Date of Hearing: June 28, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 1338(Umberg) – As Amended June 16, 2022
AS PROPOSED TO BE AMENDED

SENATE VOTE: Not relevant

SUBJECT: Community Assistance, Recovery, and Empowerment (CARE) Court Program.

SUMMARY: Establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Program and the CARE Act to provide comprehensive treatment, housing and support services to Californians with complex behavioral health care needs. Specifically, **this bill**:

I. Specifies the Following Findings and Declarations

1) That thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

2) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. Too often, this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

   California has made unprecedented investments in behavioral health, housing, and combating homelessness and CARE Court helps those with the greatest needs access these resources and services. CARE Court provides a framework to ensure counties and other local government entities focus their efforts to provide comprehensive treatment, housing and support services to Californians with complex behavioral health care needs so they can stabilize and find a path to wellness and recover.

3) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses (SMI) and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new CARE Court Program.

4) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated SMI with the establishment of a new CARE Supporter role, in addition to legal counsel, for CARE proceedings.

5) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution for some of the most ill and most vulnerable Californians.

II. General Provisions

1) Establishes the CARE Act and states it is the intent of the Legislature that the CARE Act be implemented in a manner that ensures it is effective.

2) Requires the CARE Act to be implemented, with technical assistance and continuous quality improvement as follows:

    a) A first cohort of counties, representing at least half of the population of the State, will begin no later than July 1, 2023, with additional funding provided to support the earlier implementation date; and,
    b) A second cohort of counties, representing the remaining population of the State, will begin no later than July 1, 2024.

3) Defines, for purposes of this bill, certain terms, including:

    a) "CARE agreement" means a voluntary settlement agreement, which includes the same elements as a CARE plan in accessing community-based services and supports;
    b) "CARE plan" means an individualized, appropriate range of community-based services and supports as set forth in the CARE Act, which includes clinically appropriate behavioral health care and stabilization medications, housing and other supportive services as appropriate;
    c) "Counsel" means the attorney representing the respondent, as provided by the CARE Act or chosen by the respondent, in CARE proceedings and matters related to CARE agreements and CARE plans;
    d) "County behavioral health agency" means the local director of mental health services, the local behavioral health director or both as applicable, or their designee;
    e) "Court-ordered evaluation" means an evaluation ordered by a superior court under the CARE Act.
    f) "Graduation plan" means a voluntary agreement entered into by the parties at the end of the CARE program that shall include a strategy to support a successful transition out of court jurisdiction and may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing services and supports. A graduation plan may not place additional requirements on local government entities and is not enforceable by the court;
    g) "Indian health care provider" means a health care program operated by the Indian Health Services, an Indian tribe, a tribal organization, or urban Indian organization, as specified in the federal Indian Health Care Improvement Act;
    h) "Licensed behavioral health professional" means either of the following:
        i) A licensed mental health professional, as defined; or,
        ii) A person who has been granted a waiver of licensure requirements by the California Department of Health Care Services (DHCS).
    i) "Parties" means the respondent, the county behavioral health agency in the county where CARE Court proceedings under the CARE Act are pending, and other parties that the court may add if they are providing services to the respondent;
    j) "Psychiatric advance directive" means a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis;
    k) "Respondent" means the person who is subject to the petition for CARE Court proceedings;

l) "Stabilization medications" means medications included in the CARE plan that primarily consist of antipsychotic medication to reduce symptoms of hallucinations, delusions, and disorganized thinking. Stabilization medications may be administered as long acting injections if clinically indicated. Stabilization medication cannot be forcibly administered;
m) "Supporter" means an adult, as designated, who assists the respondent to include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE Court process, including a CARE agreement, a CARE plan, and developing a graduation plan. A supporter may not act independently.
n) "Trauma-informed care" means practices that recognize and respond to the signs, symptoms, and risks of trauma to better support the health needs of patients who have experienced Adverse Childhood Experiences (ACEs) and toxic stress.

III. Process:

1) Requires a respondent to qualify for CARE proceedings only if all of the following criteria are met:

   a) The person is 18 years of age or older;
   b) The person is currently experiencing a SMI, as defined and has a diagnosis of schizophrenia spectrum or other psychotic disorder as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, provided that nothing is construed to establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including but not limited to physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. Prohibits a person who has a current diagnosis of substance use disorder (SUD) as defined but who does not meet the required criteria above, from qualifying for CARE proceedings;
   c) The person is not clinically stabilized in on-going treatment;
   d) At least one of the following is true:
      i) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating; and/or,
      ii) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others;
   e) Participation in the CARE proceedings would be the least restrictive alternative necessary to ensure the person's recovery and stability; and,
   f) It is likely that the person will benefit from CARE proceedings.

2) Permits proceedings to commence in any of the following:

   a) The county in which the respondent resides;
   b) The county where the respondent is found. If the respondent does not reside in the county in which proceedings are initiated under the CARE Act and, and the CARE Act is operative in the respondent's county of residence, the proceeding will, with the respondent's consent, be transferred to the county of residence as soon as reasonably feasible. Should the respondent not provide consent to the transfer, the proceedings will continue in the county where the respondent was found; and,
   c) The county where the respondent is facing criminal or civil proceedings.

3) Allows a petition to initiate a CARE proceedings to be brought by:

   a) A person 18 years of age or older with whom the respondent resides or a spouse, parent, adult sibling, adult child, or grandparent of the respondent, or another adult who stands in loco parentis to the respondent;
   b) The director of a hospital, or their designee, in which the respondent is hospitalized, or the director of a public or charitable organization, agency, or home, or their designee, that is currently, or within the previous 30 days, providing behavioral health services to the respondent or in whose institution the respondent resides;
   c) A licensed behavioral health professional, or their designee, who is treating, or has been treating within the last 30 days, the respondent for a mental illness;
   d) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated interactions with the respondent in the form of multiple arrests, multiple detentions and transportation under the Lanterman-Petris-Short (LPS) Act, multiple attempts to engage the respondent in voluntary treatment or other repeated efforts to aid the respondent in obtaining professional assistance;
   e) The public guardian or public conservator, or their designee of the county in which the respondent is present or reasonably believed to be present (a respondent may be referred from conservatorship proceedings);
   f) The director of a county behavioral health agency, or their designee, of the county in which the respondent resides or is found (a respondent may be referred from assisted outpatient treatment (AOT) proceedings);
   g) The director of the county Adult Protective Services or their designee of the county in which the respondent resides or is found;
   h) The director of a California Indian health services program, California tribal behavioral health department, or their designee;
   i) The judge of a tribal court that is located in California, or their designee;
   j) A prosecuting attorney (a respondent may be referred from misdemeanor proceedings, as provided); and,
   k) The respondent.

4) Requires the CARE petition to be signed under penalty of perjury and to contain all of the following:

   a) The name of the respondent, their address, if known, and the petitioner's relationship with the respondent;
   b) Facts that support petitioner's allegation that the respondent meets the criteria in III.1) above; and,
   c) Either of the following:
      i) An affidavit of a licensed behavioral health professional stating that the health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent to submit to an examination, within 60 days of submission of the petition, and that the licensed behavioral health professional has determined that the respondent meets, or has reason to believe, explained with specificity in the affidavit, that the respondent meets, the diagnostic criteria for CARE proceedings; or,

ii) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to the LPS Act, the most recent of which must be within 60 days from the date of the petition.

5) Provides that if a person other than the respondent files a petition for CARE proceedings that is unmeritorious or intended to harass or annoy the respondent, and that person had previously filed petitions for CARE proceedings that were unmeritorious or intended to harass or annoy the respondent, the petition is grounds to declare the person a vexatious litigant, as provided.

6) Requires the respondent to:

a) Receive notice of the hearings;
b) Receive a copy of the court-ordered evaluation;
c) Be represented by counsel at all stages of a proceeding regardless of the ability to pay;
d) Be allowed to have a supporter;
e) Be present at the hearing unless the respondent waives the right to be present;
f) Have the right to present evidence;
g) Have the right to all witnesses; and,
h) Have the right to appeal decisions, and to be informed of the right to appeal.

7) Requires all CARE Court hearings to be presumptively closed to the public. Allows the respondent to demand that the hearings be public and allows them to request the presence of a family member or friend without waiving their right to keep the hearing closed to the rest of the public. Permits a request by another party to make a hearing public to be granted if the judge conducting the hearing finds that the public interest clearly outweighs the respondent's privacy interest. Requires before commencing a hearing, the judge to inform the respondent of their rights.

8) Requires upon receipt of a CARE Court petition, the court to promptly review the petition to determine if it meets the requirements in III. 4) above. Specifies the following about the petition:

a) If the court finds the petition does not meet the requirements in III. 4) above , the court is to dismiss without prejudice, subject to III. 5) above; and,
b) If the court finds that the petition may meet the requirements in III. 4) above, the court is to order a county agency, or their designee, as determined by the judge, to investigate as necessary and file a written report with the court within 21 days that includes:
   i) A determination as to whether the respondent meets, or is likely to meet, the criteria for CARE proceedings; and,
   ii) The outcome of efforts made to voluntarily engage the respondent during the 21-day report period. Requires the court to provide notice to the respondent and petitioner that a report has been ordered.

