

California Behavioral Health Planning Council

Legislation and Public Policy Committee Quarterly Meeting

October 15, 2025
Meeting Minutes

Members Present:

Barbara Mitchell, Chairperson

Javier Moreno, Chair-Elect

Karen Baylor
Jason L. Bradley
Monica Caffey
Erin Franco
Ian Kemmer
Catherine Moore
Noel O'Neill
Liz Oseguera

Danielle Sena
Daphne Shaw
Deborah Starkey
Tony Vartan
Susan Wilson
Milan Zavala
Uma Zykofsky

Staff Present: Jenny Bayardo, Maydy Lo, Naomi Ramirez

Agenda Item: **Welcome, Introductions, and Housekeeping**

Chairperson Barbara Mitchell called the meeting to order and welcomed Council Members and attendees. Council Members, Council staff, and attendees were invited to introduce themselves. A quorum was established with 17 of 20 members present.

Agenda Item: **Review and Accept June 2025 and July 2025 Meeting Minutes**

The meeting minutes for the June 2025 Quarterly Meeting and July 2025 In-between Meeting were accepted with no revisions.

Agenda Item: **Nomination of Chair-Elect for 2025 (Action Item)**

The committee decided to withdraw this agenda item and defer it to the January 2026 meeting.

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Agenda Item: Year-End Legislative Report and Advocacy Activities Update

Council Staff Maydy Lo reviewed the 2025 Year-End Legislative Report with the committee and highlighted priority bills that the Council took a position on, as well as legislative outcomes, which included:

- Assembly Bill 255 (Haney) was supported by the Council but vetoed by the Governor. It proposed allowing 10 percent of state homelessness funds to be used toward supportive recovery residences.
- Assembly Bill 1037 (Elhawary) was supported by the Council and chaptered. It clarifies that anyone can obtain and carry over-the-counter Naloxone and extends Good Samaritan protection to people who in good faith administer the medication to someone at risk of overdose.
- Senate Bill 27 (Umberg) was opposed by the Council, but chaptered. It expands the eligibility for the Community Assistance, Recovery, and Empowerment (CARE) Act to include those with Bipolar I Disorder with psychotic features.
- Senate Bill 820 (Stern) was opposed by the Council, but chaptered. It authorizes the least restrictive administration of antipsychotic medication to individuals found incompetent to stand trial after having been charged with a misdemeanor, without prior informed consent on an emergency basis when treatment is necessary to address emergency conditions.
- Senate Bill 28 (Umberg) was watched by the Council and became a two-year bill. Among its provisions, the bill would require a drug addiction expert to conduct substance abuse and mental health evaluations for individuals participating in treatment court programs. It would also require treatment programs to be offered to eligible individuals under the Treatment Mandated Felony Act of Proposition 36. The committee was informed that this bill was not included in the report, and that an updated version would be provided.

Agenda Item: Peer Voices: Perspectives on Recent State Behavioral Health Legislation and Federal Actions

Samuel Jain, Senior Mental Health Policy Attorney and Monica Porter Gilbert, Senior Mental Health Policy Advocate from Disability Rights California (DRC) presented to the committee on the federal executive order *Ending Crime and Disorder on America's Streets*, the House of Representatives (H.R.) 1 federal bill, and DRC high priority behavioral health bills for 2025. The following are key points from the presentation:

***Ending Crime and Disorder on America's Streets* Federal Executive Order**

- An executive order is a directive from the President of the United States (U.S.); it is not legislation and does not require approval from Congress, therefore

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Congress cannot overturn an executive order. Only a sitting U.S. President can overturn an existing executive order by issuing another executive order to that effect. An executive order does not have any legal effects, and its enforcement is limited to the President's ability to discipline the officials it directed to if they do not carry out the actions outlined in executive orders. The executive order itself does not require action unless specific federal guidance is issued.

- The National Alliance to End Homelessness has filed a lawsuit against the Department of Housing and Urban Development (HUD) Secretary Scott Turner. They have also obtained a temporary restraining order to ensure providers are not barred from competing for HUD grants on the basis of being aligned with the administration's objectives.

House of Representatives (H.R.) 1 Federal Bill

- States that broadened eligibility for Medicaid under the Affordable Care Act are anticipated to have the most significant impact from the federal Medicaid cuts.
- Medi-Cal serves 15 million Californians, which is approximately 35 percent of the state's population. As a result of the Medicaid cuts, it is expected that approximately 3 million Medi-Cal beneficiaries will lose coverage.
- The changes to federal reimbursements that states receive from Medicaid would result in California receiving a reduction in federal revenue for services.
- California could lose up to \$30 billion a year in federal funding due to the elimination and reduction of income streams that states can use to pay for their share of Medicaid.
- Optional Medi-Cal services such as peer support, mobile crisis, and crisis residential could be cut either by county behavioral health plans or at the state level.
- Providers could also receive lower reimbursement rates for services, which could lead to lower quality of care or termination of operations altogether.

