 each to community-based organizations, non-profit entities, or tribal organizations.

2) *Large Grants* – The program will award a minimum of three grants of between $500,000 and $5 million to organizations of any size or type.

Grantees will enter into a contract with CBH that will require a workplan within the first 90 days, a semi-annual implementation and outcomes survey for staff and clients, a semi-annual data submission, a semi-annual quality improvement plan, an annual report detailing information about the project, and an annual expenditure summary.

Applications are due to CBH by May 8, 2026, with award announcements anticipated on June 15, 2026. Contracts would begin in July 2026.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested CBH to respond to the following:

1. Please provide a brief overview of the status and implementation of the Innovation Partnership Fund pursuant to Proposition 1.

2. What types of projects is the Commission considering as innovation for the purposes of the Innovation Partnership Fund?

3. With such a low level of resources provided in Proposition 1 for the Innvoation Partnership Fund, compared to the previous MHSA allocations for innovative programs, how does the Commission plan to ensure these resources are able to have the same level of impact as previous innovative programs approved and facilitated by the Commission?

Issue 7: Allcove Youth Drop-In Centers Extension

Reappropriation – Governor's Budget. CBH requests reappropriation of expenditure authority from the Behavioral Health Services Fund of up to $4.1 million, extending the period to liquidate encumbrances until June 30, 2027. If approved, these reappropriated resources would continue to support youth drop-in centers.

Background. In 2018, CBH approved a four-year, $15 million innovation plan for Santa Clara County to launch alcove®, an integrated mental health youth drop-in center designed by youth and for youth. The following year, the 2019 Budget Act included expenditure authority from the Behavioral Health Services Fund of $15 million to support statewide expansion of youth drop-in centers that provide integrated mental health services for individuals between 12 and 25 years of age and their families. In January 2020, the commission allocated $10 million for grants to expand allcove® centers and $4.6 million to contract with the Center for Youth Mental Health and Wellbeing at Stanford to provide implementation support. These resources supported the following applicants:

1) Beach Cities Health District (Los Angeles County)
2) Peninsula Health Care District (San Mateo County)
3) Sacramento County Behavioral Health Services (Sacramento County)
4) University of California, Irvine and Wellness and Prevention Center (Orange County)

Funding available through the Children and Youth Behavioral Health Initiative provided funding for six additional allcove® centers:

1) Chinatown Service Center (Los Angeles County)
2) Coastpride, Inc. (San Mateo County)
3) Pajaro Valley Community Health Trust (Santa Cruz County)
4) Ruby's Place (Alameda County)
5) The Yurok Youth Center (Humboldt County)
6) Yuba County Office of Education (Yuba County)

Reappropriation - Extend Encumbrance and Expenditure Period. CBH requests reappropriation of expenditure authority from the Behavioral Health Services Fund of up to $4.1 million to continue to support youth drop-in centers. According to CBH, these resources were reappropriated to extend expenditure authority until June 30, 2026. However, due to delays in implementing allcove® centers that have received awards, CBH is requesting to extend the period to liquidate encumbrances until June 30, 2027.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested CBH to respond to the following:

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 8: Community Behavioral Health Programs Overview

Funding for Community Mental Health Programs – *Multi-Year Funding Summary*			
Fund Source	**2024-25**	**2025-26**	**2026-27**
1991 Realignment (base and growth):			
Mental Health Subaccount	$559,274,000	$601,420,000	$634,696,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,122,442,000	$1,131,271,000	$1,127,163,000
Behavioral Health Subaccount	$2,248,517,000	$2,355,720,000	$2,421,844,000
Realignment Total	**$3,930,233,000**	**$4,088,411,000**	**$4,183,703,000**
Medi-Cal SMHS Federal Funds	**$4,763,694,000**	**$4,953,752,000**	**$5,439,508,000**
Medi-Cal SMHS State/County Funds	**$3,208,922,000**	**$3,287,325,000**	**$3,568,356,000**
BHSA Local Expenditures	**$3,500,899,000**	**$4,233,132,000**	**$4,159,067,000**
Total Funds	**$15,403,748,000**	**$16,562,620,000**	**$17,350,634,000**

Community Behavioral Health - Overview. California's system of community behavioral health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, which resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Behavioral Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Behavioral Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional behavioral health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

2. **Managed care plans –** SB 1 X1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition

- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

   - Individual and group mental health evaluation and treatment (psychotherapy)
   - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
   - Outpatient services for the purposes of monitoring drug therapy
   - Outpatient laboratory, drugs, supplies and supplements
   - Psychiatric consultation

Background – The Mental Health Services Act (Proposition 63; 2004). In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in five main categories: 1) Community Services and Supports (CSS); 2) Prevention and Early Intervention (PEI); 3) Innovation; 4) Workforce Education and Training; and 5) Capital Facilities and Technological Needs.

The Behavioral Health Services Act – Reforming the MHSA. SB 326 (Eggman), Chapter 790, Statutes of 2023, and AB 531 (Irwin), Chapter 789, Statutes of 2023, made significant changes to the MHSA, with many provisions appearing on the ballot as Proposition 1, approved by voters in March 2024. These changes recast the Mental Health Services Act as the Behavioral Health Services Act (BHSA), revising categories of expenditures for county behavioral health systems with a focus on housing interventions, expanding access to substance use disorder services, increasing transparency in county behavioral health planning, increasing evaluation and reporting on outcomes in the behavioral health system, and realigning oversight responsibilities between state departments and entities. In addition, Proposition 1 authorized $6.4 billion in bonds to construct, acquire, and rehabilitate more than 10,000 new treatment beds and supportive housing units, as well as sites to help serve more than 100,000 people annually.

The BHSA requires county funding to be allocated as follows:

1) *Behavioral Health Services and Supports*. 35 percent of funding must be used for behavioral health services and supports, including early intervention, outreach and engagement, workforce, education and training, capital facilities and technological needs, and innovative pilots and projects.

   a) Early Intervention – A majority, or 51 percent, of behavioral health services and supports funding must be used for intervention in the early signs of mental illness or substance use disorders.
   b) Early Intervention for Children and Youth – A majority, or 51 percent, of early intervention funding must be for children and youth 25 years of age or younger.

2) *Full Service Partnership Programs.* 35 percent of funding must be used for Full Service Partnership programs, including comprehensive and intensive care for people at any age with the most complex needs. The Full Service Partnership model adopts a "whatever it takes" approach to address the health, behavioral health, and other needs of clients.

3) *Housing.* 30 percent of funding must be used for housing, including interventions for rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, and the non-federal share of transitional rent.

    a) Half of this amount, or 50 percent, must be prioritized for housing interventions for the chronically homeless
    b) Up to 25 percent of this amount may be used for capital development.

The BHSA also allows counties to move up to seven percent of funding from one category to another, for a maximum of 14 percent added to any one category. These reallocations allow counties to address local needs and priorities and must be based on data and community input.

Reallocation of County Behavioral Health Funding Has Led Counties to Close Programs. After more than 20 years of county expenditures and programs supported by MHSA and governed by the MHSA expenditure categories, the BHSA added a new housing expenditure category, requiring counties to spend 30 percent of funding on various housing interventions. In addition, the BHSA authorizes the use of funding to support substance use disorder treatment services in addition to the mental health services previously funded by the MHSA. However, the BHSA did not include any additional revenue to support these expanded categories of interventions and services for which county behavioral health departments must provide access to beneficiaries. As a result, county behavioral health departments have been required to reassess the fiscal sustainability of continuing existing county programs that have been funded under the previous MHSA expenditure categories. According to the County Behavioral Health Directors Association, the types of programs that are most at risk include:

- Stigma Reduction
- Community Mental Health and Substance Use Disorder Awareness Programs
- Suicide Prevention Program
- Youth and Transition Age Youth (TAY) Specific Programs
- Underserved and Marginalized Focused Programs
- BIPOC Focused Programs
- LGBTQ+ Focused Programs
- Wellness Centers
- Older Adults/Senior Programs
- Peer Run Wellness Programs
- Veterans Specific Programs
- NAMI Population-Based Prevention Services

For example, San Diego County's Behavioral Health System plans to end the following contracted programs by July 1, 2026:

- Supported Employment Technical Consultants (San Diego Workforce Partnership)
- Fire Captain Ryan J. Mitchell First Responder Behavioral Health Support Program (Pathways Community Services)
- Community Violence Response Team (Union of Pan Asian Communities)
- Family and Adult Peer Support Program (NAMI San Diego)
- Warmline (NAMI San Diego)
- Family Education (NAMI San Diego)
- Next Steps (NAMI San Diego)
- Safe Connections (Neighborhood House Association)
- Behavioral Health and Primary Care Integration Services (Health Quality Partners)
- Come Play Outside (City of San Diego Parks and Rec Dept)
- Mental Health First Aid (Mental Health Association of San Diego County)
- HERE Now (San Diego Youth Services)
- Caregiver Support Services (Southern Caregivers Resource Center)
- Homebound/Positive Solutions (Union of Pan Asian Communities)
- Older Adult PEI Community Based EMASS Program (Union of Pan Asian Communities)
- Vista Hill Smartcare BHCS (Vista Hill Foundation)
- Vista Hill Smartcare Rural (Vista Hill Foundation)
- Courage to Call (MHS)
- Positive Parenting Program (Jewish Family Service of San Diego)
- Just Be U (Urban Street Angels, Inc.)
- ACES Prevention Program for Fathers – North Central (New Alternatives, Inc.)
- ACES Prevention Program for Fathers – South Region (SBCS Corporation)
- ACES Prevention Program for Fathers – North Coastal (Vista Community Clinic)
- ACES Prevention Program for Fathers – Central (Mental Health Association of San Diego County)
- ACES Prevention Program for Fathers – East (Mental Health Association of San Diego County)
- ACES Prevention Program for Fathers – North Inland (New Alternatives, Inc.)
- Youth/Family Support Services (Harmonium, Inc.)
- Faith Based Training (Interfaith Community Services)
- Faith Based Training (Stepping Higher, Inc.)
- Community Harm Reduction Team (Family Health Centers of San Diego)
- Public Mental Health Academy (San Diego Community College District)
- BHS Community Engagement Services (University of California San Diego)
- Media Advocacy Services (Center for Community Research)

Monterey County reports that programs and activities that resulted in 85,135 engagements in 2024-25 will lose their primary source of funding, with total reductions of $6.4 million annually, including the following providers:

- Academy of Cognitive Therapy
- Alliance on Aging
- Applied Crisis Training and Consulting
- CBDIO
- Center for Community Advocacy

- Community Human Services
- Door to Hope
- Family Services Agency
- First 5 Monterey County
- Harmony at Home
- NAMI Monterey County
- Partners for Peace
- Public Consulting Group, LLC
- Monterey County Public Health Bureau
- PVPSA
- Senior Council
- The Epicenter
- The Village Project
- United Way of Monterey County
- University of Southern California
- Zia Partners

Some of these programs may be eligible to receive funding through the BHSA Population-Based Prevention Program administered by the Department of Public Health. However, given these are examples from only two of California's 58 counties, it is likely that the vast majority of these programs, and other similarly situated programs throughout the state, will lose funding entirely as a result of the new BHSA allocations.

