Date of Hearing: April 14, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1825 (Krell) – As Amended March 9, 2026

SUBJECT: Health care: state hospitals.

SUMMARY: Requires that various factors be considered when determining whether an incarcerated person is an offender with a mental health disorder (OHMD) subject to treatment by the Department of State Hospitals (DSH) as a condition of parole, and requires an exit plan for an individual determined by the court to not pose a substantial risk of physical harm to others to include specific services. Specifically, **this bill**:

1) Requires that the following factors be considered when determining if an incarcerated person poses a substantial danger of physical harm to others:

    a) A recent threat of violence or act of violence directed toward another individual, group, or location;

    b) A recent threat of violence or act of violence directed toward themselves;

    c) A pattern of violent acts or violent threats within the past 12 months, including, but not limited to, threats of violence or acts of violence directed toward themselves or another individual, group, or location;

    d) A history of violent behavior, including prior convictions for violent offenses;

    e) Treatment compliance history and response to treatment; and,

    f) Prior history of state hospital commitment.

2) Specifies that, when a court reverses a determination that an incarcerated person is an OHMD, the California Department of Corrections and Rehabilitation (CDCR) is required to notify the behavioral health department, in addition to the probation department as required by existing law, of the county of supervision pending release to help facilitate an exit plan.

3) Requires that an exit plan, if an incarcerated person is found not to be an OHMD by court order, include the following:

    a) A submission of a Medi-Cal application;

    b) A determination of whether the offender is appropriate for Assisted Outpatient Treatment (AOT), a petition under the Community Assistance Recovery and Empowerment (CARE) Act, or a forensic assertive community treatment (ACT) program; and,

    c) A determination of whether the offender appears to be gravely disabled to the court, specifying that the Board of Parole Hearings (BPH) may apply to the county of last legal residence for a court-ordered mental health evaluation.

4) Expands presumptive eligibility for a full-service partnership (FSP) to individuals transitioning to a community after six months or more in a state hospital.

5) Expands the eligibility for receiving targeted Medi-Cal services, as provided by the California Advancing and Innovating Medi-Cal (CalAIM) Act, to include a qualifying inmate of a state hospital.

EXISTING LAW:

1) Provides that, as a condition of parole, a prisoner who meets the following criteria shall be provided necessary treatment by DSH:

    a) The prisoner has a severe mental health disorder that is not in remission or that cannot be kept in remission without treatment;

    b) The severe mental health disorder was one of the causes of, or was an aggravating factor in, the commission of a crime for which the prisoner was sentenced to prison;

    c) The prisoner has been in treatment for the severe mental health disorder for 90 days or more within the year prior to the prisoner's parole or release; and,

    d) Prior to release on parole, the person in charge of treating the prisoner and a practicing psychiatrist or psychologist from DSH have evaluated the prisoner at a facility of the CDCR, and a chief psychiatrist of CDCR has certified to BPH the following:

        i) The incarcerated person has a severe mental health disorder;

        ii) The disorder is not in remission and cannot be kept in remission without treatment;

        iii) The severe mental health disorder was one of the causes of, or was an aggravating factor in, the prisoner's criminal behavior;

        iv) The prisoner has been in treatment of the severe mental health disorder for 90 days or more within the year prior to the prisoner's parole release day; and,

        v) By reason of the prisoner's severe mental health disorder, the prisoner represents a substantial danger of physical harm to others. [Penal Code (PEN) § 2962 (a)-(d)]

2) Provides that, if the professionals doing the evaluation do not concur that the prisoner has a severe mental health disorder, that the disorder is not in remission or cannot be kept in remission without treatment, or that the severe mental health disorder was a cause of, or aggravated, the prisoner's criminal behavior, and a chief psychiatrist has certified the prisoner to the BPH pursuant to this paragraph, BPH shall order a further examination by two independent professionals, as provided. [PEN § 2962 (d)(2)]

3) Provides that, if at least one of the independent professionals who evaluate the prisoner concurs with the chief psychiatrist's certification of the issues, the person may be involuntarily committed. [PEN § 2962 (d)(3)]

4) States that the crimes which qualify an individual for involuntary commitment if the individual's severe mental health disorder was one of the causes of, or was an aggravating factor in its commission, meets both of the following criteria:

   a) The defendant received a determinate sentence for the crime; and,

   b) The crime of, among others, voluntary manslaughter; mayhem; kidnapping, a specified; robbery with a deadly or dangerous weapon, as specified; carjacking with a deadly or dangerous weapon, as specified; rape and other sex crimes, as specified; arson, as specified; a felony in which the defendant used a firearm, as specified; attempted murder; a crime in which the prisoner used force or violence, or caused serious bodily injury, as specified; and a crime in which the perpetrator expressly or impliedly threatened another with the use of force or violence likely to produce substantial physical harm in a manner that a reasonable person would believe and expect that the force or violence would be used. [PEN § 2962 (e)(1)(2)]

5) Provides that the existence or nature of the crime for which the person has been convicted may be shown with documentary evidence. Permits the details underlying the commission of the offense that led to the conviction, including the use of force or violence, causing serious bodily injury, or the threat to use force or violence likely to produce substantial physical harm, be shown by documentary evidence, including, but not limited to, preliminary hearing transcripts, trial transcripts, probation and sentencing reports, and evaluations by DSH. [PEN § 2962 (f)]

6) Provides that "substantial danger of physical harm" does not require proof of a recent overt act. [PEN § 2962 (g)]

7) Defines "severe mental health disorder" to mean an illness, disease, or condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment; or that grossly impairs behavior; or that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely. [PEN § 2962 (a)(2)]

8) Provides that the term "severe mental health disorder" does not include a personality or adjustment disorder, epilepsy, intellectual disability or other developmental disabilities, or addiction to or abuse of intoxicating substances. [PEN § 2962 (a)(2)]

9) Defines "remission" to mean a finding that the overt signs and symptoms of the severe mental health disorder are controlled either by psychotropic medication or psychosocial support. [PEN § 2962 (a)(3)]

10) Provides that a person "cannot be kept in remission without treatment" if during the year prior to the question being before BPH or a trial court, the person has been in remission and has been physically violent, except in self-defense, or has made a serious threat of substantial physical harm upon the person of another so as to cause the target of the threat to reasonably fear for their safety or the safety of their immediate family, or the person has intentionally caused property damage, or has not voluntarily followed the treatment plan. [PEN § 2962 (a)(3)]

11) Provides that, in determining if a person has voluntarily followed the treatment plan, the standard is whether the person has acted as a reasonable person would in following the treatment plan. [PEN § 2962 (a)(3)]

12) Allows BPH, upon a showing of good cause, to order an incarcerated person to remain in custody for up to 45 days past the scheduled release date for a full OMHD evaluation. [PEN § 2963]

13) Allows the prisoner to challenge the OMHD determination both administratively (a hearing before the board) and judicially (a superior court jury trial). [PEN § 2966]

14) Requires OMHD treatment to be inpatient treatment unless there is reasonable cause to believe that the parolee can be safely and effectively treated on an outpatient basis. [PEN § 2964 (a)]

15) Requires that if the person's severe mental disorder is put into remission during the parole period and can be kept that way, the director of the hospital to notify BPH and discontinue treatment. [PEN § 2968]

16) Allows the district attorney to file a petition with the superior court seeking a one-year extension of the OMHD commitment. [PEN § 2970]

17) Provides that a qualifying inmate of a public institution shall be eligible to receive targeted Medi-Cal services for 90 days prior to release. [Welfare and Institutions Code (WIC) § 14184.800]

18) Requires counties to spend their allocation of Behavioral Health Services Act (BHSA) funds as follows: 30% for housing interventions, 35% for FSPs, and 35% for Behavioral Health Services and Supports (BHSS), and defines these service categories. Requires counties to spend half of the housing category on those experiencing chronic homelessness, with an emphasis on those in encampments, and 51% of the BHSS category on early intervention, with 51% of that focused on youth 25 and younger. Allows counties some flexibility to move up to 7% from one expenditure category to another with approval from the Department of Health Care Services (DHCS). [WIC § 5892]

19) Requires each county to establish an FSP program to provide: mental health, supportive, and substance use disorder treatment services; specific treatment models, such as ACT, high fidelity wraparound, and other evidence-based treatment models specified by DHCS; assertive field-based initiation for substance use disorder treatment services; outpatient behavioral health services; ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services; service planning; and housing interventions. [WIC § 5887(a)]

20) Requires, beginning January 1, 2027, an individual with a serious mental illness to be presumptively eligible for an FSP if they meet one or more of the following criteria:

    a) Is currently experiencing unsheltered homelessness;

b) Is transitioning to the community after six months or more in a secured treatment or residential setting, including, but not limited to, a mental health rehabilitation center, institution for mental disease, or secured skilled nursing facility;

c) Has been detained five or more times on a 72-hold for assessment, evaluation, and treatment over the last five years; or,

d) Is transitioning to the community after six months or more in the state prison or county jail. [WIC § 5887]

21) Establishes the Lanterman-Petris-Short (LPS) Act to end the inappropriate, indefinite, and involuntary commitment of individuals with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard their rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to their needs. Permits involuntary detention of an individual deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours (known as "5150 holds") for evaluation and treatment; for up-to 14 days after certification of the need for initial intensive treatment; and up-to 30 days for additional intensive treatment in counties that opt in to provide additional intensive treatment. [WIC § 5000, *et seq.*]

22) Implements AOT (known as "Laura's Law") statewide, whereby an entity can petition for a court to order a person over the age of 18 with a mental illness to receive AOT if the court finds the individual meets specified criteria, including: a clinical determination that the person is unlikely to survive safely in the community without supervision; the person has a history of noncompliance with treatment for their mental illness; the person's condition is substantially deteriorating; and, participation in AOT would be the least restrictive placement necessary to ensure the person's recovery. Permits a county or group of counties that do not wish to implement Laura's Law to opt out of the requirements of AOT services through a specified process. [WIC §§ 5345-5349.1]

23) Establishes the CARE Act to help connect an individual (known as a "respondent") with a court-ordered CARE agreement or CARE plan for up to 12 months, with the possibility to extend for an additional 12 months, that provides individualized, appropriate community-based services and supports, which include clinically appropriate behavioral health care and voluntary stabilization medications, housing, and other supportive services. [WIC § 5970, *et seq.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the OMHD program is a key tool to help ensure that formerly incarcerated individuals can safely and smoothly transition back to our California communities, but reforms on both the front-end and the back-end will better protect public safety. The author argues that the existing criteria used to determine eligibility for the OMHD program have been broadly interpreted, allowing offenders with severe conditions to successfully challenge their status in court and reenter society, even though they pose a serious risk to themselves and the community. Furthermore, once these individuals are released, they lack access to appropriate services. The author concludes this bill takes a multi-layered approach, addressing these issues by requiring specific criteria to be

evaluated when determining OMHD status, further defining what constitutes an exit plan, and expanding Medi-Cal eligibility. This ensures that those who need treatment receive it and prioritizes the safety of our communities.

2) BACKGROUND.

a) Impetus for this bill. The case of Bill Gene Hobbs has received extensive media coverage since his release from state prison last year. Hobbs has a history of involvement with the criminal justice system for repeatedly harassing women. He has spent time in jail for misdemeanor convictions for stalking and sexual battery, and recently he was released from state prison after serving time for felony false imprisonment. After his release, Hobbs was sent to a state hospital for treatment as an OMHD, but five months later he was released when a local judge determined that he no longer satisfied criteria for commitment. Hobbs soon began to harass women on the streets of San Francisco, where he was quickly rearrested on a parole violation. Since his return to San Francisco, media outlets have asked why Hobbs was released from DSH after only a short commitment and whether more could be done to prevent his release without more monitoring.

b) Overview of the Commitment Process for an OMHD. An OMHD commitment, formerly known as a mentally disordered offender commitment, is a post-prison civil commitment to further detain a person with a severe mental health disorder. The OMHD Act is designed to confine a mentally ill individual who is about to be released on parole when it is deemed that that the person's mental illness not only contributed to the commission of a violent crime, but also continues to make them dangerous to others. Rather than release the person to the community, CDCR paroles the incarcerated person to the supervision of the state hospital, and the individual remains under hospital supervision throughout the parole period.

Penal Code section 2962 lists the criteria that must be proven for an initial OMHD certification, namely, whether: the incarcerated person has a severe mental disorder; the severe mental disorder was one of the causes or an aggravating factor in the commission of the offense; the disorder is not in remission or capable of being kept in remission without treatment; the incarcerated person was treated for the disorder for at least 90 days in the year before their release; and by reason of the severe mental disorder, the person poses a substantial danger of physical harm to others.

The initial determination that the incarcerated person meets the OMHD criteria is made administratively. The person in charge of treating the incarcerated person and a practicing psychiatrist or psychologist from the DSH evaluate the incarcerated person. If it appears that the incarcerated person qualifies, the chief psychiatrist then will certify to BPH that the person meets the criteria of an OMHD. The incarcerated person may request a hearing before BPH to require proof that they qualify as an OMHD. If the BPH determines that the person meets the criteria of an OMHD, the person may file a petition in the superior court of the county in which they are incarcerated or are being treated for a hearing on whether they, as of the date of the board hearing, meet the criteria. The person is entitled to a jury trial, which can be waived. The jury must unanimously agree that the allegations of the petition were proven beyond a reasonable doubt. If the superior court or jury reverses the BPH determination, the court is required to stay the execution of the decision for 30 days to allow for an orderly release of the prisoner.

c) LPS. The LPS Act provides for involuntary detentions for varying lengths of time for the purpose of evaluation and treatment, provided certain requirements are met, such as that an individual is taken to a county-designated facility. Designated facilities are mental health treatment facilities that are designated by the county for evaluation and treatment, approved by DHCS, and licensed as a health facility. A designated facility may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and certified crisis stabilization units. Typically, one first interacts with the LPS Act through a hold initiated pursuant to WIC § 5150 by a peace officer or other person authorized by a county, who must determine and document that the individual meets the standard for a hold. A county-designated facility is authorized to then involuntarily detain an individual for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The professional person in charge of the county-designated facility is required to assess an individual to determine the appropriateness of the involuntary detention prior to admitting the individual. Subject to various conditions, a person who is found to be a danger to self or others, or gravely disabled, can be subsequently involuntarily detained for an initial period of intensive treatment up to 14 days, an additional period of 14 days (or up to an additional 30 days in counties that have opted to provide this additional up-to 30-day intensive treatment episode), and ultimately a conservatorship, which is typically for up to one year and may be extended, as appropriate. A person can also be released prior to the end of intensive treatment if they are found to no longer meet the criteria or are prepared to accept treatment voluntarily.

d) AOT. As an alternative to an LPS conservatorship, current law provides for court-ordered outpatient treatment through Laura's Law, or the AOT Demonstration Project, established by AB 1421 (Thomson), Chapter 1017, Statutes of 2002, and made permanent with the passage of AB 1976 (Eggman), Chapter 140, Statutes of 2020. 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. AOT is available only in those counties in which the county board of supervisors, by resolution, have not opted out of its application and makes a finding that no voluntary mental health program serving adults and no children's mental health program may be reduced to implement the law.

Laura's Law is designed to provide counties with tools for early intervention. It allows family members, relatives, cohabitants, treatment providers, or peace officers to initiate the AOT process with a petition to the county behavioral health director or designee. The health director must then determine how to proceed. If the individual is found to meet the AOT eligibility requirements, an individual 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 proceeds. It is then up to the judge to either grant or reject the AOT petition. If an AOT petition is approved by the court, treatment ordered is valid for up to 180 days. The law allows for a county to opt out of the requirements of

Laura's Law if by resolution adopted by the county's governing body stating the reasons for opting out and any facts or circumstances relied upon in making that decision.

e) CARE Act. In 2022, the Legislature enacted SB 1338 (Umberg), known as the CARE Act. The CARE Act established a new civil court process to provide clinically appropriate, community-based services and supports that are culturally and linguistically competent, to Californians with schizophrenia spectrum disorders or bipolar I with psychotic features (referred to as the "respondent" in the CARE process), while also preserving these individuals' self-determination to the greatest extent possible.

Under the CARE Act, a county behavioral health agency, spouse, parent, sibling, child, or grandparent of the respondent, a treating behavioral health professional, the county public guardian or public conservator, and others, as specified, may petition to begin the CARE process. If the original petitioner is not the county behavioral health agency, the county behavioral health agency will replace the original petitioner as the CARE petition proceeds. There are two paths to court-ordered services: if the respondent and the behavioral health agency are able to agree on a plan, it is known as a "CARE agreement" and if they are unable to reach an agreement, one or both parties may present a proposed "CARE plan" to the court and the court may accept a proposed plan or adopt a modified plan, which becomes a court order that lasts for up to one year. The CARE Plan/Agreement may provide for behavioral health services and housing supports, as well as other services, and counties may face financial penalties for failure to provide the required services. The court may allow the original petitioner to participate in the respondent's CARE proceedings, to the extent that the respondent consents.

f) CalAIM. CalAIM is a multiyear DHCS initiative to improve cost savings and health outcomes by implementing a broad delivery of systems, programs, and payment reforms across Medi-Cal. DHCS implements CalAIM through partners with Medi-Cal providers, managed care plans, counties, community-based organizations, and other stakeholders. The behavioral health components of CalAIM are designed for Medi-Cal's behavioral health to become a more consistent and seamless system by reducing complexity and increasing flexibility, improving quality outcomes, reducing health disparities, improving behavioral health policies, and reforming payments for behavioral health.

The Justice-Involved Reentry Initiative provides medical and behavioral health services for Medi-Cal eligible adults and youth in state prisons, county jails, and youth correctional facilities in the 90 days before their release. The initiative is focused on ensuring Medi-Cal members have continuity of coverage and are supported to enable access to key services to help them successfully return to their communities. Medi-Cal members who receive pre-release services in prison, jail, or a youth correctional facility are screened to identify their needs and receive a comprehensive care transition plan to coordinate the medical, behavioral, and social services that will support them following release. This includes screening and transition planning for health-related social needs, like housing and food supports, and other services, such as In-Home Supportive Services, to provide whole-person wraparound supports to the individuals upon release. Further, all Medi-Cal members who are eligible for pre-release services may receive reentry support from an Enhanced Care Management care manager, both while the individual is still in custody and for a period of up to 12 months after the individual is released from the prison, jail, or youth correctional facility.

The DHCS Policy and Operational Guide for implementation of the Justice-Involved Initiative specifies that targeted pre-release services will only be provided to individuals prior to leaving a correctional facility and reentering the community. Generally, individuals who are in state hospitals and return to prisons or jails prior to their release and will be eligible to receive services upon their return to the correctional facility. Based on the waiver authority granted by the Centers for Medicare and Medicaid Services, individuals who are incarcerated in the correctional facility but incompetent to stand trial and awaiting placement in a state hospital may not receive pre-release services if they will not be released into the community. There may be circumstances where an individual is found to be incompetent to stand trial and transferred to a state hospital from a jail to get a mental health assessment. In situations where the individual is transferred back to the jail, the 90-day period will restart. Medi-Cal reimbursement for pre-release services will not be available while the individual is in the state hospital.

3) **SUPPORT.** The California State Association of Psychiatrists (CSAP) support this bill stating that the absence of clear standards for evaluating dangerousness and the lack of structured exit planning can result in abrupt termination of OMHD classification and direct discharge to the community without adequate clinical coordination or safeguards. CSAP contends a violence risk assessment is most effective when it incorporates well-established factors, including recent threats or acts of violence toward others or oneself, patterns of violent behavior, prior violent offenses, treatment compliance and response, and prior state hospital commitments. Establishing these factors in statute will help ensure that risk evaluations are thorough, consistent, and informed by evidence-based practices. CSAP argues this bill strengthens continuity of care by requiring structured exit plans and by allowing individuals in state hospitals to enroll in Medi-Cal and receive Medi-Cal services during the 90 days prior to release, aligning them with policies already available to people leaving prisons and jails. CSAP concludes these provisions support effective coordination and timely access to psychiatric care, medication, and community-based services—interventions that are essential for stabilizing serious mental illness and reducing the likelihood of relapse or re-offense.

4) **CONCERNS.** The County Behavioral Health Director's Association (CBHDA) expresses concerns with this bill stating that the proposed elements of the exit plan could lead to potentially significant increases in CARE Court petitions and respondents, and while any increase in CARE costs is to be funded by the state, the costs for the clinical determination by behavioral health clinicians and subsequent treatment are not, and present fiscal pressures for county behavioral health programs. CBHDA states that the FSP presumptive eligibility criteria presents a future increase in workload and costs to counties to assume the newly eligible population and is of serious concern along with the already concerning expansion in this area of the law by previous legislation.

Disability Rights California (DRC) also expresses concerns with this bill would increase the volume of people funneled into the most restrictive mental health programs in California. In particular, this bill would require CDCR to determine whether people with mental health disabilities leaving CDCR may be eligible for interventions such as court-ordered AOT, CARE Court, or an involuntary hold or conservatorship. DRC argues that if agencies have concerns about people who do not consent to voluntary mental health programs, they have other mechanisms to petition the courts, so this bill is unnecessary. DRC contends that requiring CDCR to make such determinations as part of an "exit plan" raises concerns on how these determinations will be completed if people do not consent to them, what will

happen to someone who does not consent to them, the quality of determinations, potential delays in release dates, workforce shortages in relevant departments and programs, and significant administrative costs to implement this bill.

5) **DOUBLE REFERRAL.** This bill is double referred; it was heard in the Assembly Public Safety Committee on March 17, 2026 and passed by a vote of 9-0.

6) **RELATED LEGISLATION.**

   a) AB 1782 (DeMaio) would reduce the number of factors to which the chief psychiatrist of CDCR must certify to BPH prior to the involuntary commitment of an OMHD. AB 1782 failed passage in the Assembly Public Safety Committee.

   b) AB 1897 (Haney) would require the chief psychiatrist of CDCR to certify among other things that a incarcerated person represents a threat of physical harm to others, rather than a substantial danger of physical harm to others. AB 1897 is pending in the Assembly Appropriations Committee.

7) **PREVIOUS LEGISLATION.**

   a) AB 348 (Krell), Chapter 688, Statutes of 2025, establishes specific criteria that would make a person with a serious mental illness (SMI) presumptively eligible for an FSP, including the person is transitioning to the community after six months or more in a state prison or county jail, has been detained five or more times as a danger to themselves or others, or gravely disabled, over the last five years, or is currently experiencing unsheltered homelessness. Specifies that a county is not required to enroll an individual if doing so would conflict with contractual Medi-Cal obligations or court orders, or would exceed county FSP capacity or funding.

   b) AB 2475 (Haney), Chapter 963, Statutes of 2024, requires a court to stay the execution of a decision determining an incarcerated person is not an OMHD for up to 30 days, instead of the current five working days, in order to allow for the person's orderly release.

   c) SB 326 (Eggman), Chapter 790, Statutes of 2023, recasts the Mental Health Services Act as the BHSA and modifies state and local spending requirements, including the establishment of the FSP program in statute, and creates additional oversight and reporting requirements for counties.

   d) SB 591 (Galgiani), Chapter 649, Statutes 2019, states that a practicing psychiatrist or DSH or CDCR psychologist be afforded prompt and unimpeded access to an inmate temporarily housed at a county jail, when the psychiatrist or psychologist is conducting an evaluation of the inmate as an OMHD; and made changes to the process to determine whether an inmate is an OMHD.

8) **POLICY COMMENTS.**

   a) **Criteria and exit plan.** A factor to be considered includes prior history of state hospital commitment. While there are categories of forensic commitments to DSH, prior history of a civil commitment may have no bearing on whether a person currently presents a substantial danger of physical harm to others. Currently the exit plan proposed by the bill

requires the treating psychiatrist to make determinations about the appropriateness of various county mental health programs. It may be more appropriate for the psychiatrist to make recommendations to the county behavioral health director.

b) **CalAIM.** The Justice-Involved Initiative currently does not include people releasing directly from state hospitals to the community. Moving forward, the author may wish to explore with DHCS the policy rationale for the exclusion of those discharging from state hospitals and whether the state has the flexibility to include them under current waiver author granted by CMS or whether the state would need to seek an amendment.

c) **FSP eligibility.** The new FSP programs under the BHSA go into effect July 1, 2026. Under AB 348 (Krell), Chapter 688, Statutes of 2025, new presumptive eligibility criteria for FSPs take effect on January 1, 2027. Under this bill, discharge from a state hospital would be added to those presumptive eligibility criteria. While those exiting a state hospital seem like a population likely to benefit from FSPs, moving forward the committee may wish to consider how ongoing implementation of the BHSA requirements is proceeding before making further changes.

9) COMMITTEE AMENDMENTS. The committee may wish to amend this bill as follows:

a) Specify that consideration of prior history of state hospital commitment be limited to forensic commitments;

b) Specify that the county behavioral health department should be consulted in developing the exit plan; and,

c) Strike from the elements of the exit plan the determinations about appropriateness for various mental health programs and instead require the treating psychiatrist to make recommendations on county resources and programs appropriate for individuals exiting treatment pursuant to this bill, including, but not limited to, the following: suicide prevention; substance use disorder treatment; Medi-Cal Enhanced Care Management; Full Service Partnership pursuant to Section 5887 of the Welfare and Institutions Code; Assisted Outpatient Treatment pursuant to Section 5346 of the Welfare and Institutions Code; The Community Assistance, Recovery, and Empowerment (CARE) Act, pursuant to Section 5978 of the Welfare and Institutions Code; and early psychosis intervention services.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists

Opposition

None on file

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