CSAP
CALIFORNIA STATE ASSOCIATION OF PSYCHIATRISTS

CSAP Legislative Priorities for 2026-2027

Executive Summary

CSAP advocates for the below legislative priorities to improve the health of Californians:

1. **Expand and ensure access to evidence-based psychiatric treatment across the continuum of care.** Legislative actions should A) strengthen the mental health workforce, B) strengthen enforcement of insurance coverage requirements for psychiatric services through effective oversight and accountability mechanisms to ensure fair insurer conduct, C) expand access to child and adolescent mental health services, and D) modernize regulations and funding to enable telehealth and digital technologies that improve care access, care quality, privacy, and patient safety. Such initiatives can ensure that Californians have timely access to evidence-based treatments that can prevent SMI, increase long-term recovery, and reduce disability.

2. **Prioritize and Modernize Care for Californians With Severe Mental Illness and Severe Substance Use Disorders.** CSAP urges legislative action to prioritize individuals with treatment-refractory SMI and SSUD through fundamental reforms to behavioral health funding and law. This includes expanding robust emergency psychiatric response, ensuring adequate high-acuity inpatient capacity, developing high-quality long-term supported living options, and repealing the IMD exclusion. CSAP also supports modernizing the Lanterman-Petris-Short Act to reflect best practices, reduce unnecessary detention, facilitate timely medical and psychiatric treatment when consent cannot be obtained, reduce stigma, and expand use of technology to ensure meaningful court access for individuals with SMI, including those who are justice-involved.

3. **Establish comprehensive statewide quality monitoring for county mental health systems:** We advocate legislative initiatives that establish more uniform, comprehensive, and measurable statewide quality monitoring for county mental health systems. Such monitoring should be paired with significant financial rewards for those counties that increase access to evidence-based services and improve measures of health for patients with SMI. Quality metrics must include number of individuals incarcerated with severe mental illness, competency proceedings, and individuals awaiting state hospital placement. Counties that do not submit data reporting must be penalized.

Priority 1: Expand and modernize access to evidence-based psychiatric care

Goal

Ensure that all Californians—across the lifespan—have timely access to the full continuum of evidence-based psychiatric care by expanding the workforce, enforcing insurance coverage consistent with clinical standards, strengthening child and adolescent-focused services, and modernizing tele-mental health policies.

Why This Matters

California's mental health system is constrained by workforce shortages, inadequate treatment capacity, and insurance practices that delay or deny medically necessary care. These barriers drive preventable disability, emergency department boarding, homelessness, incarceration, and progression to severe mental illness. Strategic legislative and budget reforms can realign coverage with evidence-based standards and improve outcomes statewide.

CSAP Legislative Priorities

Expand the Psychiatric and Mental Health Workforce

- Increase training, loan repayment, and retention incentives
- Strengthen training pipelines for child and adolescent psychiatrists and mental health professionals
- Reduce administrative burdens that divert clinician time from patient care

Invest Through the Budget

- Increase funding for child and adolescent psychiatry services
- Incentivize expansion of residential (both short-term and long-term) and intermediate-acuity treatment programs, including partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs)

Enforce Mental Health Parity

- Require annual state parity audits of commercial insurers
- Mandate public reporting of psychiatric vs. medical/surgical reimbursement and denial rates, and claims processing timelines
- Penalize inappropriate denials and "ghost networks"
- Establish a state parity ombudsperson

Guarantee Coverage of Evidence-Based Care

- Establish a multidisciplinary board defining minimum coverage standards
- Prohibit step-therapy for psychiatric medications
- Require medication formulary alignment with evidence-based clinical guidelines
- Mandate coverage of long-acting injectable medications for psychiatric disorders, including substance use disorders
- Mandate coverage of interventional psychiatry (including electroconvulsive therapy and transcranial magnetic stimulation)
- Require full coverage for psychiatric emergency services and for the full medically-necessary duration of inpatient psychiatric care
- Require adequate networks of contracted inpatient psychiatric facilities

- Ensure coverage of psychotherapy, PHPs, IOPs, residential care, Assertive Community Treatment (ACT) and Intensive Case Management (ICM), long-term supportive group living, peer support, and family psychoeducation services
- Prohibit pharmacists from refusing to fill clinically indicated prescribed medications; prohibit geographical restrictions regarding pharmacy distance from patient or prescribers