9) Requires the agency in III. 8 b) above to submit a written report to the court with the findings and conclusions of its investigation, along with any recommendations. Provides that if the agency is making progress to engage the respondent, it may request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

10) Requires the court within five days of the receipt of the report in III. 9) above, to review the report and do one of the following:

    a) If the court determines that respondent meets, or likely meets, the CARE criteria, and engagement is not effective, the court is to do the following:

        i) Set an initial hearing within 14 days;
        ii) Appoint counsel, unless the respondent has their own counsel;
            (1) If the respondent has not retained legal counsel and does not plan to retain legal counsel, whether or not the respondent lacks or appears to lack legal capacity, the court is to, before the time of the initial hearing, appoint a qualified legal services project, as defined, or if no legal services project has agreed to accept such appointments a public defender to represent the respondent for all purposes related to the CARE Act, including appeals; and,
            (2) Counsel appointed in this case will have the authority to represent the individual in any proceeding the CARE Act, and will have the authority to represent the individual, as needed, in matters related to CARE agreements and CARE plans.
        iii) Allows the respondent to select a supporter, unless the respondent chooses not to have one; and,
        iv) Provide notice of the hearing to the petitioner, the respondent, the appointed counsel, the supporter, and the county behavioral health agency in the county where the respondent resides and, if different, the county where the CARE Court proceedings have commenced.

    b) Requires the court, if it determines that the individual meets, or likely meets the CARE criteria, that voluntary engagement is effective, and that the individual has enrolled in behavioral health treatment, to dismiss the matter; or,
    c) Requires the court, if it determines that the individual does not meet, or is likely not to meet the CARE criteria, to dismiss the matter. Requires the court to notify the petitioner and the respondent of the dismissal and the reason for dismissal. Provides that the petitioner may request reconsideration of the dismissal within 10 days.

11) Provides that the court may at the initial hearing, permit the respondent to substitute their own counsel for appointed counsel and substitute their own supporter for the appointed CARE supporter or elect to proceed without a supporter.

12) Specifies that all of the following apply at the initial hearing:

    a) If the petitioner is not present, allows the court to dismiss the matter;
    b) The respondent may waive their appearance and appear through their counsel. If the respondent elects not to waive their appearance and is not present, and appropriate attempts to elicit the attendance of the respondent have failed, allows the court to conduct the hearing in the respondent's absence. If the hearing is conducted without the respondent present, requires the court to set forth the factual basis for doing so and the reasons the proceedings will be successful without the respondent's presence;
    c) Requires a county behavioral health agency representative to be present;
    d) Allows a supporter to be present, subject to the consent of the respondent;
    e) Allows a tribal representative to attend for a respondent who is tribal member, as provided, and subject to the respondent's consent;

f) Requires the court to make a determination whether the petitioner has presented prima facie evidence that the respondent meets the CARE criteria. In making the determination, the court is to consider all evidence properly before it, including the report from the county and any additional evidence presented by the parties;
g) If the court finds there is no reason to believe that the facts stated in the petition are true, requires the court is to dismiss the case without prejudice, unless the court makes a finding on the record that the petitioner's filing was not in good faith. Requires any new petition to be based on changed circumstances that warrant a new petition;
h) If the court finds there is reason to believe that the facts stated in the petition appear to be true, the court is to order the county behavioral health agency to work with the respondent and the respondent's counsel and supporter to engage in behavioral health treatment. Requires the court to set a case management hearing within 14 days; and,
i) If the respondent is enrolled in a federally recognized Indian tribe, the court is to provide notice of the case management hearing to the tribe subject to the respondent's consent.

13) Requires at the case management hearing for the court to make a determination whether the parties may enter into a CARE agreement and requires a recitation of all terms and conditions on the record.

14) Requires the court, if the parties have agreed to a CARE agreement and the court agrees with the terms, to stay the matter and set a progress hearing in 60 days.

15) Requires the court, if the court finds that the parties have not and are not likely to reach a CARE agreement, to order a clinical evaluation of the respondent, as provided. Requires the evaluation to address the clinical diagnosis and the issue of whether the defendant has capacity to give informed consent regarding psychotropic medication.

16) Requires the county behavioral health agency, through a licensed behavioral health professional, to conduct the evaluation unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation. Requires the court to set a clinical evaluation hearing to review the evaluation within 14 days.

17) Requires the court to review the evaluation and any other evidence from the petitioner, the county behavioral health agency, the respondent, and, if requested by the respondent, the supporter.

18) Permits the petitioner and the respondent to present evidence and call witnesses, including the person who conducted the evaluation.

19) Requires the court to only consider relevant and admissible evidence that fully complies with the rules of evidence.

20) Permits the clinical evaluation hearing to be continued for a maximum of 14 days upon stipulation of the respondent and the county behavioral health agency, unless there is good cause for a longer extension.

21) Requires, if the court finds, by clear and convincing evidence, that the respondent meets the CARE criteria, the court to order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan. Allows, if another

entity will provide services or supports under the CARE plan, that entity to be joined as a party.

22) Requires if the court finds that the evidence does not, by clear and convincing evidence, support that the respondent meets the CARE criteria, the court to dismiss the petition.

23) Allows the respondent and the county behavioral health agency to request appellate review of an order to develop a CARE plan.

24) Requires if the respondent is an American Indian or Alaska Native individual as defined, or is otherwise receiving services from an Indian health care provider or tribal court, the county behavioral health agency is to use best efforts to meaningfully consult with and incorporate the Indian health care provider or tribal court available to the respondent to develop the CARE plan.

25) Requires the date for the hearing to review and consider approval of the proposed CARE plan not be set more than 14 days from the date of the order to develop a CARE plan, unless there is good cause for an extension.

26) Permits the county behavioral health agency or the respondent, or both, to present a proposed CARE plan.

27) Allows the court to issue any orders necessary to support the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding, as provided.

28) Allows a court to order medication if it finds, upon review of the court-ordered evaluation and hearing from the parties that, by clear and convincing evidence, the respondent lacks the capacity to give informed consent to the administration of medically necessary medication, including antipsychotic medication. Requires that to the extent that the court orders medically necessary stabilization medications, the medication may not be forcibly administered and the respondent's failure to comply with a medication order shall not result in a penalty, including but not limited to contempt or the accountability measures in IV. 1) and IV. 2) below.

29) Allows supplemental information to be provided to the court, as provided.

30) Specifies that the issuance of any orders in III. 27) above begins the "up to one-year CARE program" timeline.

31) Requires that a status review hearing occur at least every 60 days during the CARE plan implementation.

32) Requires county behavioral health agency to file with the court, and serve on the respondent and the respondent's counsel and supporter, a report not less than seven days prior to the hearing, with specified information, including progress the respondent has made on the CARE plan, what services and supports in the CARE plan were provided, and what services and supports were not provided, any issues the respondent expressed or exhibited in adhering to the CARE plan; and, recommendations for changes to the services and supports to make the CARE plan more successful.

33) Requires that, subject to applicable law, intermittent lapses or setbacks described in the report may not impact access to services, treatment, or housing

34) Requires the status review hearing to occur unless waived by all parties and approved by the court.

35) Allows the county behavioral health agency, the respondent, or the court to request more frequent reviews, as necessary.

36) Requires the court, in the 11th month of the program, to hold a one-year status hearing, which is an evidentiary hearing, to determine if the respondent graduates from the CARE plan or should be reappointed for another year.

37) Requires that at least seven days prior to the one-year status hearing, the county behavioral health agency to submit to the court, the respondent, the respondent's counsel, and the respondent's supporter, a report on the progress the respondent has made on the CARE plan as provided in III.32) above.

38) Grants the respondent the right to call witnesses and present evidence information at the one-year status hearing as to whether or not the respondent agrees with the report.

39) Specifies that if the respondent has successfully completed the CARE program, the respondent will not be reappointed to the program. Requires the court to review with the parties the voluntary agreement for a graduation plan to support a successful transition out of court jurisdiction and which may include a psychiatric advance directive. Prohibits the graduation plan from placing additional requirements on local government entities and is not enforceable by the court.

40) Permits at the one-year status hearing, the respondent to request reappointment to the CARE proceedings.

    a) If the respondent elects to accept voluntary reappointment to the program, the respondent can request to be re-appointed to the CARE program for up to one additional year; and,
    b) Allows the court to reappoint the respondent to the CARE program for up to one year if the court finds, by clear and convincing evidence, that: i) the respondent did not successfully complete the program; ii) all of the required services and supports were provided to the respondent; iii) the respondent would benefit from continuation of the CARE program; and, iv) the respondent currently meets the requirements in III. 1) above.

41) Provides that a respondent can only be reappointed to the CARE program for up to one additional year.

42) Specifies mandatory timeframes, as well as continuances for good cause, throughout the CARE Court proceedings.