Drug Medi-Cal - Overview. The Drug Medi-Cal program covers substance use disorder services by certified providers under contract with the counties or with DHCS. Drug Medi-Cal services are offered by counties either through the State Plan or through the Drug Medi-Cal Organized Delivery System (DMC-ODS), an expanded service delivery model offered under an 1115 Waiver authorized by the federal Centers for Medicare and Medicaid Services (CMS). Drug Medi-Cal provides State Plan services under four primary modalities:

- Narcotic Treatment Program – The Narcotic Treatment Program (NTP) provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.
- Outpatient Drug Free – Outpatient Drug Free (ODF) counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group counseling sessions per month. Counseling and rehabilitation services include: 1) admission physical examinations, 2) intake, 3) medical necessity establishment, 4) medication services, 5) treatment and discharge planning, 6) crisis intervention, 7) collateral services, and 8) individual and group counseling.
- Intensive Outpatient Treatment – Intensive Outpatient Treatment (IOT) services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include: 1) admission

physical examinations, 2) intake, 3) medication services, 4) treatment planning, 5) crisis intervention, 6) collateral services, 7) individual and group counseling, and 8) parenting education.

- Residential Treatment Services – Residential Treatment Services (RTS) provides rehabilitation services to perinatal beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in an effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

DMC-ODS counties, in addition to the four primary modalities, are required to offer the following services: 1) non-perinatal RTS, 2) withdrawal management (levels 1.0, 2.0, and 3.2), 3) recovery services, 4) case management, 5) physician consultation, and 6) expanded medication assisted treatment (buprenorphine, naloxone, and disulfiram). DMC-ODS counties may also offer: 1) additional medication assisted treatment (through non-NTP providers), 2) partial hospitalization, and 3) withdrawal management (levels 3.7 and 4.0).

Behavioral Health Continuum Infrastructure Program. The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million. DHCS announced the BHCIP funding would be released in six rounds, as follows:

- Round 1: Mobile Crisis - $205 million
- Round 2: County and Tribal Planning Grants - $16 million
- Round 3: Launch Ready - $518.5 million
- Round 4: Children and Youth - $480.5 million
- Round 5: Behavioral Health Needs Assessment Phase One - $480 million
- Round 6: Behavioral Health Needs Assessment Phase Two - $480 million

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g. outpatient detox or withdrawal management)
- Intensive outpatient treatment
- Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment
- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for substance use disorders (SUD)
- Adult residential treatment facilities for SUD

- Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)
- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite
- Recovery residence/sober living homes

Funding may also be used for mobile crisis infrastructure.

Proposition 1 – Bond BHCIP. Proposition 1 included a $6.38 billion general obligation bond to develop an array of behavioral health treatment, residential care settings, and supportive housing to help provide appropriate care facilities for individuals experiencing mental health and substance use disorders. $4.4 billion of the bond funding will be used by DHCS for BHCIP competitive grants. On May 12, 2025, Round 1 of Bond BHCIP, focused on Launch Ready projects, awarded 111 infrastructure projects totaling nearly $3 billion to support 4,365 new beds and 23,288 outpatient treatment slots. On March 11, 2026, Round 2 of Bond BHCIP, focused on projects that support unmet needs, awarded 66 infrastructure projects totaling nearly $1.2 billion to support 2,554 new beds and 4,273 new outpatient treatment slots.

Subcommittee Staff Comment—This is an informational item.

Questions. The subcommittee requests DHCS respond to the following:

1. Please provide a brief overview of the significant program changes related to specialty mental health or Drug Medi-Cal services for the 2025-26 and 2026-27 fiscal years.

2. Has the Administration done any tracking or analysis of the local county behavioral health programs that are being defunded or closed entirely due to the reallocations of funding included in the BHSA?

3. How does the department plan to address the loss of reach and capacity represented by the closure of such a large number of local programs? How does the Administration expect the community behavioral health system to address local needs without these programs?

4. House Resolution 1 (H.R. 1), as well as recent actions in the state budget related to individuals with unsatisfactory immigration status (UIS), will lead to a decline in Medi-Cal coverage for individuals with mild-to-moderate behavioral health needs. What planning has the department done to help address individuals with these conditions and prevent decompensation into more acute diagnoses?

5. Has the department estimated the size and scope of the cost shifts to county behavioral health systems of individuals losing coverage through H.R. 1 or the UIS budget solutions?

Issue 9: Behavioral Health Crisis Continuum – 988 and Mobile Crisis Infrastructure

Budget Change Proposal and Trailer Bill Language Proposals – Governor's Budget. DHCS requests eight positions and expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund (988 Fund) of $25.9 million in 2026-27, $25.8 million in 2027-28 through 2029-30, and $4.4 million annually thereafter. If approved, these positions and resources would support increased workload related to 988 and to support 988 Crisis Centers.

DHCS also proposes trailer bill language to establish a process and standard criteria for entities to apply for approval as designated 988 centers, quality standards designated 988 centers must meet to maintain designation, and comprehensive monitoring and oversight of designated 988 centers.

DHCS also proposes trailer bill language to repeal the statewide mobile crisis benefit in Medi-Cal when it is scheduled to expire in April 2027, and instead transition mobile crisis services to a voluntary, county-funded benefit program.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3414 – 988 State Suicide and BH Crisis Services Fund	$25,906,000	$25,834,000
Total Funding Request:	**$25,906,000**	**$25,834,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested 2028-29 through 2029-30: $25,834,000; 2030-31 and ongoing: $4,373,000

Background – 988 and the Behavioral Health Continuum. The National Suicide Hotline Designation Act of 2020 designated 988 as the new three-digit number for the national suicide prevention and mental health crisis hotline. To support the 988 system, the act authorized states to impose a fee on access lines for providing 988 related services. Revenue from the fee must be held in a designated account to be spent only in support of 988 services, including 1) ensuring the efficient and effective routing of calls made to the 988 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and 2) the provision of acute mental health crisis outreach and stabilization by directly responding to the 988 national suicide prevention and mental health crisis hotline.

