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UNFINISHED BUSINESS

Bill No: SB 1338
Author: Umberg (D) and Eggman (D), et al.
Amended: 8/25/22
Vote: 21

SENATE JUDICIARY COMMITTEE: 10-0, 4/26/22
AYES: Umberg, Caballero, Durazo, Gonzalez, Hertzberg, Jones, Laird, Stern, Wieckowski, Wiener
NO VOTE RECORDED: Borgeas

SENATE HEALTH COMMITTEE: 9-0, 4/27/22
AYES: Pan, Eggman, Gonzalez, Hurtado, Leyva, Limón, Roth, Rubio, Wiener
NO VOTE RECORDED: Melendez, Grove

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/19/22
AYES: Portantino, Bates, Bradford, Jones, Kamlager, Laird, Wieckowski

SENATE FLOOR: 39-0, 5/25/22
AYES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Melendez, Min, Newman, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
NO VOTE RECORDED: Hertzberg

ASSEMBLY FLOOR: 73-2, 8/30/22 - See last page for vote

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

SOURCE: Governor Gavin Newsom

DIGEST: This bill establishes the Community Assistance, Recovery, and Empowerment (CARE) Act.

Assembly Amendments add a two-cohort implementation rollout, with the first cohort of counties implementing the CARE Act by October 1, 2023, and the second cohort implementing the CARE Act by December 1, 2024; make implementation contingent on the Department of Health Care Services (DHCS) developing a CARE Act allocation of financial assistance; modify the CARE Act petition process and graduation plan structure; add privacy protections for respondents; clarify a CARE Act participant's right to refuse forcibly administered medication; remove the factual presumption that a respondent's failure to complete a CARE plan demonstrates that there are no suitable community alternatives to treat the individual; strengthen and clarify accountability measures for counties and local government entities; modify the role and administration of supporters for persons in the CARE process; require funding to be provided for counsel to be appointed for respondents in the CARE process; expand the potential funding sources for housing programs for persons in a CARE plan; and require the California Health and Human Services Agency (CHHSA) to provide specified technical assistance for the CARE Act.

ANALYSIS:

Existing law:

1) Establishes the Lanterman-Petris-Short (LPS) Act, assisted outpatient treatment (AOT), and a housing conservatorship pilot program which are intended to provide for the care of persons who suffer from a serious mental illness or substance use disorder and are unable to, or are likely to become unable to, care for their basic personal needs. (Welf. & Inst. Code, div. 5, pt. 1, §§ 5000 et seq.)

2) Provides that, where a person is found mentally incompetent before standing trial for a misdemeanor or misdemeanors, the court may order pretrial diversion for persons with a mental disorder, as defined, hold a hearing to determine whether to order modification of the defendant's treatment plan, refer the defendant to AOT, or refer the defendant to the county conservatorship investigator for possible conservatorship proceedings under the LPS Act. If the person satisfactorily completes AOT or the conservatorship, the charges shall be dismissed. (Welf. & Inst. Code, §§ 1367, 1370.01.)

This bill:

1) Establishes the CARE Act, which must be implemented by Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties by

October 1, 2023, and the remaining counties by December 1, 2024, subject to delays based on a state or local emergency, or discretionary approval by the Department of Health Care Services (DHCS), up until December 1, 2025. Provide that the CARE Act only becomes operative upon DHCS, in consultation with county stakeholders, developing a CARE Act allocation to provide state financial assistance to counties to implement the CARE process.

2) Defines, for purposes of the CARE Act, certain terms, including:

   a) "CARE agreement" is a voluntary settlement agreement, which includes the same elements as a CARE plan.

   b) "CARE plan" is an individualized, appropriate range of services and supports consisting of behavioral health care, stabilization medications, housing, and other supportive services, as provided.

   c) "Graduation plan" is a voluntary agreement entered into by the parties at the end of the CARE program that includes 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 the local government entities and is not enforceable by the court.

   d) "Parties" are the person who file the petition, respondent and the county behavioral health agency, along with other parties that the court may add if they are providing services to the respondent.

   e) "Petitioner" is the entity who files the CARE Act petition, but if other than the county behavioral health agency, the court is required, at the initial hearing, to substitute the director of county behavioral health agency or their designee as the petitioner, limiting the initial petitioner's rights to potentially receiving ongoing notice of the proceedings, and the right to make a statement at the hearing on the merits of the petition, with broader participation rights only if the respondent consents.

   f) "Respondent" is the person who is subject to the petition for the CARE process.

   g) "Supporter" is an adult who assists the respondent, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE process, including a CARE agreement, a CARE plan, and developing a graduation plan.

3) Provides that a respondent may qualify for the CARE process 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 severe mental illness, as defined, and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Specifically exempts specified others conditions or disorders.

   c) The person is not clinically stabilized in on-going voluntary 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.

      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 a CARE plan or agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

   f) It is likely that the person will benefit from participation in a CARE plan or agreement.

4) Provides venue provisions for where CARE Act proceedings may be brought.

5) Allows a petition to initiate a CARE proceedings to be brought by specified adults, including a person with whom the respondent resides or a spouse, parent, sibling, child, or grandparent of the respondent, or another individual who stands in loco parentis to the respondent, and specified medical professionals, peace offices, specified local and county employees and officers, or a judge.

6) Allows a court, if a criminal defendant is found to be mentally incompetent and ineligible for a diversion, to refer the defendant to the CARE program, as provided,

7) Requires the CARE petition, which must be developed as a mandatory form by the Judicial Council (along with other forms necessary for the CARE process) and must be signed under penalty of perjury, to include, among other things,

either (a) an affidavit from 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 had 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 (b) evidence that the respondent was detained for a minimum of two intensive treatments pursuant to under LPS Act, the most recent of which must be no longer ago than 60 days from the date of the petition.

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

9) Sets out the respondent's rights, including the right to be represented by counsel at all stages of a CARE proceeding, and requires the court to appoint specified counsel if the respondent does not have their own attorney.

10) Provides that all CARE Act hearings are presumptively closed to the public, subject to the respondent's right to have a family member or friend present for support or a court order granting a request if the public interest clearly outweighs the respondent's privacy interest.

11) Requires, for all CARE Act proceedings, that the judge 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. Except where there is a contested issue of fact or law, the proceedings should 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.

12) Provides that all reports, evaluations, diagnoses, or other information related to the respondent's health and all evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings are confidential.

13) Requires a court, upon receipt of a CARE Act petition, to promptly review the petition to see if it makes a prima facie showing that the respondent is or may be a person described in 3).

    a) If the court finds the petitioner has not made a prima facie showing that the respondent is or may be a person described in 3), the court shall dismiss without prejudice, subject to 8).

    b) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), and the petitioner is the county behavioral health agency, the court shall do all of the following: (i) set the matter for an initial appearance; (ii) appoint counsel; (iii) determine if the petition includes all the required information and, if not, order the county to submit a report with the information; and (iv) require notice be provided.

    c) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), and the petitioner is not the county behavioral health agency, the court shall order the county agency to investigate whether the respondent meets the CARE proceedings criteria and is willing to engage voluntarily with the county, file a written report with the court, and provide notice, as required.

14) Allows, if the county agency is making progress to engage the respondent, the agency to request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

15) Provides that, within five days of the receipt of the report in 13), the court must review the report and either (a) dismiss the matter, if the court determines that voluntary engagement with the respondent is effective, as provided, or that the report does not support the petition's prima facie showing that the respondent meets the CARE criteria; or (b) if the court determines that the county's report supports the petition's prima facie showing that the respondent meets the CARE criteria, and engagement is not effective: (i) set an initial hearing within 14 days; (ii) appoint counsel, unless the respondent has their own counsel; and (iii) provide notice of the hearing, as provided.