High Priority Behavioral Health Bills

- Senate Bill 27 (Umberg): This bill expands the eligibility for the Community Assistance, Recovery, and Empowerment (CARE) Act to include those with Bipolar I Disorder with psychotic features. DRC has been involved with the implementation of the CARE Act since its inception. Their concerns about this legislation include:
 - The bill does not include additional funding and expands eligible populations without addressing gaps in housing, the behavioral health workforce, and behavioral health services.
 - It was analyzed that the estimated costs per CARE Act participant for 2023-2024 were \$713,000, which is over 40 times the cost of Full-Service Partnership programs.
 - CARE Act participants are placed on the same waiting list for behavioral health services and housing as those who are not CARE participants.
 - It can take 10 to 200 days before an initial contact with a participant is successful.

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- Senate Bill 820 (Stern): The bill authorizes the least restrictive administration of antipsychotic medication to individuals found incompetent to stand trial after having been charged with a misdemeanor, without prior informed consent on an emergency basis when treatment is necessary to address emergency conditions. It also reverses the author's previous 2021 bill, Senate Bill 317, which eliminated involuntary medication for the population. The bill also requires jails to make a documented attempt to transfer individuals to a community-based facility before moving forward with involuntary medication. Their concerns about this legislation include:
 - The bill expands the use of involuntary medication for individuals outside of clinically appropriate settings and without consistent monitoring.
 - Under this bill, courts can move forward with ordering involuntary medication if they "have considered the due process protections". DRC is concerned about the lack of clarity with this language.

Committee members also engaged in a question-and-answer discussion with the presenters. Some of the key discussion points, responses, and additional information included:

- Disability Rights California (DRC) is advocating for automatic Medi-Cal renewals for specific populations receiving certain services, eliminating the need to recertify Medicaid eligibility every six months as outlined under H.R. 1.
- Work reporting requirements already exist in various states, including Arkansas, and have been associated with confusion among beneficiaries and a lack of clarity regarding reporting expectations. Additionally, the work reporting requirements under H.R. 1 add administrative burdens on recipients who are already employed.

Public Comment:

Lynn Rivas, Executive Director for California Association of Mental Health Peer-Run Organizations, stated that peer-run organizations have experienced significant financial impacts by Proposition 1/the Behavioral Health Services Act. These organizations are billing Med-Cal in attempts to recover costs for services. However, they are only allowed to bill Medi-Cal for individuals with serious mental illness. Those with mild to moderate mental illnesses and receiving services through Managed Care Plans are unable to be billed under those codes. Lynn encouraged the committee to support legislation in the next year that helps to resolve these challenges.

Agenda Item: CAADPE Legislative Priorities

Trent Murphy, Legislative Policy Analyst from California Association of Alcohol and Drug Program Executives, INC. (CAADPE), presented to the committee on CAADPE's recent legislative priorities and the upcoming policy focus areas.

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CAADPE is a professional association representing executives from community-based, nonprofit substance use disorder (SUD) treatment agencies. Its membership is composed of local providers who deliver SUD treatment services to Californians. Their collective experience and expertise help shape and inform CAADPE's advocacy efforts. The organization is governed by a member-elected board and structured into committees and regional chapters, each focusing on specific issues and geographic areas, all working toward the shared goal of improving SUD treatment systems across the state.

During the 2025 legislative session, CAADPE sponsored Assembly Bill 1267 (Pellerin) which proposed to streamline the state licensing process for SUD programs that are co-located in the same geographic locations. Trent emphasized that the current licensing process and paperwork are duplicative for providers who operate facilities in close proximity to each other. Streamlining this process could help reduce administrative costs and allow providers to redirect more resources toward care and services. Trent highlighted that this bill has become a two-year bill.

Additionally, CAADPE opposed Assembly Bill 3 (Dixon), which proposed to restrict where recovery residences can be. Trent highlighted that opposing legislation promoting "Not in My Backyard" (NIMBY) policies is a key CAADPE priority. CAADPE also opposed Assembly Bill 396 (Tangipa) which would have required all Syringe Service Programs (SSPs) to serialize each distributed needle and proposed monetary penalties for programs unable to account for all syringes. Although both bills did not advance by the required deadlines for this year's legislation session, they have become two-year bills that CAADPE will continue to monitor.