The Miles Hall Lifeline and Suicide Prevention Act, AB 988 (Bauer-Kahan), Chapter 747, Statutes of 2022, implemented the 988 system in California, establishing 988 as the three-digit number for the National Suicide Prevention Hotline, which is now known as the 988 Suicide and Crisis Lifeline. Among other provisions, AB 988 requires the following:

- Requires the California Governor's Office of Emergency Services (CalOES) to appoint a 988 system director and convene an advisory board to guide how 988 is implemented and made interoperable with 911, including the creation of a new surcharge for 988 to fund the crisis services.
- Requires CalHHS to participate in the State 988 Technical Advisory Board convened by CalOES no less than quarterly until December 31, 2028.
- Requires CalHHS to convene a state 988 policy advisory group to advise on a set of recommendations for the implementation and administration of the five-year implementation plan for the 988 System;
- Requires health plan and insurer coverage of 988 center services when medically necessary and without prior authorization;

- Establishes a 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month, and for years beginning January 1, 2025, at an amount based on a specified formula, but not greater than $0.30 per access line per month;
- States the intent of the Legislature that, by June 30, 2024, CalHHS and CalOES develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services.
- Specifies the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030.

DHCS contracts with an administrative entity, Advocates for Human Potential, to subcontract California's 988 Crisis Centers and provides funding for 988 services through the 988 Fund, which receives revenue from the 988 surcharge, currently set at $0.05 per access line per month. The state's eleven 988 Crisis Centers are as follows:

- Buckelew Programs (Novato)
- Kings View (Fresno)
- Contra Costa Crisis Center (Walnut Creek)
- Crisis Support Services of Alameda County (Oakland)
- Didi Hirsch Mental Health Services (Century City)
- Kern Behavioral and Recovery Services (Bakersfield)
- United Behavioral Health/Optum (San Diego)
- San Francisco Suicide Prevention – Felton Institute (San Francisco)
- County of Santa Clara Behavioral Health Services (San Jose)
- Family Service Agency of the Central Coast (Santa Cruz)
- Wellspace Health (Sacramento)

According to DHCS and the Crisis Centers, California is experiencing significant growth in 988 contact volume as the system has been implemented. At the time of implementation in July 2022, California averaged approximately 33,000 contacts per month. From May 2024 through April 2025, total monthly 988 contacts averaged 52,000, a 57 percent increase. Based on this higher contact volume, DHCS estimates its minimum funding need for 988 Crisis Center operations in 2026-27 would be $32 million from the 988 Fund. Currently, DHCS has a $12.5 million local assistance appropriation for 988 centers. The Crisis Centers report their total funding needs for operations at $105 million.

988 Five Year Implementation Plan. In December 2024, CalHHS released *Building California's Comprehensive 988 System: A Strategic Blueprint*, which was the five year implementation plan for 988 required by AB 988. The plan, developed by the 988 Policy Advisory Group, included a set of Foundational Principles for a comprehensive 988 crisis system:

1) All Californians, regardless of insurance coverage, location, or other factors (including but not limited to age, race, ethnicity, gender, gender identity, disability status, sexual orientation), should have timely access to quality crisis care.

2) Californians should have timely access to 988 through phone, text, and chat 24 hours a day, seven days a week, with contacts answered, whenever possible, in-state by 988 Crisis Centers with knowledge of how to connect with local resources.

3) Individuals in crisis should have access to timely therapeutic and appropriate care (and reduce unnecessary law enforcement involvement where possible).

4) Individuals seeking help should be connected to a crisis care continuum that prioritizes community-based support and focuses on preventing further crises and trauma.

The plan also made the following recommendations in four main categories:

Goal A: Increase Public Awareness of and Trust in 988 and Behavioral Health Crisis Services

- *Recommendation A1.* Coordinate statewide behavioral health crisis communications strategies informed by the 988 Suicide and Crisis Lifeline and Substance Abuse and Mental Health Services Administration (SAMHSA)

- *Recommendation A2.* Engage key partners in developing and disseminating statewide and regional communications strategies regarding behavioral health crisis services including 988 and other support lines (e.g. 211, County Access Lines, CalHOPE Red Line, and other Warm Lines)

- *Recommendation A3.* Monitor the success and impact of communications strategies.

Goal B: Establish the Systems, Inclusive of Technology, Policies, and Practices, To Connect Help Seekers to the Appropriate Call/Chat/Text Takers

- *Recommendation B1.* Support the technology to route 988 contacts safely and efficiently anywhere in California, including to mobile crisis dispatch.

- *Recommendation B2.* Promote coordination and communications across state technology implementation partners to ensure alignment of technology, policy, and practice.

Goal C: Support the 988 System in Delivering a High-Quality Response

- *Recommendation C1.* Support 988 Crisis Centers in meeting current national standards in preparation for meeting future statewide standards and California's vision for a comprehensive crisis care continuum.

- *Recommendation C2.* Building on national standards and best practices to ensure trauma-informed, person-centered, and culturally responsive care, establish state-specific standards for staffing and training to equip 988 Crisis Centers to respond to suicide, mental health, and substance use-related 988 contacts.

- *Recommendation C3.* Establish a process to review, designate, and re-designate California 988 Crisis Centers.

Goal D: Increase Coordination of Behavioral Health Crisis Services

- *Recommendation D1.* Coordinate state, tribal, county, and regional behavioral health along with payers, providers, and cross-sector partners to connect individuals in behavioral health crises to immediate and ongoing care.

- *Recommendation D2.* Support connection, coordination, and referrals of 988 help seekers to timely and effective community-based, culturally responsive crisis response, including mobile crisis dispatch, when appropriate.

- *Recommendation D3.* Continue to assist communities in expanding the range of facilities and services to individuals before, during, and after a behavioral health crisis.

- *Recommendation D4.* Develop more options or expand existing options for transporting individuals in crisis to a safe place to be.

Cross Cutting Recommendations – Equity, Funding and Sustainability, Data and Metrics, and Peer Supports

- *Equity.* Prioritize inclusion and equity in crisis care service delivery for populations that may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and/or need adaptive/tailored services for equitable access due to physical, intellectual/developmental disability, or unique cultural and/or linguistic needs.

- *Funding and Sustainability.* Continue to implement strategies to support sustainable crisis systems at the local level that are connected to broader behavioral health transformation efforts, including behavioral health parity.