43) Requires hearings to occur in person unless the court allows a party or a witness to appear remotely. Provides the respondent with the right to be in-person for all hearings.

44) Allows the Judicial Council to adopt rules to implement the CARE Court provisions.

45) Requires, for all CARE proceedings, the judge to control all hearings with a view to the expeditious and effective ascertainment of the jurisdictional facts and the ascertainment of all information relative to the present condition and future welfare of the respondent. Requires where there is a contested issue of fact or law, the proceedings to be conducted in an informal, non-adversarial atmosphere with a view to obtaining the maximum cooperation of the respondent, all persons interested in respondent's welfare, and all other parties, with any provisions that the court may make for the disposition and care of the respondent.

46) Requires all evaluations and reports, documents, and filings submitted to the court pursuant to CARE proceedings to be confidential.

IV. Accountability

1) Allows the court, at any point in the proceedings, if it determines, by clear and convincing evidence, that the respondent, after receiving notice, is not participating in the CARE proceedings, to terminate respondent's participation in the CARE program. Allows the court to make a referral under the LPS Act, as provided.

2) Requires that, if a respondent was provided timely with all of the services and supports required by the CARE plan, the fact that the respondent failed to successfully complete their CARE plan, including the reasons for that failure: a) is a fact considered by a court in a subsequent hearing under the LPS Act, provided that hearing occurs within six months of termination of the CARE plan; and, b) creates a presumption at that hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan.

3) Allows the court, at any time in the proceeding, if it finds that the county, or other local government entity, is not complying with its orders, to fine the county, or other local government entity, up to $1,000 per day for noncompliance. Allows the court, if a county is found to be persistently noncompliant, to appoint a receiver to secure court-ordered care for the respondent at the county's cost. In determining the application of the remedies available, requires the court to consider whether there are any mitigating circumstances impairing the ability of the county agency or local government entity to fully comply with the CARE Act requirements.

4) Establishes the CARE Act Accountability Fund (fund) in the State Treasury to receive penalty payments from each county as collected. Requires that all monies in the fund are reserved and continuously appropriated, without regard to fiscal years. Requires that subject to approval from the Department of Finance, DHCS will determine the use of the funds to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders who experience or are at risk of homelessness, criminal justice involvement, hospitalization or conservatorship.

V. The Supporter and Counsel

1) Requires, subject to appropriation, DHCS to provide optional training and technical resources for volunteer supporters on CARE Act proceedings, community services and supports, Supported Decision Making, and people with behavioral health conditions, trauma-informed care and psychiatric advance directives, with support and input from relevant stakeholders. Allows DHCS to enter into a technical assistance and training agreement.

2) Provides that the supporter is designed to do all of the following:

    a) Offer the respondent flexible and culturally responsive ways to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating and implementation their own informed choices;
    b) Strengthen the respondent's capacity to engage in and exercise autonomous decisionmaking and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship; and,
    c) Assist the respondent with understanding, making and communicating decisions, and expressing preferences throughout the CARE Court process.

3) Permits that notwithstanding any other provisions of the CARE Act, the respondent to have a supporter present in any meeting, judicial proceeding, status hearings, or communications related to an evaluation, development of a CARE agreement or CARE plan; establishing a psychiatric advance directive; and, development of a graduation plan.

4) Specifies that a supporter is intended to do all of the following:

    a) Support the will and preferences of the respondent to the best of their ability and to the extent reasonably possible;
    b) Respect the values, beliefs, and preferences of the respondent;
    c) Act honestly, diligently, and in good faith; and,
    d) Avoid, minimize and manage, to the greatest extent possible, conflicts of interest. Disclose conflicts of interest to the court, the respondent and the respondent's counsel. Allows a court to remove a supporter because of any conflict of interest with the respondent, and to remove the supporter if the conflict cannot be managed in such a way to avoid any possible harm to the respondent.

5) Prohibits a supporter, without explicit authorization by the respondent with capacity to make that authorization from making decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury, and to sign documents on behalf of the respondent.

6) Provides that in addition to the obligations specified, a supporter is bound by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. Specifies that the CARE Act does not limit a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion or mistreatment including liability under the Elder Abuse and Dependent Adult Civil Protection Act.

7) Requires subject to appropriation, the Judicial Council to provide funding to qualified legal services projects, as defined to be used to provide legal counsel appointed under III. 10) a) above for representation in CARE proceedings, matters related to CARE agreements and CARE plans, and to qualified support center as defined for training, support and coordination.

VI. Care Plan

1) Requires the CARE plan to only include the following:

    a) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, health care plans and insurers, services provided as specified within portions of the County Aid and Relief to Indigents and services supported by the Mental Health Services Act (MHSA) as specified;
    b) Medically necessary stabilization medication to the extent not described in VI. 1) above;
    c) Housing resources funded through programs as specified including but not limited to the No Place Like Home Program; the California Housing Accelerator; the Homeless Housing Assistance and Prevention Program, the Project Roomkey and Rehousing Program; the Community Care Expansion Program; the Transitional Housing Placement Program; the Behavioral Health Continuum Infrastructure Program; and, the Community Development Block Grant Program; and,
    d) Social services funded through the Supplemental Security Income/State Supplementary Payment Case Assistance program for Immigrants, CalWORKs, California Food Assistance Program, In-Home Supportive Services. and Cal Fresh.

2) Requires individuals who are CARE program participants to be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

3) Requires all CARE plan services and supports ordered by the court to be subject to all applicable federal and state statutes and regulations, contractual provisions and policy guidance governing program eligibility and available funds. Requires that in addition to the resourced funded through programs listed in VI. 1) above, DHCS to identify other adjacent covered Medi-Cal services, including but not limited to, enhanced case management and available community supports, which may be provided, although not ordered by the court, subject to all applicable federal and state statute, regulations contractual provisions, and policy guidance.

4) Requires that for respondents who are Medi-Cal beneficiaries, the county in which the respondent resides is the county of responsibility, as defined.

5) Provides that if a proceeding commences in a county where the respondent is found or is facing criminal or civil proceedings that is different than the county in which the respondent resides, the county in which the respondent is found or is facing criminal or civil proceedings cannot delay proceedings and is the responsible county behavioral health agency for providing or coordinating all components of the CARE agreement and CARE plan.

6) Provides that the county in which respondent resides as defined in VI. 4) above is responsible for the costs of providing all CARE agreement or CARE plan behavioral health services as defined in V.1) a) above.

7) Requires, in the event of a dispute over responsibility for any costs of providing components of the CARE agreement or CARE plan, the impacted counties to resolve the dispute in accordance with the arbitration process established for county mental health plans, including for respondents who are not Medi-Cal beneficiaries.

VII. Technical Assistance and Administration:

1) Requires, subject to appropriation, the California Health and Human Services Agency (CHSSA) or a designated department within CHSSA to:

    a) Engage an independent, research-based entity, as described in VII. 12) below, to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act; and,
    b) Provide coordination, on-going engagement, and support collaboration among relevant state and local partners and other stakeholders throughout the phases of county implementation to support the successful implementation of the CARE Act.

2) Requires, subject to appropriation, DHCS to provide training and technical assistance to county behavioral health agencies to support the implementation of the CARE Act, including training regarding the CARE statute, CARE plan services and supports, supported decision making, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives, and data collection.

3) Requires, subject to appropriation, the Judicial Council, in consultation with DHCS, other relevant state entities, and the County Behavioral Health Directors Association, to provide training and technical assistance to judges to support the implementation of the CARE Act, including training regarding the CARE statutes, CARE plan services and supports, working with the supporter, supported decision making, the role of the supporter, trauma -informed care, elimination of bias, best practices, and evidence-based models of care for people with severe behavioral health conditions.

4) Permits for purposes of implementing the CARE Act, the CHSSA and DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

5) Permits CHHSA and DHCS to implement, interpret, or make specific the CARE Act, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

6) Requires DHCS to develop, in consultation with county behavioral health agencies, other relevant state or local government entities, disability rights groups, individuals with lived experience, families, counsel, and other appropriate stakeholders, an annual report. Requires DHCS to post the annual report on its internet website.

7) Requires county behavioral health agencies and any other state or local governmental entity, as identified by DHCS to provide to DHCS data related to the CARE Act participants, services, and supports. Requires DHCS to determine the data measures and specifications, and publish through guidance.

8) Requires each county behavioral health department and any other state and local governmental entity, as identified by DHCS, to provide the required data in a format and frequency as directed by DHCS

9) Requires DHCS to provide information on the populations served and demographic data, stratified by age, sex, race, ethnicity, languages spoken, disability, sexual orientation and gender identity, and county, to the extent statistically relevant data is available.