16) Provides that at the initial hearing:

    a) If the petitioner is not present, the court may to dismiss the matter.

    b) If the respondent elects not to waive their appearance and is not present, allow the court to conduct the hearing in the respondent's absence if the

court makes a finding on the record that reasonable attempts to elicit the attendance of the respondent have failed, and conducting the hearing without the participation or presence of the respondent would be in the respondent's best interest.

c) Require a county behavioral health agency representative to be present, allows a supporter to be appointed, and allow a tribal representative to attend for a respondent who is tribal member, as provided, and subject to the respondent's consent.

d) If the court finds that there is no reason to believe that the facts stated in the petition are true, require the court 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.

e) If the court finds that there is reason to believe that the facts stated in the petition appear to be true, require the court to order the county behavioral health agency to work with the respondent and the respondent's counsel and CARE supporter to engage in behavioral health treatment. Require the court to set a case management hearing within 14 days.

f) If the petitioner is other than the county behavioral health director, substitute the county behavioral health director or their designee for the petitioner, as provided in 2e).

g) Require the court to shall set a hearing on the merits of the petition, which may be conducted concurrently with the initial appearance on the petition upon stipulation of the petitioner and respondent and agreement by the court.

17) Provides that at the hearing on the merits:

a) If the court finds that the petitioner has not shown, by clear and convincing evidence, that the respondent meets the CARE criteria, requires the court 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.

b) If the court finds that the petitioner has shown by clear and convincing evidence that the respondent meets the CARE criteria, requires the court to order the county behavioral health agency to work with the respondent, the respondent's counsel, and the supporter to engage in behavioral health treatment and determine if the parties will be able to enter into a CARE agreement. Requires the court to set a case management hearing.

18) Provides that at the case management hearing:

    a) If the parties have entered, or are likely to into, a CARE agreement, requires the court to approve or modify and approve the CARE agreement, stay the matter, and set a progress hearing for 60 days.

    b) If the court finds that the parties have not entered, and are not likely to enter, into a CARE agreement, requires the court to order a clinical evaluation of the respondent and set a clinical evaluation review hearing. The evaluation must address, at a minimum, a clinical diagnosis, whether the respondent has capacity to give informed consent regarding psychotropic medication, other information, as provided, and an analysis of recommended services, programs, housing, medications, and interventions that support the respondent's recovery and stability.

19) Requires, at the clinical evaluation review hearing, the court to consider the evaluation and other evidence, including calling witnesses, that fully complies with the rules of evidence may be considered by the court. If the court finds, by clear and convincing evidence, that the respondent meets the CARE criteria, the court must order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan. If the court finds that clear and convincing evidence does not support that the respondent meets the CARE criteria, the court must dismiss the petition.

20) Provides that, at the hearing to review the proposed CARE plan:

    a) Either or both parties may present a CARE plan.

    b) The court must adopt the elements of a CARE plan that support the recovery and stability of the respondent and may 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. These orders are the CARE plan.

    c) A court may 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 stabilization medication. 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 may not result in a penalty, including but not limited to contempt or the accountability measures in 29).

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

21) Provides that the issuance of any orders in 20) begins the CARE program timeline, which may last up to one year.

22) Requires that a status review hearing occur at least every 60 days during the CARE plan implementation. The petitioner must file with the court, and serve on the respondent and the respondent's counsel and supporter, a report not less than five court 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, and any recommendations for changes to the services and supports to make the CARE plan more successful. The respondent may respond to the report and introduce their own information and recommendations.

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

a) The respondent may be graduated from the CARE program and may be allowed to enter into a voluntary graduation plan with the county, but such a plan may not place additional requirements on the county and is not enforceable, other than a psychiatric advance directive if included.

b) If the respondent elects to accept voluntary reappointment to the CARE program, the respondent may request to be re-appointed to the program for up to one additional year, subject to court approval.

c) Allow the court to involuntarily 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 CARE process; (ii) all of the required services and supports were provided to the respondent; (ii) the respondent would benefit from continuation of the CARE process; and (iv) the respondent currently meets the requirements in 3).

d) Provide that a respondent may be reappointed to the CARE program only for up to one additional year.