- *Data and Metrics.* Establish data systems and data standards to support monitoring of 988 and the behavioral health crisis care continuum's performance.

- *Peer Supports.* Integrate peer support across the crisis care continuum to support person-centered, culturally responsive, and recovery-oriented care.

Background – Community-Based Mobile Crisis Response. Section 9813 of the federal American Rescue Plan Act of 2021 authorizes state Medicaid programs to provide qualifying community-based mobile crisis intervention services for a period of up to five years, beginning April 1, 2022, and ending March 31, 2027. States that implement the mobile crisis intervention benefit receive an 85 percent federal match for reimbursement of these services for the first three years of the five year period. The 2022 Budget Act authorized DHCS to implement this benefit in the Medi-Cal program beginning January 1, 2023.

Mobile crisis intervention services are intended to provide rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals with behavioral health conditions. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes three core components of a robust crisis system: 1) a 24 hour clinically staffed call center that can serve as a the hub of an integrated mental health crisis system, 2) mobile crisis response teams that can respond rather than law enforcement, and 3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments.

The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources as part of the Behavioral Health Continuum Infrastructure Program (BHCIP). Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million.

According to CalHHS, as of September 2024 the state had funded more than 450 Crisis Care Mobile Units (CCMU) through BHCIP. As of December 2024, 48 counties were approved to provide mobile crisis services under the Medi-Cal Mobile Crisis benefit, covering 98 percent of Medi-Cal members statewide. When the enhanced federal match under the American Rescue Plan Act expires at the end of March 2027, DHCS is proposing to transition the Medi-Cal Mobile Crisis benefit to a voluntary, county-funded service.

Staffing and Resource Request. DHCS requests eight positions and expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund (988 Fund) of $25.9 million in 2026-27, $25.8 million in 2027-28 through 2029-30, and $4.4 million annually thereafter to support increased workload related to 988 and to support 988 Crisis Centers. Specifically, DHCS requests the following:

State Operations

Medi-Cal Behavioral Health Policy Division – Seven positions and contract funding of $5 million through 2029-30 and $3 million annually thereafter

- **One Supervisor II** position would serve as a section chief for 988 Crisis Services, providing strategic leadership over policy, operations, and compliance with state and federal requirements.

- **One Supervisor I** position would have supervisory responsibility over the unit's workload and analytical staff, and would be responsible for project managing 988 administrative and policy activities related to 988 staffing and training standards, 988 Crisis Center and 988 counselor performance, compliance and corrective actions, data collection and reporting, budgeting procedures for 988, and admitting prospective 988 Crisis Centers to the network.

- **One Health Program Specialist II** position would serve as a highly specialized expert program advisor and program consultant to support implementation of policy recommendations related to 988 staffing and training standards, 988 Crisis Center and 988 counselor performance standards,

compliance and corrective actions, data collection and reporting, budgeting procedures for 988, and admitting prospective 988 Crisis Centers to the network.

- **One Health Program Specialist I** position would perform detailed coordination and supportive project management functions related to the development of 988 staffing and training standards, 988 Crisis Center and 988 counselor performance standards, compliance and corrective actions, data collection and reporting, budgeting procedures for 988, and admitting prospective 988 Crisis Centers to the network.

- **Three Analyst II** positions would conduct research related to 988, draft process and procedure guidance documents related to the development of 988 staffing and training standards, 988 Crisis Center and 988 counselor performance standards, compliance and corrective actions, data collection and reporting, budgeting procedures for 988, and admitting prospective 988 Crisis Centers to the network. The positions would also facilitate meetings, review and analyze documents and data, provide recommendations to management, collaborate with stakeholders, and provide analytical and administrative support to the unit.

- Contract resources of $3 million 988 Fund annually would support a contract with the California 988 Network Administrative Entity, which would subcontract with and provide direct funding to 988 Crisis Centers, serve as project manage for California's 988 Network, provide training and technical assistance, collect and analyze 988 Crisis Center data, develop reporting and implementation plans, and implement a comprehensive statewide communication strategy.

- Contract resources of $2 million 988 Fund annually between 2026-27 and 2029-30 would support a contractor to support the development of 988 Crisis Center application policies, procedures, and toolkits, and provide expertise and guidance on the development of statewide 988 Crisis Center application policies and procedures.

Office of Legal Services – One position

- **One Attorney III** position would provide comprehensive legal support as DHCS implements 988, interpret and apply state and federal statutes and regulations, assist with program policy development, develop and review legal instruments, draft standards concerning the designation of 988 centers, support oversight and monitoring activities, and take enforcement actions.

Local Assistance

988 Network Administrative Entity - $19.5 million 988 Fund annually between 2026-27 and 2029-30

- Contract resources of $19.5 million 988 Fund annually between 2026-27 and 2029-30, in addition to the existing $12.5 million 988 Fund in ongoing authority, would support a local assistance contract for 988 Crisis Center operations. Based on current volume for 988 calls, chats, and texts, and related 988 Crisis Center staffing level recommendations to meet new federal 988 Network requirements published in April 2024.

Trailer Bill Language Proposal – 988 Call Centers. DHCS also proposes trailer bill language to establish a process and standard criteria for entities to apply for approval as designated 988 centers, quality standards designated 988 centers must meet to maintain designation, and comprehensive monitoring and oversight of designated 988 centers.

Trailer Bill Language Proposal – Community-Based Mobile Crisis Response. DHCS also proposes trailer bill language to repeal the statewide mobile crisis benefit in Medi-Cal when it is scheduled to expire in April 2027, and instead transition mobile crisis services to a voluntary, county-funded benefit program.