Trent also shared CAADPE's legislative priorities for 2026 which include the following:

- Monitor Proposition 36 implementation and system alignment.
- Expand access to opioid antagonists and overdose training.
- Protect treatment resources amid federal healthcare cuts.

Committee members engaged in a question-and-answer discussion with the guest speaker. Some of the key discussion points, responses, and additional information included:

- CAADPE frequently collaborates with other associations, such as the California Consortium of Addiction Programs and Professionals (CCAPP). For example, CAADPE worked closely with CCAPP on Assembly Bill 2473 (Nazarian) during the 2022 legislative session, which introduced a new 80-hour training requirement for SUD counselors. Additionally, CAADPE supported Assembly Bill 669 (Haney) during this year's legislative session which was co-sponsored by CCAPP. The bill proposed to ensure 28 days of uninterrupted medical treatment for substance use. Trent highlighted CAADPE's contribution to an amendment that ensured the bill would include residential facilities, not just inpatient settings.
- Current Syringe Service Programs (SSPs) provide designated drop-off locations for the safe disposal of used needles.

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- Assembly Bill 396 (Tangipa) would impose requirements that are not applied universally to all individuals who use syringes, which would further contribute to the stigma surrounding substance use disorders.

Agenda Item: Patients' Rights Committee Meeting Update

Council Member Daphne Shaw provided an update from the Patients' Rights Committee (PRC) meeting, where members discussed ways to improve the Council's legislative process to be more proactive in responding to patient rights-related legislation. Representatives from Disability Rights California (DRC) and the California Association of Mental Health Patients' Rights Advocates (CAMHPRA) were present during PRC's meeting and expressed willingness to maintain communication with the committee on relevant bills that both agencies are monitoring. The committee also discussed the possibility of holding interim meetings to ensure timely responses to legislative developments.

Agenda Item: Committee Discussion on 2025 Policy Priorities

Chairperson Barbara Mitchell facilitated a discussion with committee members to generate recommendations for next year's policy priorities and key activities.

Council Chairperson, Tony Vartan, shared that the Executive Committee identified four strategic areas of focus for the Council, which will guide committee activities and priorities moving forward. These focus areas include:

- 1) **Integration of Mental Health and Substance Use Disorders (SUD)** – addressing issues such as the impacts of Medicaid cuts and enhancing SUD education for Council members.
- 2) **Stakeholder Engagement** – involving key partners such as the Behavioral Health Services Act (BHSA) stakeholders, County Integrated Plans, and advancing peer certification efforts.
- 3) **Patient Rights and Lanterman-Petris-Short Act Reform** – examining the implications of involuntary treatment, Senate Bill 43 (Eggman), the Community Assistance, Recovery, and Empowerment (CARE) Act, and ensuring adequate patient rights advocates in both community and correctional settings.
- 4) **Justice-Involved Populations** – exploring resource limitations, the shift of responsibilities back to counties without adequate support, the potential increase in conservatorships, Proposition 36, and federal policy changes that may impact housing.

Committee member recommendations included:

- Early episodes of psychosis in children and youth.

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- Provision of services and support for individuals with substance use disorders (SUD) throughout the continuum of care.
- Increase partnerships with agencies and organizations such as California Association of Alcohol and Drug Program Executives (CAADPE), California Association of Mental Health Peer-Run Organizations (CAMHPRO), and Housing California to collaboratively identify, shape, and advocate for legislative and policy initiatives that reflect and advance the Council's mission and goals.
- Review two-year bills that the Council took positions on and categorize them into key legislative priority areas, or 'buckets'—such as Housing, Substance Use Disorder (SUD), Patients' Rights, Peer Support/Health Navigators, and Behavioral Health Funding. To ensure focused and effective advocacy, the committee should include a process to identify one to two high-priority bills within each bucket to prioritize.
- Identify additional state behavioral health funding opportunities.
- Continue efforts to schedule interim meetings, as quorum allows, to discuss and take action on legislative matters.

Agenda Item: Harm Reduction in California: Framework, Principles, and Impacts

Ilana Rub, Assistant Division Chief of the Community Services Division at the Department of Health Care Services (DHCS), provided an overview of California's harm reduction strategies to address substance use, including their impact on state efforts and state and federal policies that have shaped these initiatives.