24) Provides mandatory timeframes, as well as continuances for good cause, throughout the CARE court proceedings.

25) Requires hearings to occur in person unless the court allows a party or a witness to appear remotely; the respondent may elect to appear in-person for all hearings.

26) Allows the respondent and the county behavioral health agency to appeal an adverse court determination.

27) Requires the Judicial Council to adopt rules to implement the CARE court provisions.

28) 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 process. The court may then make a referral under the LPS Act, as provided.

29) 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. Prohibit a respondent’s failure to comply with any order from resulting in nay penalty outside of this paragraph, including, but not limited to contempt or failure to appear. Prohibit a respondent’s failure to comply with a medication order from resulting in any penalty, including under this paragraph.

30) Creates a process for penalizing counties or other local government entities that do not comply with CARE court orders. If the presiding judge or designee of the county finds, by clear and convincing evidence, that a local government entity has substantially failed to comply with an order, the presiding judge or designee may impose a fine of up to $1,000 per day for noncompliance, not to exceed $25,000 for each violation. If the presiding judge or designee finds that a county is persistently noncompliant, they may appoint a special master to secure court-ordered care for the respondent at the county’s cost. In determining the application of the remedies available, the court should consider whether there are mitigating circumstances impairing the county

agency or local government entity's ability to fully comply with the CARE Act requirements.

31) Requires DHCS, in consultation with specified groups and subject to appropriation, to provide optional training and technical resources for volunteer supporters. A CARE supporter must provide specified assistance to a CARE respondent.

32) Allows a respondent to have their supporter be in any meeting, judicial proceedings, status hearing, or communication related to an evaluation; creation of the CARE plan; establishing a psychiatric advance directive; and development of a graduation plan.

33) Sets forth the duties and limitations of the supporter. Bounds a supporter 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. Prohibits a supporter from being subpoenaed or called to testify against the respondent in any CARE Act proceeding, and provides that the supporter's presence at any meeting, proceeding, or communication does not waive confidentiality or any privilege.

34) Requires the Legal Services Trust Fund Commission to provide funding to qualified legal services projects to provide appointed legal counsel in CARE proceedings. Allows the Legal Services Trust Fund Commission to enter into no bid contracts.

35) Sets forth the provisions of a CARE plan, which may include only:

    a) Specified behavioral health services;

    b) Medically necessary stabilization medications;

    c) Housing resources, as provided;

    d) Social services, as provided; and

    e) General assistance, as provided.

36) Requires that CARE participants be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program. If the county behavioral health agency elects not to enroll the respondent into a full service partnership, as defined, the court may review why not.

37) Provides that all CARE plan services and supports ordered by the court are subject to available funding and all applicable federal and state statutes, regulations, contractual provisions and policy guidance governing program eligibility, as provided.

38) Sets forth rules by which a county is responsible for the costs of providing services to CARE participants.

39) Requires CHHSA, as provided, to (a) engage an independent, research-based entity to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act; (b) convene a working group to provide coordination and on-going engagement with, 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, including during implementation.

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

41) Requires the Judicial Council, in consultation with others, to provide training and technical assistance to judges to support the implementation of the CARE Act.

42) Requires DHCS, in consultation with others, to provide training to counsel on the CARE statutes, and CARE plan services and supports.

43) Allows CHHSA and DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

44) Allows 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.

45) Requires DHCS, in consultation with specified others, to prepare an annual CARE Act report including data provided by specified state or local governmental entities.

46) Requires DHCS to report on court data, as specified.

47) Requires an independent, research-based entity retained by DHCS, in consultation with others, to develop an independent evaluation of the effectiveness of the CARE Act. The independent evaluation must employ statistical research methodology and include a logic model, hypotheses, comparative 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, highlighting racial, ethnic, and other demographic disparities, and including causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts. DHCS must provide a preliminary evaluation of the effectiveness of the CARE Act to the Legislature three years after its implementation and a final report five years after implementation.

48) Requires a health care service plan and an insurance policy, after July 1, 2023, to cover various costs under the CARE program, and provide requirements for health care services plans and insurance policies, effective July 1, 2023, to cover CARE plans, as provided.

49) Provides immunity to a county, or an employee or agent of a county, for any action by a respondent in the CARE process, except when the act or omission of a county, or the employee or agent of a county, constitutes gross negligence, recklessness, or willful misconduct.

50) Includes a severability clause.

51) Adds chaptering-out amendments with SB 1223.

Comments

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. This legislation seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.”

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee:

1) Costs (General Fund (GF)) in the tens of millions of dollars to Judicial Council of California (JCC) for courts to operate the CARE Act. The 2022 Budget allocates $39.5 million from the GF in fiscal year (FY) 2022-23 and $37.7 million ongoing for the courts to conduct CARE court hearings and provide resources for self-help centers. According to the Administration, it is continuing to work with the JCC and counties to estimate costs associated with this new process. JCC estimates costs of approximately $40 million to $50 million related to conducting additional hearings, expanding self-help centers, and updating court case management systems.

2) Possibly reimbursable costs (GF and local funds) in the hundreds of millions of dollars to low billions of dollars to counties, including local behavioral health departments, to provide services to CARE court participants. According to the California State Association of Counties (CSAC), costs include as much as $40,000 per participant for at least 12,000 participants (although county offices believe the number of participants could be much higher - as high as 50,000 participants), court-ordered investigations, evaluations, and reporting requirements, and one-time start-up costs. Costs to the GF will depend on whether the duties imposed by this bill constitute a reimbursable state mandate, as determined by the Commission on State Mandates.

3) Possible cost pressure (GF) to the California Department of Health and Human Services (CHHSA), possibly in the millions of dollars to engage in an independent, research-based entity to advise on the development of data-drive processes and outcome measure for the CARE Act and provide support and coordination between stakeholders during the implementation process.

4) Costs (GF) possibly in the tens of millions of dollars to the Department of Health Care Services (DHCS) to provide training to support to people enrolled in CARE court. Costs include providing technical assistance to counties and contractors, overseeing stakeholder engagement on the CARE Court model, developing guidance for counties on CARE Court responsibilities; implementing processes to support ongoing data collection and reporting; analyzing data and developing an annual legislative report; and, publishing an independent evaluation. Costs may also result from increased Medi-Cal utilization rates by individuals referred to the CARE court program, who otherwise may not have been existing beneficiaries. Possible cost savings to state public health systems to the extent that peer support services provide

support and assistance to Medi-Cal beneficiaries with mental illness and reduce the need for more expensive downstream services, such as inpatient hospitalizations or incarceration.

5) Possibly reimbursable costs (GF and local funds) in the millions of dollars to counties for public defender services. This bill requires a person to receive counsel before ruling on a CARE court petition. Section 5977, subdivision (a)(5)(A)(ii)(II) requires a court to appoint a qualified legal services project to represent any person in the CARE court program that does not already have counsel. If a legal services project declines representation, the public defender is appointed. Only 14 counties have legal services organizations and most do not have enough attorneys to handle even their existing workload. Therefore, it seems far more likely this bill will result in increased duties on county public defenders. Existing law already requires public defenders to represent individuals in LPS and other conservatorships. The

6) Cost pressure (GF), possibly in the hundreds of millions of dollars on state and local housing programs, to the extent this bill increases utilization of the specified housing programs, including the Bridge Housing program, HOME Investment Partnership Program, Housing and Urban Development (HUD) Continuum of Care program, and emergency housing vouchers, among other programs identified in this bill. In addition, as this bill reprioritizes CARE plan program participants in the Behavioral Health Bridge Housing program, it does not increase the funding for Bridge Housing in this bill. The 2021 Budget Act allocated a $12 billion multi-year investment for local governments to build housing and provide critical supports and homelessness services. The 2022 Budget Act includes an additional $3.4 billion GF over three years to continue the state's efforts by investing in immediate behavioral health housing and treatment, as well as encampment cleanup grants, and extends for an additional year support for local government efforts. It is unknown whether existing allocations for housing will be sufficient.

7) Costs (GF) to the Department of Insurance (CDI) of $17,000 in FY 2022-23 and $12,000 FY 2023-24.

8) California Department of Social Services (CDSS) reports no costs. However, this bill may result in considerable cost pressures, possibly in the millions of dollars, downstream to local county welfare departments. The Care Act will likely result in increased use of several programs such as the CalWORKS Housing Support Program, SSI/SSP, Cash Assistance Program for immigrants, CalWORKs, CalFresh, and homeless housing assistance and prevention. This

bill may generate costs in the form of local assistance, as county welfare departments will have to conduct participant eligibility, redetermination, and screening for programs. While the bill would be implemented on a county-level, the workload for CDSS to provide technical assistance, program monitoring, and to issue new or updated guidance or all county letters to implement the bill may result in the need for GF money.

9) Department of Managed Health Care (DMHC) reports costs (GF) to draft regulations and provider technical assistance will be minor and absorbable.

SUPPORT: (Verified 8/29/22)

Governor Gavin Newson (source)
Alameda County Families Advocating for the Seriously Mentally Ill
Association of California Cities – Orange County
Bay Area Council
Big City Mayors
Building Owners and Operators Association
California Association of Code Enforcement Officers
California Chamber of Commerce
California Hospital Association
California Professional Firefighters Association
California Travel Association
Central City Association of Los Angeles
City of Alhambra
City of Bakersfield
City of Berkeley
City of Buena Park
City of Carlsbad
City of Cathedral City
City of Chino Hills
City of Chula Vista
City of Claremont
City of Coachella
City of Concord
City of Coronado
City of Cotati
City of Del Mar
City of El Cajon
City of Encinitas
City of Escondido

City of Fontana
City of Fountain Valley
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 Laguna Niguel
City of Lemon Grove
City of Mission Viejo
City of Montclair
City of National City
City of Ontario
City of Palm Desert
City of Palm Springs
City of Paramount
City of Poway
City of Rancho Mirage
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
Civic Center Community Benefit Districts
Communities Actively Living Independent & Free
County of San Diego
Family & Consumer Advocates for California's Severely Mentally Ill
Family Services Association
Fontana Chamber of Commerce
Fremont Chamber of Commerce
Garden Grove Chamber of Commerce
Golden Gate Restaurant Association
Govern for California

Harbor Association of Industry and Commerce
Hotel Council of San Francisco
Inland Empire Coalition of Mayors
Inland Empire Economic Partnership
Laguna Niguel Chamber of Commerce
Lake Elsinore Valley Chamber of Commerce
League of California Cities
Los Angeles Area Chamber of Commerce
Los Angeles Business Council
Los Angeles County Business Federation, BizFed
Mayor of Anaheim, Harry Sidhu
Mayor of Bakersfield, Karen Goh
Mayor of Fresno, Jerry Dyer
Mayor of Long Beach, Robert Garcia
Mayor of Los Angeles, Eric Garcetti
Mayor of Oakland, Libby Schaaf
Mayor of Riverside, Patricia Lock Dawson
Mayor of Sacramento, Darrell Steinberg
Mayor of San Diego, Todd Gloria
Mayor of San Francisco, London Breed
Mayor of San Jose, Sam Liccardo
Mayor of Santa Ana, Vicente Sarmiento
Mayor of Stockton, Kevin Lincoln
NAMI-CA
Neighborhood Partnership Housing Services, Inc.
North Bay Leadership Council
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
Redondo Beach Chamber of Commerce
Sage Leadership Academy
San Diego Regional Chamber of Commerce
San Diego Tourism Authority
San Francisco Chamber of Commerce
San Francisco Partnership
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
SF Partnership
South Bay Association of Chambers of Commerce
Steinberg Institute
Tulare Chamber of Commerce
Union Square Alliance
Valley Industry and Commerce Association
West Ventura County Business Alliance
One individual

OPPOSITION: (Verified 8/29/22)

504 Democratic Club, New York
Abolitin Study Group of Psychologists for Social Responsibility
ACLU California Action
Affordable Housing Advocates, San Diego
Alabama Disabilities Advocacy Program
Alameda County Homeless Action Center
American Association of People with Disabilities
American Civil Liberties Union
Anti-Police Terror Project
Arizona Center for Disability Law
Bay Area Legal Aid
Bazelon Center
Black Men Speak, Inc.
Caduceus Justice
Cal Voices
California Advocates for Nursing Home Reform
California Association of Mental Health Peer-Run Organizations
California Behavioral Health Planning Council
California Black Health Network
California Foundation for Independent Living Centers
California Homeless Union Statewide Organizing Council
California Institute of Behavioral Health Solutions
California Pan-Ethnic Health Network
Calloway Holistic Peer Concepts
Caravan4Justice
Care First California
Center for Public Representation
Centro Legal de la Raza

Coalition for Supportive Housing
Coalition on Homelessness
Community Advocates for Just and Moral Governance
Community Legal Aid SoCal
Community Legal Aid Society, Inc., Disabilities Law Program, Delaware
Connecticut Legal Rights Project
Corporation for Supportive Housing
Crip the Vote
Decarcerate Sacramento
Depression and Bipolar Support Alliance – California
Disability Law Center of Alaska
Disability Law Colorado
Disability Rights Advocates
Disability Rights Arkansas
Disability Rights California
Disability Rights Center – New Hampshire
Disability Rights Center of Kansas
Disability Rights Connecticut
Disability Rights Education & Defense Fund
Disability Rights Florida
Disability Rights Idaho
Disability Rights Iowa
Disability Rights Maine
Disability Rights Maryland
Disability Rights Michigan
Disability Rights Mississippi
Disability Rights Montana
Disability Rights Nebraska
Disability Rights New Mexico
Disability Rights New York
Disability Rights North Carolina
Disability Rights Oregon
Disability Rights Pennsylvania
Disability Rights Rhode Island
Disability Rights South Carolina
Disability Rights South Dakota
Disability Rights Texas
Disability Rights Vermont
Disability Rights Washington
Drug Policy Alliance

Elder Law and Disability Rights Center
Ella Baker Center for Human Rights
Escuchen Mi Voz
Funders Together to End Homelessness
Housing and Economic Rights Advocates, Oakland
Housing California
Housing is a Human Right, Orange County
Human Rights Watch
Immigrant Defense Advocates
Indiana Disability Rights
Justice in Aging
Justice2Jobs Coalition Sacramento
JusticeLA
Keep the Promise Coalition, Connecticut
Kentucky Protection & Advocacy
La Defensa
Law Foundation of Silicon Valley
Law Office of Robert Rootenberg
Los Angeles Community Action Network
Love & Justice In The Streets
Mental Health Advocacy Services
Mental Health America
Mental Health America of California
Mental Health Association of San Francisco
Mental Health First
National Asian Pacific American Families Against Substance Abuse
National Association of Social Workers – California Chapter
National Disability Rights Network
National Health Care for the Homeless Council
National Health Law Project
National Homelessness Law Center
National Lawyers Guild, San Francisco Bay Area Chapter
National Union of the Homeless
Native American Disability Law Center, New Mexico
New Life Ministries of Tulare County
North Valley Radical Mental Health
Peers Advocating for Rights and Recovery
People's Budget Orange County
People's Homeless Task Force, Orange County
Project Amiga

Psychologists for Social Responsibility
Public Counsel
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld LLP
Sacramento Homeless Organizing Community
Sacramento Homeless Union
Sacramento LGBT Community Center
Sacramento Loaves & Fishes
Sacramento Regional Coalition to End Homelessness
Safe Black Space
Salinas/Monterey County Homeless Union
San Bernardino Free Them All
San Diego Tenants Union
San Francisco Pretrial Diversion Project
San Francisco Public Defender's Office
Senior & Disability Action
Stanford Sierra Youth & Families
Starting Over, Inc.
Street Watch LA
Stronger Women United
SURJ Sacramento
The Asian Americans with Disabilities Initiative
The Coelho Center for Disability Law, Policy, and Innovation
The Harkin Institute for Public Policy and Citizen Engagement
The Justice Teams Network
The SmithWaters Group
Venice Justice Committee
We Are Not Invisible
Western Center on Law and Poverty
Western Regional Advocacy Project
Over 400 individuals

ARGUMENTS IN SUPPORT: In support of this bill, local governments from San Diego, including the City and County of San Diego County, write:

> The creation of CARE Courts by SB 1338 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, San Diego'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 serious mental health and substance use disorder issues that have developed over many years resulting in an inability to care for themselves. . . .

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 SB 1338 provides numerous safeguards to ensure personal civil liberties are respected and protected. Distinct from the Lanterman Petris Short (LPS) conservatorship process, this bill requires the County Health and Human Services Agency to establish a cadre of "supporters" who have the obligation to advocate for each person enrolled or potentially enrolled in CARE Court. Further, CARE Court enrollment is time-limited and is intended to last only one year, although it can be extended for one additional year. During the enrolled period, CARE plans can provide the needed time and intensive care to assist those more seriously ill on our streets.

ARGUMENTS IN OPPOSITION: A coalition of over 40 advocacy organizations, including Disability Rights California, writes in opposition:

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 organizations submitting this letter agree that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, 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. . . .

Instead of allocating vast sums of money towards establishing an unproven system of court-ordered treatment that does not guarantee housing, the state

should expend its resources on a proven solution to homelessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing is proven to reduce utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing homelessness. . . .

Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court sets up a system of coerced, involuntary outpatient civil commitment that deprives people with mental health disabilities of the right to make self-determined decisions about their own lives. Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment provided in accordance with evidence-based practices. Conversely, evidence shows that involuntary, coercive treatment is harmful. . . .

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face homelessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court.

ASSEMBLY FLOOR: 73-2, 8/30/22
AYES: Aguiar-Curry, Alvarez, Arambula, Bauer-Kahan, Bennett, Berman, Bigelow, Bloom, Boerner Horvath, Mia Bonta, Calderon, Carrillo, Cervantes, Chen, Choi, Cooley, Cooper, Cunningham, Daly, Davies, Flora, Mike Fong, Fong, Friedman, Gabriel, Gallagher, Cristina Garcia, Eduardo Garcia, Gipson, Gray, Grayson, Haney, Holden, Jones-Sawyer, Kiley, Lackey, Levine, Low, Maienschein, Mathis, McCarty, McKinnor, Medina, Mullin, Muratsuchi, Nazarian, Nguyen, O'Donnell, Patterson, Petrie-Norris, Quirk, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Salas, Santiago, Seyarto, Smith, Ting, Valladares, Villapudua, Voepel, Waldron, Ward, Akilah Weber, Wicks, Wilson, Wood, Rendon
NOES: Kalra, Stone

NO VOTE RECORDED: Bryan, Megan Dahle, Irwin, Lee, Mayes

Prepared by: Allison Meredith / JUD. / (916) 651-4113
8/30/22 23:35:59

****** END ******