Panel Discussion. Given the significant changes to the behavioral health crisis continuum proposed by the Administration related to both 988 and mobile crisis services, the subcommittee has requested the following panelists to offer their insights on these issues and the Administration's proposals:

- **Elise Jones**
  Director
  Lake County Behavioral Health Services

- **Nadia Privara Brahms**
  Director
  Behavioral Health Services, County of San Diego

- **Emily Allison, MSW**
  Chief Strategy Officer
  Seneca Family of Agencies

- **Dr. Jana Lord**
  Chief Operating Officer
  Sycamores

- **Matthew Taylor**
  Senior Director of Crisis Line Operations
  Didi Hirsch Mental Health Services, Los Angeles

- **Narges Dillon**
  Executive Director
  Crisis Support Services of Alameda County

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS and panelists to respond to the following:

DHCS:

1. Please provide a brief overview of the proposals and the associated trailer bill language related to 988 and Community-Based Mobile Crisis Response.

2. What role does the department envision for the 988 system and the mobile crisis benefit in the overall continuum of behavioral health crisis services?

3. Does the Administration have any plans to create a mechanism to reimburse for mobile crisis services within the 988 system, consistent with the intent of the 988 statute?

4. How does DHCS coordinate with CalOES to determine the level of call center funding needs?

5. Has the department performed any analysis or fiscal estimates of the potential impacts of loss of the statewide mobile crisis benefit on emergency departments, psychiatric hospital admissions, and justice-involvement? In particular, what is the potential size and scope of increased expenditures in the Medi-Cal program and at the county level from higher acuity utilization of services due to the unavailability of mobile crisis services?

6. What transition planning has the department undertaken for individuals and communities that rely heavily on the mobile crisis benefit and may no longer have access if a county is unable to continue funding the benefit?

7. What type of geographic disparities in access to mobile crisis services would the department expect if the Legislature were to approve the Administration's proposed transition to a voluntary, county benefit?

County Behavioral Health Departments:

8. Please provide a brief overview of how your county behavioral health department manages the provision of the mobile crisis benefit, including any available statistics on number of mobile crisis teams, referrals received, deployments to address behavioral health crises, and any information on outcomes of those encounters.

9. How has your county benefitted from the state investment in mobile crisis infrastructure included in the Behavioral Health Continuum Infrastructure Program (BHCIP)? What was the amount of the award and what types of mobile crisis infrastructure did that award support?

10. How is the mobile crisis benefit integrated with the 988 system in your county? How are 988 calls that constitute a behavioral health crisis referred for a mobile crisis response?

11. If the Legislature approves the Administration's proposal to transition the mobile crisis benefit to county responsibility, how would this transition impact your county's ability to provide this benefit? How would the broader behavioral health system be impacted, including utilization of emergency departments or other services, justice-involvement, educational impacts, etc.?

12. What reforms or budget actions should the Legislature consider to create a comprehensive continuum of behavioral health crisis response capacity throughout the state?

Mobile Crisis Providers (Seneca and Sycamores):

13. Please provide a brief overview of the mobile crisis services you provide in California.

14. What is the most common referral mechanism for deployment of one of your mobile crisis teams to a behavioral health crisis? How, if at all, are your services integrated into the 988 system?

15. (*for Seneca*) How does the availability of mobile crisis services help children and youth experiencing behavioral health crises avoid more serious adverse outcomes, including justice-involvement, family issues, or negative educational impacts?

16. (*for Seneca)* How are your mobile crisis service integrated with the Family Urgent Response System (FURS) to provide support to foster youth and their families? What would be the impact of loss of the Medi-Cal mobile crisis benefit on your ability to serve this population?

17. (*for Sycamores*) How does the availability of mobile crisis services help deescalate and support adults experiencing behavioral health crises in the community?

18. (*for Sycamores)* How would the loss of the Medi-Cal mobile crisis benefit impact outcomes for adults experiencing behavioral health crises, including emergency department utilization, justice-involvement, and other impacts?

19. What reforms or budget actions should the Legislature consider to create a comprehensive continuum of behavioral health crisis response capacity throughout the state?

Crisis Line Providers:

20. Please provide a brief overview of the crisis line services you provide through the 988 system, including trends in call/text volumes, modes of crisis response (e.g. phone support, referrals, mobile crisis, etc.), the types of support provided by staff members who answer 988 calls/texts, and any available information or evidence regarding outcomes?

21. What are the primary funding sources for your crisis line services? How well does this level of funding support the work that you do?

22. How does availability of behavioral health crisis support through the 988 system help impact the broader community, including the health and behavioral health system (e.g. emergency department and other high-acuity utilization), the justice system, and the educational system?

23. How do your crisis line staff manage follow-up services for individuals who need additional support for a behavioral health crisis? Are you able to make referrals for a mobile crisis response and, if so, how often does that occur?

24. In your view, how well is the state performing in meeting and implementing the goals in the Five Year 988 Implementation Plan?

25. What reforms or budget actions should the Legislature consider to create a comprehensive continuum of behavioral health crisis response capacity throughout the state?

Issue 10: Behavioral Health Services Act Revenue and Stability

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to implement reforms to the Behavioral Health Services Act to reduce revenue volatility and ensure appropriate local prudent reserve levels to support the sustainability of county programs and services, pursuant to the requirements of SB 326 (Eggman), Chapter 790, Statutes of 2024, approved by voters as Proposition 1 (2024).

Background. The Mental Health Services Act, approved by voters as Proposition 63 (2004), imposes a one percent tax on personal income in excess of $1 million. Proposition 63 utilized this revenue to support mental health services at the state and county level. The Behavioral Health Services Act (BHSA), SB 326 (Eggman), Chapter 790, Statutes of 2024, approved by voters as Proposition 1 (2024), expanded the use of these funds to support behavioral health services, or both mental health and substance use disorder treatment.

The implementation of the one percent tax on million-dollar incomes has resulted in significant year-over-year variations in revenue received to support behavioral health services. Similar to how the state's highly progressive personal income tax structure is subject to volatility based on economic conditions, particularly among the state's wealthiest taxpayers, this tax on the very highest earners in the state experiences even greater volatility than the state's tax structure. As a result, the BHSA required DHCS to establish a BHSA Revenue Stability Workgroup to assess year-over-year fluctuations in tax revenues, to develop and recommend solutions to reduce volatility, and to propose appropriate prudent reserve levels to support the sustainability of count programs and services.