10) Requires the report to include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing homelessness, criminal justice involvement, conservatorships, and hospitalization of participants. Requires the annual report to include process measures to examine the scope of impact and monitor the performance of the CARE Act model implementation, such as the number and source of petitions filed for CARE Court; the number, rates, and trends of petitions resulting in dismissal and hearings; the number, rates, and trends of supporters; the number, rates, and trends of voluntary CARE agreements; the number, rates, and trends of ordered and completed CARE plans; the services and supports included in CARE plans, including court orders for stabilizing medications; the rates of adherence to medication; the number, rates, and trends of psychiatric advance directives; and, the number, rates, and trends of developed graduation plans. Requires the report to include outcome measures to assess the effectiveness of the model, such as improvement in housing status, gaining and maintaining housing; reductions in emergency department visits and inpatient hospitalizations; reductions in law enforcement encounters and incarceration; reductions in involuntary treatment and conservatorship; and reduction in substance use. Requires the annual report to examine these data through the lens of health equity to identify racial/ethnic and other demographic disparities and inform disparity reduction efforts.

11) Requires that the outcomes be presented to relevant state oversight bodies, including, but not limited to, the California Interagency Council on Homelessness.

12) Requires that an independent, research-based entity be retained by DHCS to develop, in consultation with county behavioral health agencies, county CARE Courts, and other appropriate stakeholders, an independent evaluation of the effectiveness of the CARE Act.

13) Requires the independent evaluation to employ statistical research methodology and include a logic model, hypotheses, comparative and/or quasi-experimental analyses, and conclusions regarding the extent to which the CARE Act model is associated, correlated, and causally related with the performance of the outcome measures included in the annual reports. Requires the independent evaluation to highlight racial/ethnic and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts.

14) Requires DHCS to provide a preliminary report to the Legislature three years after the implementation date of the CARE Act and a final report to the Legislature five years after the implementation date of the CARE Act. Requires DHCS to post the preliminary and final reports on its internet website.

15) Requires each county behavioral health department, each county CARE Court, and any other state or local governmental entity, as determined by DHCS, to provide the required data to DHCS, in a format and frequency as directed by DHCS.

VIII. Health Plans and Insurance

1) Requires a health care service plan (health plan) contract that covers hospital, medical, or surgical expenses and an insurance policy, issued, amended, renewed, or delivered on or after July 1, 2023, to cover the cost of developing an evaluation as defined in III. 15) above and the provision of all health care services for an enrollee when required or recommended for

the enrollee under a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under the CARE Act regardless of whether the services are provided by an in-network or out-of-network provider.

2) Prohibits a health care service plan or an insurer from requiring prior authorization for services, other than prescription drugs, required under a CARE agreement or CARE plan approved by a court under the CARE Act.

3) Permits a health plan or an insurer to conduct a postclaim review to determine appropriate payment of a claim. Allows payment for services to be denied only if the health plan or insurer reasonably determines the enrollee was not enrolled at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

4) Permits, notwithstanding VIII. 2) above, a health plan or insurer to require prior authorization for services as permitted by the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI) under VIII. 9) below.

5) Requires a health plan or insurer to provide for reimbursement of services provided to an enrollee under the CARE Act, other than prescription drugs, at the greater of either of the following amounts:

   a) The health plan's or insurer's contracted rate with the provider; or,
   b) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the DHCS.

6) Requires a health plan or insurer to provide for reimbursement of prescription drugs provided to an enrollee under the CARE Act at the contracted rate of the health plan/insurer.

7) Requires a health plan or insurer to provide reimbursement for services provided under the CARE Act in compliance with the requirements for timely payment of claims, as specified.

8) Prohibits from subjecting services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, to copayment, coinsurance, deductible, or any other form of cost sharing. Prohibits an individual or entity from billing the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan regardless of whether such service is delivered by an in-network or out-of-network provider.

9) Requires no later than July 1, 2023, DMHC and CDI to issue guidance to health plans or insurers regarding compliance with the CARE Act. Exempts the guidance from being subject to the Administrative Procedure Act (APA). Provides that such guidance is effective only until DMHC and CDI adopt regulations under the APA.

10) Requires a health plan or insurer to comply with the California Mental Health Parity Act of 2020.

11) Specifies that the health plan/insurer provision does not apply to Medi-Cal managed care contracts between DHCS and a health plan for enrolled Medi-Cal beneficiaries as specified.

12) Specifies that the health plan/insurer provisions become operative on July 1, 2023.

IX. Miscellaneous

1) Permits, if a person who is charged with a misdemeanor or misdemeanors only, or a violation of formal or informal probation for a misdemeanor, where the judge finds reason to believe that the defendant has a mental health disorder, and may, as a result of the mental health disorder, be incompetent to stand trial, and the individual after a hearing is determined to be ineligible for diversion, the court to refer the defendant to the CARE Program.

2) Requires that a hearing to determine eligibility for the CARE Program to be held within 14 days after the date of the referral in IX. 1) above. Requires that if the hearing is delayed beyond 14 days, the court to order the defendant, if confined in a county jail, to be released on their own recognizance pending that hearing. Requires that if the defendant is accepted into CARE Program, the charges pending against the defendant to be dismissed.

3) Expands the systems of care for adults and older adults with SMI that calls for a client to be fully informed and volunteer for all treatment provided, unless danger to self or others or gravely disabled requiring temporary involuntary treatment to also include if the client is under a court order for CARE Court and prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so.

4) Permits when included in a county's MHSA County Plan and annual update, MHSA funds to be used for the provisions of services to clients under the CARE Program.

EXISTING LAW:

1) Establishes the LPS Act to end inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to provide prompt evaluation and treatment of those with mental health disorders or impaired by chronic alcoholism.

2) Defines, as a basis for involuntary commitment under the LPS Act, "grave disability" as a condition in which a person, as a result of a mental disorder, or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter, or is found to be mentally incompetent under the Penal Code. Excludes from that definition persons with intellectual disabilities by reason of that disability alone.

3) Provides that if a person is gravely disabled as a result of mental illness, or a danger to self or others, then a peace officer, staff of a designated treatment facility or crisis team, or other professional person designated by the county, may, upon probable cause, take that person into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement in a designated treatment facility.

4) Allows a person who has been detained for 72 hours to be detained for up to 14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment.

5) Allows a person to be held at the expiration of a 14-day period of intensive treatment for further intensive treatment of up to 14 days if, during the detention period, a person threatened or attempted to take their own life or was detained because they threatened or attempted to their own life and continues to present an imminent threat of taking their own life and other specified condition.

6) Allows a person who has been detained for 14 days of intensive treatment to be detained for up to 30 additional days of intensive treatment if the person remains gravely disabled and is unwilling or unable to voluntarily accept treatment.

7) Requires a certification review hearing to be held within four days of the date on which a person is certified for a 14-day period of intensive treatment or 30 additional days of intensive treatment unless judicial review has been requested or a postponement is requested by a person or their attorney or advocate.

8) Grants every person detained by certification for intensive treatment with a right to a hearing by writ of habeas corpus for their release. Enumerates specified requirements and procedures for judicial review.

9) Allows for antipsychotic medication to be administered to any person subject to specified detentions under the LPS Act if that person does not refuse that medication. Allows antipsychotic medication to be administered when a detained individual indicates refusal of that medication only when the treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient and upon a determination of that person's incapacity to refuse the treatment in a hearing. In the case of emergency, allows for antipsychotic medication to be administered over a detained person's objection prior to a capacity hearing if the medication is required to treat the emergency and is provided in the manner least restrictive to the personal liberty of the patient. Enumerates specified requirements and procedures for capacity hearings pertaining to administering antipsychotic medication.

10) Allows, under the LPS Act, a court to order an imminently dangerous person to be confined under a conservatorship for further inpatient intensive health treatment for an additional 180 days, as provided.

11) Allows the professional person in charge of a facility providing 72-hour, 14-day, or 30-day treatment to recommend an LPS conservatorship to the county conservatorship investigator for a person who is gravely disabled and is unwilling or unable to voluntarily accept treatment; and requires the conservatorship investigator, if they concur with the recommendation, to petition the superior court to establish an LPS conservatorship. Provides that a person for whom an LPS conservatorship is sought has the right to demand a court or jury trial on the issue of whether they are gravely disabled.

12) Requires an officer providing conservatorship investigation to investigate all available alternatives to conservatorship and recommend conservatorship to the court only if no suitable alternatives are available. Requires the officer to render to the court a comprehensive written report containing all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, information concerning the person's property, and information obtained from the person's family members, close friends, social

worker, or principal therapist. Requires the officer, if they recommend against conservatorship, to set forth all alternatives available.

13) Requires a conservator under an LPS conservatorship to place the conservatee in the least restrictive alternative placement, as provided. Gives the LPS conservator the right, if specified in the court order, to require the conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee's being gravely disabled.

14) Requires counties, unless they opt out, to provide AOT, also known as "Laura's Law," for people with serious mental illnesses when a court determines that a person's recent history of hospitalizations or violent behavior, and noncompliance with voluntary treatment, indicates the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment.