Patient-centered care respects and prioritizes patients' unique needs, goals, and values, fostering a shared responsibility between patients and their providers. In substance use disorder (SUD) treatment, a uniform approach to addressing individual needs is ineffective. Patient-centered care emphasizes what is most important to patients and by doing so, providers can build deeper trust, enhance engagement, and improve outcomes. This approach empowers patients to become active participants in their care, which is an essential component of sustained recovery.

Research shows that when patients are treated as partners in their care, they become more actively engaged, which leads to a deeper understanding of their condition and available treatment options. In the context of SUD treatment, patient-centered care empowers individuals to make informed decisions and take ownership of their recovery. This approach improves treatment retention, builds trust, fosters open communication, and strengthens provider-client relationships, which leads to increased satisfaction with care and encourages long-term commitment to treatment.

Ilana highlighted the release of 10 strategies for treatment programs to adopt to better serve and retain non-abstinent patients by the American Society of Addiction Medicine (ASAM) in 2024. These strategies are outlined below:

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- 1) Cultivate patient trust by creating a welcoming, nonjudgmental, and trauma-sensitive environment
- 2) Do not require abstinence as a condition of treatment initiation or retention
- 3) Optimize clinical interventions to promote patient engagement and retention.
- 4) Only administratively discharge patients from treatment as a last resort.
- 5) Seek to re-engage individuals who disengage from care.
- 6) Build connections to people with SUD who are not currently seeking treatment.
- 7) Cultivate staff acceptance and support.
- 8) Prioritize retention of front-line staff.
- 9) Align program policies and procedures with the commitment to improve engagement and retention of all patients, including non-abstinent patients.
- 10) Measure progress and strive for continuous improvement of engagement and retention.

Ilana shared that the seven regional summits hosted by the Department of Health Care Services from October 2024 to September 2025 across California, aimed to: (1) reduce stigma in SUD treatment, (2) educate SUD treatment providers and staff on integrating non-abstinent and patient-centered care approaches, and (3) support implementation of the American Society of Addiction Medicine's guidance on engaging and retaining non-abstinent patients.

Ilana discussed California's overdose prevention model and efforts and highlighted the various partnerships between state agencies and community-based organizations (CBOs). California Department of Public Health Office of Aids and Harm Reduction Branch oversees syringe services authorization, technical assistance, and naloxone distribution. County health departments and CBOs implement services such as on-the-ground mobile outreach, naloxone training, syringe exchange, and linkages to care. DHCS manages the Naloxone Distribution Project (NDP), launched in 2018, which distributes free naloxone medication directly to organizations statewide. This initiative has distributed over 5 million doses of life-saving medication and 7 million kits of naloxone, which have resulted in over 380,000 overdose reversals.

Ilana also addressed the "Dear Colleague" letter published by the Substance Abuse and Mental Health Services Administration (SAMHSA) on July 29, 2025. The letter clarifies the current administration's position on harm reduction, as outlined in the July 2025 Executive Order titled "Ending Crime and Disorder on America's Streets." It also provides guidance to state agencies and grantees of new award terms and conditions that specify which supplies and services may or may not be supported with SAMHSA funding. She elaborated that DHCS' current implementation of SAMHSA grants is consistent with existing federal guidance related to harm reduction activities including both the Executive Order and "Dear Colleague" letter. DHCS does not authorize subcontractors or subrecipient use of SAMHSA funds for any supplies or services

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identified as unallowable in the letter. DHCS will continue to engage with stakeholders to ensure ongoing alignment with the federal guidance.

Committee members also engaged in a question-and-answer discussion with the guest speaker. Some of the key discussion points, responses, and additional information included:

- DHCS is shifting away from using the term 'harm reduction' and instead prefers terminology such as 'life-saving overdose prevention and response services' or 'infectious disease prevention services,' to reflect the scope and intent of these efforts.
- The state's activities, as currently conducted and managed, remain allowable and not impacted by the Executive Order or the SAMHSA "Dear Colleague" letter. Grantees and programs continue to operate in compliance with federal guidance and are not affected by the recent updates.

Public Comment:

Vanessa Ramos, Senior Advisor at Disability Rights California, requested the presenter to speak about the community planning process within the Behavioral Health Services Act (BHSA), including the California Mental Health Services Authority's (CalMHSA) community planning document, with a focus on meaningfully engaging communities and advocating for substance use disorder treatment. She emphasized the importance of advocacy and the need to evolve the medical model to better support individuals with SUD.

Agenda Item: **Housing First in California: Policy Foundations and Impacts**

Council Member Jason L. Bradley, Branch Chief of the Project Origination Branch at the California Department of Housing and Community Development (HCD), provided an overview of the foundational principles of Housing First and its impact on the state's efforts to address homelessness and behavioral health needs.