BHSA Revenue Stability Workgroup Recommendations. In May 2025, the BHSA Revenue Stability Workgroup released its recommendations to reduce the variance of county BHSA funds. These recommendations were as follows:

4) *Minimum Expenditure Level* – Each county would be required to maintain an annual minimum expenditure level based on historical BHSA revenue distribution data and a three-year trailing weighted average with an annual inflationary adjustment of four percent. Counties would be required to spend at least the minimum expenditure level annually on BHSA programs, consistent with the local Integrated Plan or Annual Update. Counties could reduce their minimum expenditure level amounts if forecasted local assistance revenue is less than the minimum expenditure level.

5) *Reduction in Prudent Reserves* – Each county would be required to reduce their local prudent reserve to a maximum of 10 percent for medium and large counties (more than 200,000 population) and 15 percent for small counties (less than 200,000 population) of the average of the total BHSA or MHSA funds distributed to the county in the preceding five years. Counties would be required to implement a one-time decrease of their prudent reserve to align with the lower maximum levels.

Trailer Bill Language Proposal – Behavioral Health Services Act Revenue and Stability. DHCS proposes trailer bill language to implement reforms to the Behavioral Health Services Act to reduce revenue volatility and ensure appropriate local prudent reserve levels to support the sustainability of county programs and services, pursuant to the requirements of SB 326 (Eggman), Chapter 790, Statutes of 2024, approved by voters as Proposition 1 (2024).

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this trailer bill language proposal.

2. How does a reduction in the prudent reserve level for counties help address volatile revenues, when in the larger state budget context, volatile revenues generally are addressed with larger reserves?

3. Why is the minimum expenditure level calculated on the previous three years, rather than a longer trend analysis? Given the volatility of BHSA revenue, would a longer trend analysis be more appropriate to smooth out the year-over-year fluctuations?

4. How would counties be permitted to utilize excess BHSA revenue they receive above their minimum expenditure levels?

5. What would be the process for counties to access their new, lower prudent reserves if BHSA revenue were lower than their minimum expenditure levels? How would counties address such a shortfall under the framework of these proposed changes?

Issue 11: Aligning Evidence-Based Standards for Substance Use Disorder Treatment

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to align state standards for substance use disorder treatment facilities licensed or certified by the department with current, evidence-based standards of care, and update outdated clinical terminology in state law.

Background. According to DHCS, state law requires payers of substance use disorder treatment services to align with evidence-based treatment guidelines, specifically the American Society of Addiction Medicine (ASAM) Criteria. In addition, the requirement for Medi-Cal providers to align with ASAM Criteria is also memorialized through waiver requirements, policy guidance, and Medi-Cal managed care contracts. For commercial health plans, the requirement is memorialized through all plan letters and regulations administered by the Department of Managed Health Care (DMHC).

New ASAM Criteria Released in 2023. In 2023, ASAM released its latest ASAM Criteria, 4th Edition, with several changes to clinical guidelines. DHCS reports it will be implementing corresponding updates to state standards for licensed and certified substance use disorder treatment facilities and Medi-Cal policy documents. Among these changes were the following:

6) Level 3.2 Facilities – The ASAM Criteria 4th Edition formally eliminates Level 3.2 licensed residential facilities, the level of care previously known as "Clinically Managed Residential Withdrawal Management", from its clinical guidelines. According to DHCS, ASAM concluded that withdrawal management should not exist as a standalone residential level of care, but rather as a service integrated within the continuum of care. DHCS is proposing to eliminate the existing licensure type for standalone detoxification residential facilities, effective July 1, 2027, to align with the new ASAM standards.

7) "Detoxification" Renamed "Withdrawal Management" – The ASAM Criteria 4th Edition also updates the term "detoxification" to "withdrawal management". DHCS is proposing to replace outdated references to "detoxification" in state statute with "withdrawal management" to align with ASAM standards.

Trailer Bill Language Proposal – Aligning Evidence-Based Standards for Substance Use Disorder Treatment. DHCS requests trailer bill language to align state standards for substance use disorder treatment facilities licensed or certified by the department with current, evidence-based standards of care, eliminating a licensure category for residential facilities no longer clinically recognized, and updating outdated clinical terminology in state law. Specifically, the trailer bill language proposal would:

- Require DHCS to adopt regulations by January 1, 2030, and make technical updates to DHCS' authorization to implement the minimum standard of care provided by licensees by means of information notices until regulations are adopted.
- Remove detoxification services as a standalone license.
- Authorize a licensee to provide detoxification services only until June 30, 2027.
- Prohibit DHCS from issuing a new license to provide detoxification only services and not extend an existing license to provide detoxification only services after June 30, 2027.

- Amend alcohol and other drug (AOD) certification statutes to incorporate the term "withdrawal management services" in place of "detoxification."
- Amend narcotic treatment program (NTP) statutes to incorporate the term "withdrawal management services" in place of "detoxification.

According to DHCS, there are currently six facilities in California that possess the licensure that would be eliminated under this proposal. These facilities would have at least one year to transition to new services, including offering recovery treatment and withdrawal management.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this trailer bill language proposal.