15) Establishes a pilot program, until January 1, 2024, for Los Angeles and San Diego Counties, and the City and County of San Francisco, upon authorization by their respective boards of supervisors, to implement a "housing conservatorship" procedure for a person who is incapable of caring for their health and well-being due to a serious mental illness and substance use disorder, as evidenced by eight or more detentions for evaluation and treatment under Section 5150 in the preceding 12 months.

16) Permits, under the Probate Code, any interested person to petition the court for the appointment of a "conservator of the person" for a person who is unable to provide properly for their personal needs for physical health, food, clothing, or shelter, and permits the appointment of a "conservator of the estate" for a person who is unable to manage their financial resources or resist fraud or undue influence. Provides that no conservatorship of the person or of the estate may be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee.

17) Creates a court diversion program for those charged with certain drug offenses.

18) Creates a court diversion program for those with "mental disorders," as defined.

19) Allows a court, if a criminal defendant is found to be mentally incompetent, to, among other things, determine if the defendant is eligible for a diversion program, or, if ineligible, to, among other things, refer the defendant to AOT or to an LPS conservatorship investigation.

20) Defines "Housing First" to mean the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. States that Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

21) Requires all agencies and departments administering state programs, created on or after July 1, 2017, to collaborate with the California Interagency Council on Homelessness to adopt guidelines and regulations to incorporate core components of Housing First.

22) Establishes the Medi-Cal program, which is administered by DHCS, under which qualified low-income individuals receive health care services.

23) Makes children age 18 and under with family incomes up to 266% of the federal poverty level eligible for Medi-Cal.

24) Establishes a schedule of benefits in the Medi-Cal program, which includes mental health and SUD services included in the essential health benefits package adopted by the state for purposes of implementing the federal Patient Protection and Affordable Care (ACA) requirement for benefits that must be included in health plans offered in the private individual and small group market and to the Medicaid expansion population.

25) Requires DHCS to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans (MHPs). Permits MHPs to include individual counties, counties acting jointly, or an organization or nongovernmental entity determined by DHCS to meet MHP standards. Permits a contract to be exclusive and may be awarded on a geographic basis. Requires MHPs to be responsible for providing Specialty Mental Health Services (SMHS) to enrollees.

26) Requires county MHPs to be governed by specified guidelines, which include a requirement that MHPs provide SMHS to eligible Medi-Cal beneficiaries, including both adults and children.

28) Establishes the DMHC to regulate health plans and the CDI to regulate health insurers.

29) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, as specified in state law, which include the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; Mental Health and SUD services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

30) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

31) Requires emergency health care services to be available and accessible to enrollees on a 24 hour a day, seven days a week, basis within the health plan area. Requires emergency health care services to include ambulance services for the area served by the plan to transport the enrollee to the nearest 24 hour emergency facility with physician coverage, designated by the health plan.

32) Requires every health plan contract issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of Mental Health and SUD under the same terms and conditions applied to other medical conditions, as specified.

33) Defines medically necessary treatment of mental health and SUD as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

35) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

36) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by majority vote.

FISCAL EFFECT: Unknown. This bill, as amended, has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, county behavioral health departments provide Medi-Cal specialty mental health services to those who are enrolled in Medi-Cal and have severe mental illness. However, many of the most impaired and vulnerable individuals remain under or un-served because: a) the individual is so impaired they do not seek out services; b) the necessary services are not available at the right time due to administrative complexities and/or legal barriers; c) client care lacks coordination among providers and services, resulting in fragmentation among provided services; and, d) little accountability at various levels of the system results in poor outcomes for the client, who is often living on the streets. The author concludes, this bill seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.

Governor Newsom, when introducing his CARE Court proposal, stated that sadly, the status quo provides support only after a criminal justice intervention or conservatorship. CARE Court is a paradigm shift, providing a new pathway for seriously ill individuals before they end up cycling through prison, emergency rooms, or homeless encampments. He further stated that, CARE Court is about meeting people where they are and acting with compassion to support the thousands of Californians living on our streets with severe mental health and substance use disorders. The Governor concluded by stating that we are taking action to break the pattern that leaves people without hope and cycling repeatedly through homelessness and incarceration. CARE Court is a new approach to stabilize people with the hardest-to-treat behavioral health conditions.

2) BACKGROUND.

a) CARE Court proposal. In early 2022, Governor Newsom proposed the CARE Court program to help connect a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and

supports that are culturally and linguistically competent, which includes short-term stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. According to the CHHSA's website, housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent, or in a vehicle. CHHSA states that CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration, based on evidence that demonstrates many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer-acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community. CHHSA further states that CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity, before they enter the criminal justice system or become so impaired that they end up in a LPS conservatorship due to mental illness. CHSSA states that although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions, and the CARE Court proposal aims to connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness. SB 1338 (Umberg and Eggman) and AB 2830 (Bloom) of this Legislative Session implement the CARE Court proposal.

b) Housing First: In 2016, the state's efforts to address homelessness shifted to the use of Housing First core components. SB 1380 (Mitchell) Chapter 847, Statutes of 2016, which created the California Interagency Council on Homelessness to oversee implementation of the Housing First regulations and coordinate the state's response to homelessness, as well as create partnerships among state agencies and departments, local government agencies, nonprofits, and federal agencies to prevent and end homelessness in California. SB 1380 also aligned the Housing First guidelines for any state program that provides housing and supportive services to people experiencing homelessness. Housing First is an evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

As currently in print, this bill includes a housing plan as part of the respondent's CARE plan. This bill provides for the housing plan to describe the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement. It also gives the respondent diverse housing options, including, but not limited to, housing in clinically enhanced interim or bridge housing, licensed adult and senior care settings, and supportive housing. Since this bill goes on to state that "counties may offer appropriate housing placements in the region as early as feasible in the engagement process" it appears this provision "does not allow the court to order housing or to require the county to provide housing," thus an individual could be participating in CARE Court, be required to meet certain treatment plan goals and requirements, and yet remain unhoused. Under the existing Housing First framework, the state is supposed to be working with local governments and Continuums of Care to ensure housing is used as a tool in an individuals' overall path to wellness rather than as a

reward for recovery, even for those with SUD or SMI.

It is unclear how an individual meeting the requirements for participation in CARE Court can truly make progress, in terms of complying with the components of their CARE plan, if they remain unhoused. Additionally, the language of this bill is currently silent on whether an individual who is housed through the CARE Court program may lose their housing if they fail to comply with their CARE plan, stop taking their psychotropic medications, or experience a relapse. These raise questions on how the program complies with existing Housing First principals.

c) **California's mental health crisis.** Mental illness is pervasive in California. About one in six Californians experience mental illness and one in 25 experience a SMI. (California Budget & Policy Center, "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding*"* (March 2020)). These rates are higher among people of color and those living below the poverty line. Among those experiencing homelessness, one in four individuals report having a SMI.

The COVID-19 pandemic exacerbated mental illness rates in California, and the state continues to face a shortage of facilities, services, and workers to appropriately care for its mentally ill population. For example, since 1995, the number of inpatient psychiatric beds in California has been decreasing, despite population growth and increased rates of mental illness. The state is projected to continue to face a shortfall of thousands of psychiatric beds for adult inpatient and residential care. Despite the high rates of mental illness among individuals experiencing homelessness, there is a dire shortage of supportive housing and wrap-around services to adequately treat mental illness within this population. Further, the behavioral health workforce is insufficient to meet the growing demand for mental healthcare. One report projected that, if current trends continue, by 2028 California will have 41% fewer psychiatrists and 1% fewer psychologists, therapists, and social workers than are likely to be needed. The growing mental health crisis has led to calls for reforming the mental healthcare system in California, including reforming existing law providing for involuntary detentions and treatment due to mental illness.

d) **A significant portion of California's homeless population is severely mentally ill.** While accurate data on the number of people among California's unhoused population who are mentally ill is available, it is clear that a significant portion of that population has mental health disabilities. According to the 2019 annual point-in-time count, 23% of California's homelessness population is severely mentally ill. A *Los Angeles Times* review of the 2019 point-in-time homelessness count for Los Angeles County found that 51% of homeless were either reported or observed to be affected by mental illness; 46% were affected by substance abuse; and, 67% were affected by either mental illness or substance abuse. A study from the University of California's California Policy Lab, linking Los Angeles County Department of Mental Health records to Street Outreach data, found that 20% of Street Outreach clients had been diagnosed with a SMI within the previous 12 months. That study also found that homeless clients of the Street Outreach program waited, on average, 101 days for interim housing; 112 days for rapid re-housing; and, 188 days for permanent housing.

e) LPS ACT: mandatory treatment options for those with mental illness. California law provides a number of options for forcibly detaining and treating individuals with SMI. The primary option is the 1967 LPS Act, which provides for involuntary commitment for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements or preconditions are met. The goal of the LPS Act is to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities."

i) *LPS involuntary holds and conservatorships.* Under the LPS Act, an individual may be involuntary committed for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements are met. Additionally, the LPS Act provides for LPS conservatorships, resulting in involuntary commitment for the purposes of treatment, if an individual is found to meet the "grave disability" standard in which a person, as a result of a mental disorder or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter.