Reform Prior Authorization & Network Adequacy

- Eliminate prior authorization for psychiatric emergencies
- Require psychiatrist-led utilization review
- Mandate real-time electronic prior authorization and clear denial explanations
- Enforce accurate provider directories, appointment wait-time standards, and out-of-network coverage when networks are inadequate

Modernize Tele-Mental Health

- Make pandemic-era telepsychiatry flexibilities permanent
- Require reimbursement parity for tele-mental health
- Prohibit geographic and site-of-service restrictions
- Support broadband internet access for telehealth
- Update patient privacy protections for digital mental health tools and platforms
- Expand tele-based IOP, PHP, and hybrid care models

Bottom Line

Expanding access to evidence-based psychiatric care will reduce preventable crises, improve recovery, strengthen families and communities, and ensure California's mental health system meets modern clinical standards.

Priority 2: Prioritize Care for Californians With Severe Mental Illness and Severe Substance Use Disorders

Goal

Prioritize individuals with treatment-refractory Severe Mental Illness (SMI) and Severe Substance Use Disorders (SSUD), across the lifespan, by reforming funding, capacity, and legal frameworks to ensure timely, effective, and humane care for those with the highest needs.

Why This Matters

Californians with SMI and SSUD are disproportionately represented among people experiencing homelessness, repeated emergency department visits, incarceration, and competency proceedings. Chronic underinvestment in high-acuity care, long-stay treatment options, and coordinated emergency response has shifted costs to jails, hospitals, and law enforcement while failing patients and families. A statewide commitment to prioritize SMI and SSUD will reduce preventable crises, restore stability, and improve accountability across behavioral health systems.

CSAP Legislative Priorities

Invest in High-Acuity and Long-Stay Treatment Capacity

- Increase funding for high-acuity inpatient psychiatric beds
- Incentivize counties to expand long-stay supported group living facilities
- Establish capital grants and streamlined licensing for high-acuity units and group homes
- Expand eligibility for secured adult residential facilities to individuals with SMI on LPS conservatorship
- Expand residential options for individuals with major neurocognitive disorders on probate conservatorship

Strengthen Accountability for Behavioral Health Spending

- Require counties to publish line-item mental health budgets and expenditures
- Require reporting of spending on LPS services, jail mental health care, and competency proceedings
- Require cities (law enforcement and EMS) to report mental health response expenditures
- Impose penalties for failure to accurately report involuntary detention and LPS data
- Re-establish a Department of Mental Health with county oversight authority

Reform Emergency Psychiatric and Crisis Response

- Establish minimum capability and capacity standards for psychiatric care in hospital emergency departments
- Set statewide standards and funding for evidence-based hospital-based emergency psychiatry models
- Establish standards for mobile crisis teams
- Require counties to report real-time linkage capacity from emergency departments to inpatient, crisis stabilization, withdrawal management, residential, and step-down care
- Require centralized county referral systems for SMI and SUD
- Require hospitals to report high-utilization patients (≥10 visits/year) as a marker of system failure
- Require implementation of community paramedicine “triage to alternate destination” programs

Modernize the Lanterman-Petris-Short (LPS) Act

- Eliminate in-person testimony requirements for patients and psychiatrists in LPS hearings by expanding use of technology
- Clarify that “due to mental illness” includes SMI, severe substance use disorders, neurodevelopmental disorders, and cognitive disorders
- Enable timely treatment of serious medical conditions for individuals detained under LPS who lack capacity to consent

- Extend Riese-type medication procedures to individuals on medical incapacity holds in non-LPS facilities

Strengthen Discharge Infrastructure and Continuum of Care

- Require counties to maintain adequate step-down and long-stay capacity for LPS-conserved individuals
- Require public reporting of county use of realignment and BHSA funds for LPS services
- Audit county expenditures ineligible for federal reimbursement and require corrective action
- Require reporting of local funds allocated to behavioral health infrastructure

Integrate Care for Neurodevelopmental and Cognitive Disorders

- Require DHCS to recognize cognitive disorders as eligible diagnoses for inpatient mental health treatment
- Require Full Service Partnership (FSP) services for individuals with severe functional impairment related to neurodevelopmental, substance use, or cognitive disorders
- Require DHCS coordination with DDS and CDA to fund FSP services for these populations
- Require sheriff departments to report incarcerations involving neurodevelopmental, substance use, and cognitive disorders

Bottom Line

Prioritizing Californians with SMI and SSUD through targeted investments, legal modernization, and enforceable accountability will reduce homelessness, incarceration, emergency system strain, and long-term public costs—while restoring dignity and stability to the state's most vulnerable residents.