PROPOSALS FOR INVESTMENT

Issue 12: Proposals for Investment

Proposals for Investment. The subcommittee has received the following proposals for investment:

- **Protect Statewide Medi-Cal Community-Based Mobile Crisis Services.** A coalition of behavioral health organizations, including the County Behavioral Health Directors Association, NAMI-CA, the Steinberg Institute, and the CA Alliance of Child and Family Services, request General Fund expenditure authority of $30 million to $42.2 million in 2026-27 and $168 million annually thereafter to support continuation of the statewide Medi-Cal Community-Based Mobile Crisis benefit. In the January budget, Governor Newsom proposed to remove state funding for statewide mobile crisis response. This proposal would undermine the program's solid foundation, jeopardizing California's progress at a time when community-based mobile crisis response is more essential than ever. This proposal also comes amid significant fiscal and structural changes, as counties navigate the implementation of, among other things, H.R. 1, BH-CONNECT, Bond BHCIP, and the Behavioral Health Services Act, and face new fiscal pressures. Removing state support would shift the financial responsibility for mobile crisis costs to counties, resulting in counties needing to scale back or completely eliminate their local crisis response programs. The loss of state funding would fundamentally alter the state's approach to mobile crisis response.

- **Increase 988 Funding to Meet Growing Demand.** The 988 California: Crisis Center Consortium requests expenditure authority from the 988 Fund of $105 million annually. If approved, these resources would support additional staffing for 988 centers. According to the Consortium, current funding is inadequate to meet the increase in 988 demand for calls and texts to support California's behavioral health crisis needs. Some 988 centers have seen call volume growth of 30 percent in 2025 on top of prior year increases. The 2025 Budget Act included a one-time appropriation of $17.5 million on top of its ongoing 988 local assistance spending authority of $12.5 million, acknowledging that 988 centers are woefully underfunded. Previous and present funding supports centers to answer most, but not all, 988 calls and only a low percentage of 988 chats and texts. In calendar year 2025, 87 percent of California's 988 calls were answered by the eleven 988 centers, but only 33 percent of chats and texts could be answered. The rest of the contacts flowed into 988's national backup network. Californians in crisis deserve to answered by in-state local 988 centers that are familiar with their community and local resources, including mobile crisis services, warm lines, respite programs, emergency shelter care, EMS, crisis stabilization units and recovery services.

- **Returning the California Peer-Run Warm Line/CalHOPE to 24/7 Operation.** The Mental Health Association of San Francisco requests expenditure authority from the Behavioral Health Services Fund of $6.5 million in 2026-27, $7.1 million in 2027-28, and $7.4 million annually thereafter to support a return to 24 hour a day, seven days a week availability of preventive services, including bilingual and culturally competent staff, provide through the California Peer Run Warm Line/CalHOPE. According to the Association, the California Peer Run Warm Line (WL/CalHOPE) is a preventive peer model that significantly mitigates inequitable mental health access across the state. In 2024-25, the WL operated 24 hours a day, seven days a week, and served over 250,000 calls, with 37 percent of callers needing culturally competent, Spanish-speaking peer support. In 2025-26, the state cut funding to the

point that WL/CalHOPE is only operating 5 days a week, 7 am-11 pm, with less than 30 percent of calls handled after 150 staff positions were eliminated. The problem is that WL/CalHOPE needs to return to 24 hours a day, 7 days a week. Support is needed not only during the workweek. The funds from this budget request will provide 24 hours a day, seven days a week access, bilingual staff, and non-clinical, peer-led mental health support to California's high-service-demand populations with low-clinician supply. According to a recent report by the California Department of Health Care Access and Information, of the landscape "In 2025, all 58 counties [faced] a shortage across all behavioral health roles examined, with the most severe shortages in the Northern and Sierra, Inland Empire and San Joaquin Valley regions, as defined by the California Health Interview Survey (CHIS)."

In California, the ratio of Spanish-speaking patients to Spanish-speaking hospital providers is approximately 33.5 to 1, slightly worse than the national ratio of approximately 30 to 1. A projected 22 California counties may face a shortage of over 50 percent in non-prescribing licensed clinicians. This equates to a 40.6 percent shortage in 2025, requiring more than 55,000 additional providers. By 2033, the shortage is projected at 42 percent, requiring 171,000 providers to meet demand.

This budget request supports the WL/CalHOPE, providing low-barrier, readily available mental health access to Californians before their situation escalates to a crisis. This preventative pre-crisis approach saves lives and saves money, providing time-sensitive support through human connection while avoiding more expensive crisis and emergency services, as part of a system already stretched thin. Of current WL/CalHOPE users surveyed across the state, over 77 percent believe that using the line decreases the likelihood that they will call more costly crisis services such as 911, suicide prevention, or a hospital. These are people calling before a crisis, which means fewer ER visits, fewer psychiatric holds, and fewer costs passed on to counties and the state. The benefits come full circle. The line's mental health peer counselors on the answering end of the calls continue to thrive, also through meaningful, paid employment, allowing those with lived mental health experiences to join or return to the workforce.

- **Parents Anonymous Statewide Parent and Youth Helpline.** Parents Anonymous request annual General Fund expenditure authority of $5 million to support the Parents Anonymous Statewide Parent and Youth Helpline. According to Parents Anonymous, many parents and caregivers of children and youth lack access to timely, culturally responsive, and evidence-based support services, especially during moments of crisis. This gap contributes to increased risk of child abuse and neglect, family instability, and avoidable entry into higher-cost public systems such as child welfare, emergency services, and behavioral health care. Current systems are often fragmented, difficult to navigate, and not designed to provide immediate, family-centered support.

  This budget request seeks to expand and sustain the core programming of Parents Anonymous, including:

  - 24 hours a day, seven days a week access to trained Master's Level Clinicians through a statewide helpline and virtual platforms utilizing evidence-based practices
  - Weekly evidence-based support groups for diverse parents, children, and youth
  - Expansion of culturally responsive and linguistically appropriate services to underserved communities
  - Integration of lived-expertise peer support into existing health and human services systems

- Workforce development and training to scale the Parent Partner model statewide

These programmatic enhancements directly address barriers to access by providing immediate, stigma-free, and community-based support. The Parents Anonymous model emphasizes early intervention and prevention, helping families stabilize before challenges escalate into crises. By offering culturallyresponsive, evidence-based emotional support and groups, families are better equipped to manage stress, strengthen protective factors, and reduce reliance on more intensive and costly interventions. Integrating these services into broader systems ensures continuity of care and expands reach.