Typically, a person's first interaction with the LPS Act is through what is commonly referred to as a 5150 hold. This allows an approved facility to involuntarily commit a person for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5150.) The peace officer, or other authorized person, who detains the individual must know of facts that would lead a person of ordinary care and prudence to believe that the individual meets this standard. When making this determination, the peace officer, or other authorized person, may consider the individual's past conduct, character, and reputation, so long as the case is decided on facts and circumstances presented to the detaining person at the time of detention.

Following a 72-hour hold, the individual may be held for an additional 14-days, without court review, if they are found to still be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5250.) When determining whether the individual is eligible for an additional 14-day confinement, the professional staff of the agency or facility providing evaluation services must find that the individual has additionally been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. Additionally, the individual cannot be found at this point to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or third parties who are both willing and able to help. The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing.

If a person is still found to remain gravely disabled and unwilling or unable to accept voluntary treatment following their additional 14 days of intensive treatment, they may be certified for an additional period of not more than 30 days of intensive treatment. (Section 5270) The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing. Additionally, the professional staff of the agency or facility providing the treatment, must analyze the person's condition at

intervals not to exceed 10 days, and determine whether the person continues to meet the criteria for continued confinement. If the person is found to no longer meet the requirements of the 30-day hold, then their certification should be terminated.

Finally, the LPS Act provides for a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. (Section 5350.) The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled individual. The individual for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement, and they have the right to be represented by counsel. An LPS conservatorship lasts for one year, but can be renewed.

ii) *Laura's Law.* As an alternative to an LPS conservatorship, current law provides for court-ordered outpatient treatment through Laura's Law, or the AOT Demonstration Project, enacted in 2002. In participating counties, the court may order a person into an AOT program if the court finds that the person either meets existing involuntary commitment requirements under the LPS Act or the person meets non-involuntary commitment requirements, including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community. Originally, Laura's Law was only operative in those counties in which the county board of supervisors, by resolution, authorized its application and made a finding that no voluntary mental health program serving adults and no children's mental health program would be reduced in order to implement the law. The initial sunset provision provided for within Laura's Law was extended several times until 2020 when legislation was passed requiring that, rather than counties opting into Laura's Law, counties have to, by board of supervisors resolution, opt out of the program. Additionally, the sunset provision was removed, making the program permanent.

Laura's Law is designed to provide counties with tools for early intervention in mental health crises. It allows for family members, relatives, cohabitants, treatment providers, or peace officers to initiate the AOT process with a petition to the county behavioral health director or the director's designee. The health director or designee must then determine how to proceed. If the individual is found to meet the AOT eligibility requirements, a preliminary care plan is developed to meet that person's needs. If this process results in the person voluntarily engaging with treatment, then the patient is deemed to no longer meet the criteria and the petition is no longer available. However, if the client declines their preliminary plan, then a public defender is assigned and the petition process proceeds. A judge either grants or rejects the AOT petition; and if an AOT petition is approved, treatment is ordered and continues for up to 180 days.

iii) *Housing Conservatorship Pilot.* In 2018, the Legislature created a pilot project, known as the "housing conservatorship," for those who have both SMI and SUD (SB 1045 (Wiener & Stern) Chapter 845, Statutes of 2018, and SB 40 (Wiener & Stern) Chapter 467, Statutes of 2019) The counties of Los Angeles, San Diego, and San

Francisco may, through January 1, 2024, elect to establish this new conservatorship, but only after, among other requirements, the board of supervisors determines that money will not be taken from other mental health and conservatorship programs and the board of supervisors ensures that necessary services are available in sufficient quantity, resources, and funding levels to serve the identified population, including access to supportive community housing with wraparound services, public conservators, mental health services, substance use disorder services, and service planning and delivery services.

This new six-month conservatorship, which may be established following a 28-day temporary conservatorship, is designed for those who are incapable of caring for their own health and well-being due to a SMI and SUD, as evidenced not by a contemporary grave disability, but by at least eight 72-hour involuntary holds under Section 5150 in the preceding 12 months. To ensure that this new conservatorship is truly filling a gap and not replacing any existing conservatorship or program, the investigator must consider all alternatives to the proposed conservatorship and only recommend the new conservatorship if no less restrictive alternatives exist and it appears the individual will not qualify for a conservatorship under the Probate Code or the LPS Act. So far, only San Francisco has elected to participate in the pilot and, as of earlier this year, it appears that only two individuals have been conserved under the program, though more individuals could soon be eligible because they are approaching the requisite number of 5150 holds. The pilot requires a thorough evaluation, which should assist the Legislature in determining the need for, and success of, the program.

iv) *Probate Conservatorship.* In California, if an adult is, based on clear and convincing evidence, unable to provide properly for their personal needs for physical health, food, clothing, or shelter, a conservator of the person may be appointed by the court. If an adult who is, based on clear and convincing evidence, substantially unable to manage their own financial resources or resist fraud or undue influence, a conservator of the estate may be appointed by a court to manage the adult's financial matters. The appointment process requires an investigation by a court investigator and approval by the court. The conservator can be a family member, friend, a professional fiduciary, or, more rarely, a county public conservator. A conservatorship involves a court-appointed third party – the conservator – making far-reaching, life-changing decisions on behalf of the conservatee. Historically, a conservatorship lasts until the death of the conservatee or a court order terminating it, based on someone seeking a petition for termination. However, AB 1194 (Low) Chapter 417, Statutes of 2021, requires that these conservatorships be reviewed annually by the probate court and terminated unless the court can legally reestablish them. AB 1194 cannot be implemented until the Legislature specifically allocates funding for it, thus allowing conservatorships to continue indefinitely, despite the recent change in state law.

f) ***California State Auditor (CSA) report on the LPS.*** In July of 2020, the CSA released a report entitled, "Lanterman-Petris-Short Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care." The Joint Legislative Audit Committee called for the audit and the CSA examined the implementation of the LPS Act in Los Angeles County, San Francisco County, and Shasta County. Essentially the audit found that California has not ensured adequate care

of individuals with SMI in its broader mental health system. The audit found that, "perhaps most troublingly, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities." The CSA found that the LPS Act's criteria for involuntary mental health treatment allows counties sufficient authority to provide involuntary treatment to people who need it and no evidence was found to justify expanding the "grave disability" criteria, which could "potentially infringe upon people's liberties." However, while the LPS Act's criteria are sufficient for involuntary holds and conservatorships, significant issues were found with how Californians with SMI are cared for in the LPS system:

i) Individuals on conservatorships have limited treatment options – many could not receive specialized care in state hospital facilities for an average of one year because of a shortage of available treatment beds;
ii) Individual existing involuntary holds have not been enrolled consistently in subsequent care to help them live safely in their communities – in two counties, no more than 9% of these individuals were connected to ongoing services and supports; and,
iii) Less than one-third of the State's counties – only 19 at the time of the audit – had adopted AOT even though it is an effective community-based approach to mental health treatment to help prevent future involuntary holds and conservatorships.

g) Non-mandatory options for treating those with mental illness. Today there are a number of alternatives to the court-ordered involuntary holds or treatment that provide more autonomy, or advance choice, to the individual, while still providing them with necessary treatment and support. These include a durable power of attorney and advance health care directive, as well as supported decisionmaking. More broadly, there are voluntary, community-based supports and services. In addition to other community-based voluntary mental health services and supports, in 2004 California voters adopted Proposition 63, which created the MHSA. The MHSA imposed a one-percent surtax on the wealthiest Californians in order to fund mental health programs and services across the state. Under the MHSA, the DHCS allocates Proposition 63 funds to mental health programs and services through contracts with individual counties.

MHSA programs have three key components: community services and support (CSS); prevention and early intervention (PEI); and innovation. CSS programs, which account for about 80% of allocated funds, provide direct services to individuals with SMI. The guiding concept of CSS programs is to do "whatever it takes" to meet the mental health needs of those who are unserved or underserved. PEI programs, which may account for up to 20% of a county's funding, seek to identify early mental illness (especially in children and young adults) before it becomes severe and disabling. Finally, counties may use up to 5% of their funding for "innovation," or developing, testing, and implementing new approaches that may not yet have demonstrated effectiveness.

While the LPS Act and MHSA have different histories and functions, they share the common goal of helping people obtain treatment for mental illness in the least restrictive and most effective manner possible. The MHSA has the potential to provide alternatives to the choices presented by the LPS system.

h) California's muddled mental health system. While the CSA rightly noted the shortcomings of LPS holds and conservatorships, those shortcomings are not solely attributable to problems within the LPS Act, its definitions, or its implementation. LPS cannot "connect" persons to "ongoing care" if such care does not exist. The LPS Act, was enacted to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." Its primary purpose is not to provide mental health services per se, but to establish commitment criteria that protect the due process rights of persons who are experiencing a dangerous or debilitating mental health crisis. In the absence of voluntary and less restrictive treatment options, the various professionals who make determinations under the LPS Act too often face the choice of releasing a seriously mentally ill person back into the community, or committing them against their will to a locked psychiatric facility.

It was precisely this lack of alternatives in the wider mental health system that prompted California voters in 2004 to adopt the MHSA. A 2016 report by the Little Hoover Commission (Commission) cites several successful and promising local programs developed through the MHSA, but the Commission's overall conclusion was that a "muddled" governance structure makes it difficult to determine if counties use MHSA funds in the most efficient and effective manner, and who should be held accountable when they do not. For example, current law assigns various responsibilities for implementation of the MHSA to three different agencies: DHCS, which absorbed the administrative responsibilities of the now-disbanded Department of Mental Health Services in 2012; the Mental Health Services Oversight and Accountability Commission (MHSOAC), which although created by Proposition 63, has oversight responsibilities for the mental health care system as a whole; and the Mental Health Planning Council, which reviews program performance of the overall mental health system, including MHSA programs. Unfortunately, members of these three agencies informed the Commission that the broad and sometimes overlapping responsibilities mean, in practice, that there is no clear designation of who is responsible for what.

On one key issue, the Commission's report on MHSA found (and the same problem that the State Auditor found in the LPS system) was insufficient data collection. "Despite compelling claims that the MHSA has transformed mental health services in communities across California," the Commission stated, "the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars." Without robust data, policymakers cannot know which programs work with which specific populations. The Commission found that some counties – Los Angeles in particular – have done better than others in tracking outcomes of specific programs. The Commission recommended that the Legislature establish a MHSA data working group within DHCS to build upon the best of the county programs and develop a statewide MHSA database. As guidance, the Commission suggested that the Legislature look to the experience of a working group established in 2014 to collect data on the effectiveness of juvenile justice programs.

If effectively utilized, the MHSA programs may well obviate the need for an LPS hold or conservatorship in the first place, or they might provide less expensive and more effective alternatives to the choice of either releasing or committing persons who are experiencing mental illness. However, LPS decision-makers must first have knowledge of these

programs and their effectiveness with various populations, which would require much more data and analysis, as well as cooperation and collaboration.

i) **Cities and counties have a split position on CARE Courts.** Cities tend to support the legislation and counties and their associated entities, while not opposed, have raised many issues of concern with the legislation. This split is likely due to the fact that many unhoused individuals with mental illness can be found in cities, while the counties will be called upon to provide the supports and services required by the bill (although creation of housing, in large part, is limited by cities).

City support is exemplified by the City of Santee, which recognizes the bill as:

> "An important measure to provide California's civil courts with a new process for earlier action, support, and accountability to protect and care for some of our State's most vulnerable residents. This bill would provide individuals with a clinically appropriate, community-based, court-ordered care plan, including behavioral health care, stabilization medication, and housing support to adults who are suffering from specified mental health disorders (schizophrenia spectrum and psychotic disorders) and who lack medical decision making capacity.
>
> As this legislation could serve as an important tool to help in the City's effort to help address the challenges of homelessness and increase services and safety for those experiencing homelessness, the City Council of the City of Santee passed a unanimous resolution in support of the bill."

County concerns are well illustrated by the letter from the County of Humboldt:

> "…Humboldt County strongly supports a comprehensive, holistic approach to addressing the homeless crisis. However, this bill so far fails to include additional funding for the impact CARE Court would have on our behavioral health, public defender and public guardian offices. Additionally, while we and the cities are working to build our housing stock and behavioral health workforce and infrastructure utilizing recent state investments, we are not yet prepared or funded to implement this new program effectively or operate it ongoing.
>
> New expectations, whether for CARE Court or other programs, require new resources to meet them, especially given decades of underfunding for behavioral health services and zero state investment in the county public guardian offices. Importantly, much of the work envisioned by the CARE Court proposal is not reimbursed by Medi-Cal or private insurance.
>
> Additionally, the proposed sanctions are not appropriate. Our county cannot bear sanctions related to an entirely new program in which we lack the sole authority, housing units and funding to implement. Sanctions would exacerbate the issues our overloaded and underfunded public defender and behavioral health departments are already experiencing, including a severe workforce shortage."

If cities (who may be focused on moving out their unhoused residents) and counties (who will be required to place and serve those individuals) cannot work together to support

CARE Court participants, the program will most likely experience difficulties in succeeding, helping neither counties nor cities, nor, most importantly, the program participants themselves.

j) CARE Court Allocations in Budget. The Governor's May Revision (reflecting the April 7, 2022 version of this bill) includes a total of $64.7 million General Fund in 2022-23 for the support of a new CARE Court process. This amount includes: i) $39.5 million ($37.7 million ongoing) to the judicial branch for court proceedings; ii) $15.2 million (about $1 million ongoing) to the DHCS for training, technical assistance, and data collection; and, iii) $10 million ongoing to the Department of Aging (DOA) for the CARE Court Supporter program (DOA responsibility for the supporter role has been removed from the most recent bill version so it is unknown if these monies will be transferred to DHCS who in this version of the bill is charged with facilitating the supporter role.

3) SUPPORT. Over 45 cities, including the Big City Mayor Coalition write in support of the bill. Specifically, local governments from San Diego, including the City and County of San Diego County (SD), state in support that the creation of CARE Courts represents a thoughtful approach to addressing the behavioral health crisis we are witnessing on our streets and getting people connected with the care they need earlier. It appropriately recognizes the continuum of care that this small but highly visible segment of the population with significant mental health disorders deserve. As with local agencies throughout the State, SD's communities are facing a daunting homelessness crisis. However, the unsheltered population is as diverse as the general population, all who come to their housing situation with different backgrounds, upbringings, and traumas. It is imperative that we provide multi-faceted solutions to help the myriad situations our fellow Californians face. Some unsheltered individuals recently lost a job and need quick and focused assistance; some have SMI and SUD issues that have developed over many years resulting in an inability to care for themselves. SD states that CARE Court will provide a new and focused civil justice alternative to those struggling with schizophrenia spectrum or psychotic disorders and who lack medical decision-making capacity. The CARE plan envisioned by this bill provides numerous safeguards to ensure personal civil liberties are respected and protected.

The California Chamber of Commerce (Chamber), along with 27 local chambers of commerce and business associations, also in support state, the CARE Court is a thoughtful, measured response to the tragedy of homeless mentally ill or substance abuse disordered individuals. It attempts to thread the needle of providing necessary care and treatment in an environment appropriate to deliver those services; that is, a supportive setting that is neither outdoors or incarcerated. Importantly, the individuals to be served by this approach lack the capacity to make medical decisions for themselves; the only alternatives are the status quo, which is continued desperate deterioration living outdoors, or in a far more restrictive conservatorship or incarceration. The Chamber states in conclusion that California employers have a clear stake in improving the treatment and outcomes for severely mentally disabled individuals without a fixed residence. First, they are our fellow Californians, in severe need, for whom we have an obligation of care. Second, many employers share neighborhoods with mentally disabled or substance abuse disordered individuals, so have first-hand experience with the failure of our institutions to adequately serve them and address their misery. Finally, as taxpayers and business leaders, employers want to see their private investment return healthy, thriving communities.

4) **OPPOSITION**. A coalition of over 40 advocacy groups, including Disability Rights California, American Civil Liberties Union, and the Depression and Bipolar Support Alliance (Coalition), write in opposition to this bill. The Coalition states that the CARE Court framework this bill seeks to establish is unacceptable for a number of reasons:

   a) It perpetuates institutional racism through a system of coerced treatment and worsens health disparities, directly harming Black, Indigenous and People of Color;
   b) It denies a person's right to choose and have autonomy over personal healthcare decisions;
   c) It does not guarantee housing provided with fidelity to principles that prioritize voluntary services, an approach that is backed by evidence;
   d) Community evidence-based practices and scientific studies show that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment; and,
   e) It will not matter that the terms used are called "Supportive Decision-Making" and "Supporter" because the Supporter's role is to implement an involuntary medical plan ordered by a civil court, and disregards the importance of voluntary decisions in mental health treatment.

   The Coalition continues that CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction. The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness. While the Coalition agrees that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with SMI, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services. In concluding, the Coalition states that because CARE Court will harm Californians with disabilities, they strongly oppose this bill and instead, would welcome a proposal developed with input from the people CARE Court seeks to help. The Coalition believes a community-based approach would be far more likely to succeed. Such an approach would expand resources for permanent affordable housing with voluntary supports and increase early access to voluntary, community-based treatment based on principles of trauma-informed care and the complete removal of law enforcement and the courts from the process.

5) **CONCERNS**. Numerous organizations write in with significant concerns regarding this bill, including 13 individual counties. One County Coalition (CC) representing the California State Association of Counties, the Rural County Representatives of California, the Urban Counties of California, the County Behavioral Health Director's Association, the County Welfare Directors Association and the California State Association of Public Administrators, Public Guardians and Public Conservators. CC states that as currently drafted, this bill requires all 58 counties to establish a CARE Court. Counties would play a key and substantial role in implementation as the state's partners in providing critical behavioral health and social services. For these reasons, CC strongly advocates the adoption of the following policy recommendations and local investments to help ensure CARE Courts can be implemented in a practical and achievable manner in all 58 counties:

a) Phased-In Implementation**:** The path to success for counties – more importantly, for those who stand to benefit from CARE Court – must be grounded in an incremental phase-in model, in which counties most prepared to implement are the first adopters. This includes, but is not limited to, the resources and ability of courts to establish the new processes and procedures without contributing to further court backlogs; the staffing and funding capacity for behavioral health and social services to provide the necessary services to existing and new populations; and local solutions for ongoing housing shortages, which presents one of the biggest challenges and most critical elements for program success;

b) Resources: The CARE Court program includes new responsibilities and obligations imposed on counties that require additional resources and ongoing funding, likely in the hundreds of millions of dollars. Adequate and sustainable funding, as well as start-up funding is required across multiple departments, including county behavioral health, public defender, county counsel, public guardians and conservators, and county social services. This is in addition to funding required for court administration, operation, and staffing;

c) Fiscal Protections: The CARE Court proposal must provide protections to counties for any new responsibilities and costs. To ensure our counties have the appropriate long-term resources, we recommend fiscal provisions that preserve current funding and services, while also providing a mechanism for determining and allocating supplementary annual funding for new activities and duties required by this bill;

d) Sanctions: Sanctions should be reserved for deliberate and chronic deficiencies, imposed only after meaningful engagement within the existing regulatory framework along with the appropriate procedural safeguards. In addition, sanctions should not begin until after the program has been fully funded and implemented; and,

e) Housing: Housing is imperative for the successful treatment of those with SMI and foundational to addressing the larger problem of homelessness across California. To ensure that the state's recent housing investments are available to serve the CARE population, counties support recent amendments authorizing the Superior Court to order housing providers that have received specified state funds to accept placement of CARE participants at any available housing option or program as appropriate to meet the respondent's needs.

6) DOUBLE REFERRAL. This bill is double referred. It passed out of the Assembly Judiciary Committee with a 9-1 vote on June 21, 2022.

7) RELATED LEGISLATION.

a) AB 2220 (Muratsuchi) creates the Homeless Courts Pilot Program, which would be administered by the Judicial Council for the purpose of providing comprehensive community-based services to achieve stabilization for, and address the specific legal needs of, individuals who are chronically involved with the criminal justice system. AB 2220 was held in the Assembly Appropriations Committee.

b) AB 2830 (Bloom) is identical to the April 7, 2022, version of this bill. AB 2830 was pulled from hearing in the Assembly Judiciary Committee by the author.

c) SB 1416 (Eggman) expands the definition of "gravely disabled" to include the inability of an individual to provide for their basic personal needs for medical care for the purpose of involuntarily detaining the individual for evaluation and treatment of a mental health

condition, as specified. SB 1416 was not set for hearing in the Assembly Judiciary Committee.

8) **COMMITTEE CONCERNS.** Given the very significant concerns that continue to be raised about the bill by the opposition and those with concerns (many of whom will be required to implement CARE Courts), the authors and the Governor may consider further amending the bill as it moves forward, to address those concerns and other issues, including the following:

   a) Further extend the phased-in implementation period to ensure that counties have adequate time to establish the requisite infrastructure needed to meet the needs of program participants, including all needed housing, supports and services, and sufficient staff to ensure the supports and services are provided timely;
   b) Not order any unhoused individual to participate in the CARE Court unless and until housing, with wrap-around supportive services, can be guaranteed for the duration of the court order and, ideally, even after completion of the program;
   c) Revise the sanctions against counties to ensure that no county is sanctioned unless it has sufficient housing, available services, and other resources to provide the necessary supports and services to program participants. If a fine were necessary, ensure that the fine would not reduce funding for voluntary behavioral health services and supports;
   d) Ensure that funding for voluntary, community-based services is not reduced as a result of CARE Court. Reduction of voluntary services would be counterproductive and would increase the need for more expensive and likely less effective involuntary treatment; and,
   e) Provide indemnification for licensed professionals participating in the CARE Court processes, similar to that which is contained in the LPS Act.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County Families Advocating for The Seriously Mentally Ill
Bay Area Council
Big City Mayors
Building Owners and Managers Association
California Association of Code Enforcement Officers
California Chamber of Commerce
California Downtown Association
California Hospital Association
California Professional Firefighters
California Travel Association (CALTRAVEL)
Central City Association of Los Angeles
City of Alhambra
City of Bakersfield
City of Berkeley
City of Beverly Hills
City of Buena Park
City of Carlsbad
City of Chino Hills
City of Chula Vista
City of Concord

City of Corona
City of Coronado
City of Del Mar
City of El Cajon
City of Encinitas
City of Escondido
City of Fontana
City of Fullerton
City of Garden Grove
City of Half Moon Bay
City of Huntington Beach
City of Imperial Beach
City of Irvine
City of La Mesa
City of Lemon Grove
City of Mission Viejo
City of Montclair
City of National City
City of Oceanside
City of Ontario
City of Paramount
City of Poway
City of Rancho Palos Verdes
City of Redwood City
City of Riverside
City of San Diego
City of San Marcos
City of Santa Monica
City of Santa Rosa
City of Santee
City of Solana Beach
City of Upland
City of Vista
County of Contra Costa
County of Marin
County of San Diego
Family and Consumer Advocates for The Severely Mentally Ill
Family Services Association
Fontana Chamber of Commerce
Fremont Chamber of Commerce
Garden Grove Chamber of Commerce
Golden Gate Restaurant Association (GGRA)
Govern for California
Harbor Association of Industry & Commerce
Hotel Council of San Francisco
Inland Empire Economic Partnership (IEEP)
Laguna Niguel Chamber of Commerce
Lake Elsinore Valley Chamber of Commerce
Los Angeles Area Chamber of Commerce

Los Angeles Business Council
Los Angeles County Business Federation (BIZFED)
National Alliance on Mental Illness (NAMI-CA)
Neighborhood Partnership Housing Services, INC.
Oceanside Chamber of Commerce
Orange County Business Council
Orange County Hispanic Chamber of Commerce
Palos Verdes Peninsula Chamber of Commerce
Psychiatric Physicians Alliance of California (PPAC)
Redondo Beach Chamber of Commerce
Sage Leadership Academy
San Diego County District Attorney's Office
San Diego Regional Chamber of Commerce
San Francisco Chamber of Commerce
San Francisco Travel Association
San Pedro Chamber of Commerce
Santa Clarita Valley Chamber of Commerce
Santa Rosa Metro Chamber of Commerce
Santee Chamber of Commerce
South Bay Association of Chambers of Commerce
Tulare Chamber of Commerce
Valley Industry and Commerce Association
West Ventura County Business Alliance

Opposition

A & L Association
Abolition Study Group of Psychologists for Social Responsibility
American Civil Liberties Union (ACLU), Center for Advocacy & Policy CA
American Civil Liberties Union California Action
American Civil Liberties Union of California
Anti Police-terror Project
Bay Area Legal Aid
California Behavioral Health Planning Council
Cal Voices
California Advocates for Nursing Home Reform
California Assoc. of Mental Health Peer Run Organizations (CAMHPRO)
California Democratic Party Black Caucus Legislative Committee
California Pan-ethnic Health Network
Caravan 4 Justice
Care First California
Corporation for Supportive Housing (CSH)
County of Humboldt
Depression and Bipolar Support Alliance
Dignity and Power Now
Disability Rights Advocates
Disability Rights California
Disability Rights Education & Defense Fund (DREDF)
Disability Rights Legal Center

Drug Policy Alliance
Ella Baker Center for Human Rights
Funders Together to End Homelessness San Diego
Housing California
Housing Is a Human Right - Orange County
Human Rights Watch
Inland Equity Partnership
Justice in Aging
Justice LA
Justice Teams Network
Justice2jobs Coalition
Kelechi Ubozoh Consulting
LA Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Lotus Collective
Love and Justice in The Streets
Loyola Law School
Mental Health Advocacy Services
Mental Health America of California
NAACP San Mateo Branch #1068 Housing Committee
National Association of Social Workers, California Chapter
National Health Law Program
National Homelessness Law Center
Nextgen California
No CARE Court California Coalition
Norcal Resist
Peers Envisioning and Engaging in Recovery Services (PEERS)
People's Budget Orange County
People's Homeless Task Force Orange County
Project Amiga
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld, LLP
Sacramento Homeless Organizing Committee
Sacramento LGBT Community Center
Sacramento Regional Coalition to End Homelessness
San Bernardino Free Them All
San Francisco Pretrial Diversion Project
San Francisco Public Defender's Office
Senior & Disability Action
Senior and Disability Action
Starting Over INC.
Stop the Musick Coalition
Street Watch LA
Stronger Women United
The Bar Association of San Francisco
The Coelho Center for Disability Law Policy and Innovation
Western Center on Law & Poverty

Western Regional Advocacy Project
Women's Wisdom Art
10 individuals

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