Priority 3: Establish comprehensive statewide quality monitoring for county mental health systems

Goal:

Ensure that individuals living with mental health, substance use (SUD), neurodevelopmental, and/or cognitive disorders who are receiving care through county systems: will receive effective, high-quality, and integrated care through the establishment of more uniform, comprehensive, and measurable statewide quality monitoring.

Why This Matters:

Aligning funding with measurable improvements in care quality will help drive meaningful, equitable progress across counties, helping to ensure that individuals with

behavioral health disorders receive consistent, evidence-based treatment regardless of geography. Making standards uniform across programs, including those serving individuals with severe mental illness (SMI), substance abuse disorders (SUD), neurodevelopmental and/or cognitive disorders will help break down the siloing that often impedes integrated treatment for people with co-occurring disorders.

CSAP Legislative Priorities:

Establish Necessary Data and Reporting Requirements

- Standardize statewide metrics for behavioral health treatment access and outcomes.
- County metrics for incarceration of individuals with SMI and severe substance use disorders (SSUD).
    - County metrics for incompetency proceedings of individuals with SMI and SSUD
    - County metrics for Medi-Cal mental health services for the six months preceding incarceration of individuals with SMI, SSUD. This should create a presumption that mental health services are not adequately prioritizing individuals with SMI, SSUD
    - DHCS must publish points of contact for 5200 investigation requests
    - DHCS must publish link to county 5150 procedures (WIC 5121)
    - DHCS must create best practices for individualized treatment plans of people on LPS conservatorships
    - DHCS must create best practices for CARE Agreement and CARE Plans
- Mandate county reporting on the nature and quality of evidence-based practices.

Develop Performance-Based Funding

- Establish bonus payments for counties accurately reporting measurable improvement
- Consider withholding realignment, BHSA, CARE allocations if counties do not demonstrate improvement in reducing individuals with SMI/SSUD who
    - frequently utilize emergency response (reported by cities)
    - repeatedly incarcerated (reported by county sheriff)
    - are referred for incompetency proceedings (reported by superior court/JCC)
    - have CARE petitions dismissed (reported by superior court)
- Establish corrective action plans for chronic underperformance. DHCS must publish findings on county underperformance.

Support Transparency and Public Dashboards

- Develop a public-facing, easily understandable, and regularly updated statewide mental health quality portal showing performance metrics by each county, including metrics for CARE Court and conservatorship. While counties are required to report involuntary care data, the most recent DHCS report is largely incomplete. Penalties must be assessed for counties that are not in compliance.

    - DHCS should report how they determine if counties are in substantial noncompliance with the LPS Act (WIC 10744)
    - DHCS should report numbers of hearings held related to determinations of substantial noncompliance with the LPS Act (WIC 10744)

Incentivize Workforce Training

- Provide incentives for adoption of evidence-based training programs specifically serving SMI and SSUD individuals.

Improve Administrative Coordination for Key State Agencies

- Consolidate or formally coordinate mandates across state departments overseeing Mental Health, SUD, Developmental Disability services, and Probate Conservatorships.
    - Unify licensing or oversight structures for programs serving overlapping populations.
    - Eliminate regulatory barriers that exclude individuals with eating disorders from MHRC placement (CCR 784.26)

Facilitate Integrated Care Models

- Blend funding for co-located or integrated treatment programs.
- Develop requirements for cross-training of providers across Mental Health, SUD, developmental, and cognitive specialties.
- Require counties to report on mental health services available for individuals with primary neurodevelopmental, cognitive and severe substance use disorders

Promote Access to Care and Insurance Coverage

- Clarify parity regulations and associated enforcement procedures across mental health, SUD, developmental, and cognitive disorders.
- Expand eligibility for integrated specialized services and early intervention for individuals with co-occurring behavioral health disabilities.

Bottom Line

Together, these reforms create a unified statewide accountability framework that ensures individuals with behavioral health disorders receive consistent, evidence-based care regardless of county. By aligning funding with measurable outcomes, strengthening transparency, and integrating oversight across agencies, California can finally deliver on its promise of equitable behavioral health care.