Housing First under California law is defined as an evidence-based model that uses housing as a tool for recovery. Housing First requires four components for state funded housing based programs to adhere to: (1) low barrier access to permanent housing, (2) standard lease and tenant rights, (3) voluntary, client-driven services that are not a condition of maintaining housing, and (4) harm and risk reduction approach, to promote safety and wellness while supporting stability.

Jason highlighted that evaluations across various settings consistently show that when Housing First is implemented with fidelity, individuals are more likely to obtain and maintain stable housing, with significantly fewer returning to homelessness.

At the statewide level, population-level outcomes are influenced by the availability of sufficient housing units, service providers, and rental assistance vouchers. In areas

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where Point-in-Time (PIT) counts do not show improvement, the issue is typically due to insufficient system throughput, not a failure of the Housing First model itself.

Housing First is based on the premise that behavioral health recovery is more effective when individuals transition from crisis settings into stable housing with access to voluntary, collaborative services. Systems that implement this approach often see reduced reliance on crisis care, increased use of planned care, and fewer emergencies, as individuals engage in ongoing outpatient support. This leads to improved daily functioning and housing stability. Behavioral health improvements often emerge gradually—typically before noticeable changes in physical health, which is a pattern consistently reported by providers across the state.

While the Executive Order provides federal guidance, Jason explained that it does not carry the force of law. The U.S. Department of Housing and Urban Development (HUD) must still translate this guidance into actionable funding requirements consistent with applicable federal laws. Meanwhile, California's Housing First statute remains in effect for state-funded programs. If federal requirements shift, providers may face dual compliance pressures from both state and federal mandates. Jason recommended that the committee continue to monitor forthcoming agency guidance for any new requirements that may require reconciliation with existing policies.

Committee members also engaged in a question-and-answer discussion. Some of the key discussion points, responses, and additional information included:

- Recovery housing models operating under the Housing First framework can become problematic when continued tenancy is contingent upon meeting clinical sobriety requirements, as this conflicts with the model's core principle of low-barrier, non-conditional housing.
- The committee was encouraged to advocate for recovery housing options that support sobriety-focused environments, allowing individuals who choose to pursue abstinence to live in settings aligned with their recovery goals. This can be challenging to achieve within mixed-population housing models that serve individuals with varying levels of readiness for sobriety.
- There is no known timeline for when HUD may release guidance regarding any changes to Housing First policies.
- In 2024, the national Point-in-Time (PIT) count showed an 18% increase in homelessness, while California reported a comparatively smaller increase of 3%.
- Housing First is a tool that can be integrated with other supportive services and braided funding sources to support individuals with behavioral health needs who are also experiencing homelessness. First, offering what individuals most often seek, such as stable housing, creates an opportunity to build trust and rapport, which can lead to greater engagement in voluntary services.

Public Comment:

Barbara Wilson, a resident of Los Angeles County, shared several concerns in regard to the implementation of Housing First. She expressed her observation that the model appears primarily tailored for individuals with substance use challenges and noted an overall lack of coordination and awareness between housing providers and the

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Department of Behavioral Health. Barbara emphasized the challenges when individuals with primary substance use disorders are placed in housing originally intended for those with mental health conditions. She shared that, especially in Licensed Board and Care facilities, staff often lack the training and skills necessary to support individuals with substance use disorders. She further stated that there seems to be a high dropout rate among individuals with psychosis living in Housing First settings, many of whom are not engaged in supportive services. Barbara encouraged increased communication between the HCD and service providers to better address these challenges.

Agenda Item: General Public Comment

Vanessa Ramos, Senior Advisor at Disability Rights California (DRC), shared that DRC investigates reports of abuse and neglect. She highlighted that some instances of harm, which include deaths, have occurred in housing settings, some of which identify as Housing First homes or facilities. She emphasized that when there is a lack of fidelity to Housing First principles, it is often not the model itself that fails residents, but rather the failure of providers to deliver the core supportive services. She drew a parallel to Full-Service Partnerships (FSPs) and noted that when wraparound services are not effectively provided, individuals are left without the support they need. Vanessa encouraged the committee to consider examining the fidelity of service delivery and offered to share DRC's efforts and collaborate with the Council.

Agenda Item: Meeting Wrap Up and Next Steps

Agenda items for the next quarterly meeting in January 2026 will include the nomination of Chair-Elect and a discussion of the Council's annual Policy Priorities.

Members emphasized the importance of proactive engagement in the legislative process to enable quicker responses to emerging bills and advocacy opportunities.

The meeting adjourned at 4:58 p.m.