

## California's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the State of California present an **unprecedented opportunity for generational investment** in treatment capacity for chronic substance abuse (CSA) and severe mental illness (SMI).

California is set to receive **nearly \$5 billion** (\$4,722,555,024.64) in opioid settlement funds—equal to nearly one-fourth of the state's share of the monumental Tobacco Master Settlement Agreement.<sup>1</sup> With twenty-one separate settlements and with payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The state must ensure that this opportunity for treatment investment does not go underutilized. **California can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

California chose to allocate 15 percent of settlement proceeds (\$848,585,009.58) to the state, 15 percent to subdivisions, and 70 percent to its abatement fund, but importantly is allocating all of its abatement fund to participating subdivisions, making the functional split 15/85.<sup>2</sup> The legislature is tasked with allocating the state's share of funds.<sup>3</sup> This leaves the state with a small fraction of total funds to make high-impact investments that will benefit the entire state. **The legislature should enact an allocation statute that supersedes the many State-Subdivision Agreements and reserve a greater portion of funds for allocation by the legislature.**

Moreover, **reporting is lacking**, and the latest transparency report available is for Fiscal Year 2022-2023. What reporting is available is concerning, as half of all subdivision spending was allocated to harm reduction priorities.<sup>4</sup> **The state must ensure comprehensive reports are published to allow citizens to exercise sufficient oversight on the use of funds.**

The state must rein in the misallocation of these funds and prioritize investments in comprehensive treatment networks. **Three priorities** (Certified Community Behavioral Health Clinics, secure psychiatric beds, and community SMI/SUD response) **will ensure these funds have the largest impact** on the state.

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<sup>1</sup> Except the McKinsey and Publicis settlements, of which the state controls 100 percent of funds.

### *Certified Community Behavioral Health Clinics (CCBHCs)*

CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care and are stably-funded and supported by all recent presidential administrations. CCBHCs are a key response to the crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Fund the development and expansion of CCBHCs.**
  - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
  - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
  - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

### *State Psychiatric Hospitals*

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. California currently has only **5.2 state psychiatric beds** per 100,000 people available for civil (i.e., non-criminal) patients.<sup>5-6</sup> Treatment Advocacy Center recommends a rate of 30-60 beds per 100,000. Even counting non-public secure psychiatric beds, California still falls short of the minimum.<sup>7</sup> Secure beds are costly, but a necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Fund the expansion of civil psychiatric beds.**
  - Invest in expanding state hospital capacity.
  - Move forensic (criminal) commitments to a jail-based restoration facility.
  - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for IMDs.

### *Inpatient Stabilization Centers and Mobile Crisis Teams*

Emergency departments (EDs) are supposed to be a last-resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care, especially true for low- to medium-acuity mental health crises. In order for the other two priorities to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else these investments will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Fund community-based mental health response resources.**
  - Build out community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
  - Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).

- Support integration with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

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<sup>1</sup> KFF. “Actual Tobacco Settlement Payments Received by the States (in millions).” Accessed 8 September 2025. <https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments>.

<sup>2</sup> California executed a unique subdivision agreement following each settlement. See Cicero Institute, “California Opioid Settlement Documents.” <https://drive.google.com/drive/u/1/folders/1y--ezpZC4hZ4zvDI5Lue4bYAwsrTLeTe>.

<sup>3</sup> Government Code § 12354. [https://california.public.law/codes/government\\_code\\_section\\_12534](https://california.public.law/codes/government_code_section_12534).

<sup>4</sup> California Department of Health Care Services, “California Opioid Settlements Reports.” Accessed 11 September 2025. <https://www.dhcs.ca.gov/provgovpart/Pages/FY-22-23-CA-Opioid-Settlements-Reports.aspx>.

<sup>5</sup> Treatment Advocacy Center, “California Psychiatric Beds Report.” 2023. <https://www.tac.org/wp-content/uploads/2023/10/Californiabedsinformation.pdf>.

<sup>6</sup> United States Census Bureau, “2023 American Community Survey – Total Population.” [https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US\\$0400000](https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000).

<sup>7</sup> Silver, Shanti, “Estimating Psychiatric Bed Need in the United States,” p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. [https://www.tac.org/wp-content/uploads/2024/03/TAC\\_ORPA\\_ResearchSummary1.24.pdf](https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf).