Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1016 (Blakespear) – As Amended May 14, 2026

SENATE VOTE: 27-0

SUBJECT: Community Assistance, Recovery, and Empowerment (CARE) Court Program and court-ordered evaluations.

SUMMARY: Authorizes a petitioner of a CARE Act petition to request that the court order a mental health evaluation under the Lanterman-Petris-Short (LPS) Act if the petitioner believes that the person may not be willing or able to participate in the CARE process and a CARE plan or CARE agreement due to the severity of their mental disorder or lack of insight into their mental disorder, and requires the Judicial Council to include on the mandatory petition form an option for the petitioner to request that evaluation. Requires the court to issue an order for a mental health evaluation under the LPS Act if the CARE Act petition or report prepared by the county behavioral health agency establishes probable cause to support the evaluation and the respondent will not voluntarily receive crisis intervention services or an evaluation, as specified. Makes other technical, conforming changes. Specifically, **this bill**:

1) Requires the court to order a person to submit to an evaluation, as provided for in the LPS Act, whenever it appears to a judge pursuant to the process established by this bill that a person is, as a result of a mental disorder, a danger to themselves or others or gravely disabled, and that person has refused or failed to voluntarily accept an evaluation.

2) Permits a CARE petitioner, if they believe that the respondent may not be willing or able to participate in the CARE process or a CARE plan or agreement due to the severity of their mental disorder or lack of insight into their mental disorder, to request that the court order a mental evaluation under the LPS Act if the CARE petition is dismissed.

3) Requires the written report by the county behavioral health agency to include conclusions about whether the respondent is likely to need a higher level of care than is available under the CARE Act and, if so, recommendations about the appropriate level of care and the necessary steps to obtain that level of care for the respondent, as well as whether there is probable cause to believe that the respondent is, as a result of a mental disorder, a danger to themselves or others, or gravely disabled, and whether the respondent will agree voluntarily to receive crisis intervention services or an evaluation in their own home or in a designated facility.

4) Requires the court to order an evaluation under the LPS Act and direct the county to serve the order on the respondent, if a CARE respondent is not willing or able to participate in the CARE process and a CARE plan or CARE agreement and if both of the following conditions are met:

    a) The petition includes a request for a mental health evaluation under the LPS Act; and,

    b) The petition establishes probable cause to support the evaluation, as required under the LPS Act.

5) Permits a behavioral health professional to serve a court order for an evaluation ordered pursuant to an LPS Act petition or through the CARE process.

6) Modifies the required forms for a court-ordered evaluation and the report of the property of a person who was placed in an involuntary hold after refusing or failing to appear for a court-ordered evaluation.

7) Requires the Judicial Council to do both of the following:

   a) Include on the mandatory CARE Act petition form an option for the petitioner to request a court-ordered evaluation under the LPS Act upon dismissal of the CARE petition if the respondent is not willing or able to participate in the CARE process and a CARE plan or CARE agreement due to the severity of their mental disorder or lack of insight into their mental disorder.

   b) Amend the notice of dismissal form to indicate whether the court has ordered a mental health evaluation under the LPS Act upon the dismissal; the indication on the dismissal form shall serve as the court order for the mental health evaluation.

8) Permits CARE Act reports, evaluations, diagnoses, and other information filed with the court relating to the respondent's health to be transferred to a covered entity, as defined, for a court-ordered evaluation and requires the entity receiving the documentation to comply with all federal and state privacy protections.

9) Permits CARE parties and witnesses to appear through the use of remote technology unless otherwise ordered by the court or demanded by the respondent.

10) Requires the Department of Health Care Services (DHCS), as part of its required training and technical assistance to the counties, to include training and technical assistance regarding the court-ordered evaluation process under the LPS Act.

11) Requires the trial courts, as part of their reports to Judicial Council for use in the annual CARE Act report, to report the total number of court-ordered mental health evaluations under the LPS Act requested in a CARE proceeding; the total number of court-ordered mental health evaluations ordered upon dismissal of a CARE petition; the total number of cases dismissed where a court-ordered mental health evaluation was requested but not ordered; and the basis for dismissal in these cases.

EXISTING LAW:

1) Establishes the 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. [Welfare & Institutions Code (WIC) § 5000, *et seq.*]

2) Defines "gravely disabled," for purposes of evaluating and treating an individual who has been involuntarily detained or for placing an individual in conservatorship, as a condition in which a person, as a result of a mental health disorder, a severe substance use disorder (SUD), or both, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. [WIC § 5008]

3) Permits any individual to apply to the county for a petition alleging that a person is, as a result of mental disorder a danger to others, or to himself, or is gravely disabled, and request that an evaluation of the person's condition be made. [WIC § 5201]

4) Requires the person or agency designated by the county to prepare the petition and all other forms required in the proceeding, and to be responsible for filing the petition. Requires the person or agency designated by the county to request a prepetition screening to determine whether there is probable cause to believe the allegations. Requires the person or agency providing prepetition screening to conduct a reasonable investigation of the allegations and make a reasonable effort to personally interview the subject of the petition. Requires the screening to also determine whether the person will agree voluntarily to receive crisis intervention services or an evaluation in their own home or in a facility designated by the county and approved by DHCS. Requires the filing of the petition if there is probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled, and that the person will not voluntarily receive evaluation or crisis intervention. [WIC § 5202]

5) Requires the petition, if filed, to be accompanied by a report containing the findings of the person or agency designated by the county to provide prepetition screening. Requires the prepetition screening report submitted to the superior court to be confidential. [WIC § 5202]

6) Implements assisted outpatient treatment (AOT) (also 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, *et seq.*]

7) 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 stabilization medications, housing, and other supportive services. [WIC § 5970, *et seq.*]

8) Requires an individual, to qualify as a respondent in the CARE process, to meet the following criteria:

    a) Be 18 years of age or older;

    b) Be currently experiencing a serious mental disorder and have a diagnosis of bipolar I disorder with psychotic features, or a schizophrenia spectrum or other psychotic disorder.

Prohibits an individual who has a current diagnosis of SUD, but who does not also meet the required criteria, from qualifying for the CARE process;

c) Not be clinically stabilized in ongoing voluntary treatment;

d) Be unlikely to survive safely in the community without supervision and their condition is substantially deteriorating; or, be 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 self or others, resulting in involuntary detention;

e) Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the individual's recovery and stability; and,

f) Be likely to benefit from participation in a CARE plan or CARE agreement. [WIC § 5972]

9) Permits the following adult persons to file a petition to commence the CARE process:

a) A person with whom the respondent resides;

b) A spouse, parent, sibling, child, or grandparent or an individual who stands in loco parentis to the respondent;

c) The director of a hospital or the director's designee, in which the respondent is hospitalized, including hospitalized pursuant to the LPS Act involuntary detention law;

d) The director of a public or charitable organization, agency, or home, or their designee, who has, within the previous 30 days, provided or who is currently providing behavioral health services to the respondent or in whose institution the respondent resides;

e) A licensed behavioral health professional, or their designee, who is, or has been within the previous 30 days, either supervising the treatment of, or treating the respondent for a mental illness;

f) 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 pursuant to the LPS, multiple attempts to engage the respondent in voluntary treatment, or other repeated efforts to aid the respondent in obtaining professional assistance;

g) The public guardian or public conservator, or their designee, of the county in which the respondent resides or is found;

h) The director of a county behavioral health agency, or their designee, of the county in which the respondent resides or is found;

i) The director of county adult protective services, or their designee, of the county in which the respondent resides or is found;

j) The director of a California Indian health services program, California tribal behavioral health department, who has, within the previous 30 days, provided or who is currently providing behavioral health services to the respondent, or the director's designee;

k) The judge of a tribal court located in California before which the respondent has appeared within the previous 30 days, or the judge's designee; or,

l) The respondent. [WIC § 5974]

10) Permits the court to terminate the respondent's participation in the CARE process if, at any time during the proceedings, the court determines by clear and convincing evidence that the respondent is not participating in the CARE process or is not adhering to their CARE plan, after the respondent receives notice. Authorizes the court to utilize existing legal authority pursuant to LPS to pursue a mental health evaluation to ensure the respondent's safety, and requires the court to provide notice to the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority. [WIC § 5979]

11) Requires DHCS to provide training and technical assistance to county behavioral health agencies to support CARE implementation, including training regarding the CARE process; CARE agreement and plan services and supports; supported decision making; the supporter role; trauma-informed care; elimination of bias; psychiatric advance directives' family psychoeducation; and, data collection. [WIC § 5983 (b)]

12) 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, racial justice experts, and other appropriate stakeholders, an annual CARE Act report. Requires DHCS to post the annual report on its internet website. [WIC § 5985]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, potential cost pressures to the courts related to additional duties required in this bill. While the courts are not funded on a workload basis, an increase in workload could result in delayed court services. The Governor's fiscal year (FY) 2026-27 budget proposes $70 million General Fund to backfill the Trial Court Trust Fund.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill addresses a critical gap in the implementation of CARE Court. While CARE Court was designed to connect individuals with serious mental illness to treatment and housing, early data has shown that many individuals do not ultimately receive services through the program. The author argues this presents a clear problem: when CARE is not the right fit, there is no reliable pathway to ensure individuals are connected to a higher level of care. Individuals are often left without services or routed through short-term crisis interventions that are not designed to provide comprehensive evaluation or long-term stability. The author concludes this bill opens this connection, allowing individuals who cannot be served within CARE Court to be instead directed to a level of care that better matches their needs.

2) BACKGROUND.

a) CARE Act. In 2022, the Governor signed SB 1338 (Umberg), Chapter 319, Statutes of 2022, 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 and other psychotic disorders, while also preserving these individuals' self-determination to the greatest extent possible. To be eligible under the CARE Act, a person must meet all of the following:

i) 18 years of age or older;

ii) Have a serious mental illness and a diagnosis of bipolar I with psychotic features, or a schizophrenia spectrum or other psychotic disorder;

iii) They are not clinically stabilized in ongoing voluntary treatment;

iv) They are unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating or they are 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 others;

v) CARE would be the least restrictive alternative necessary to ensure the person's recovery and stability; and,

vi) It is likely that the person will benefit from participation in CARE.

The first seven pilot counties implemented the CARE Act in October 2023, Los Angeles implemented in December 2023, and all counties were required to begin accepting CARE petitions as of December 1, 2024.

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 replaces 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 or 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. No county has faced any penalties for failure to provide court ordered services. The court may allow the original petitioner to participate in the respondent's CARE proceedings, to the extent that the respondent consents.

b) CARE Act outcomes and reporting. AB 102 (Ting) Chapter 38, Statutes of 2023, required DHCS to issue an early implementation report on the CARE Act. In the first nine months of implementation (October 2023 through June 2024), across the early

implementation counties, 557 total petitions were filed and 217 of those were dismissed at the discretion of a judge. Preliminary data from July through September 2024 indicates an additional 231 petitions were filed. The report further indicates that dismissals will require further research, since the reasons for their dismissal are not available for the preliminary report, and could include people who are receiving care, those whose cases were dismissed for successful voluntarily engagement, people not being eligible for CARE who receive needed treatment another way, or people who are still not receiving care. The report also states that the CARE process can take time, like all mental health and SUD care, to build the trust and develop the self-directed plans needed for long-term recovery and stability.

The first CARE Act annual report was released in June 2025 and covered the same reporting period as the early implementation report. The annual report clarified that 556 petitions were filed and 101 (18%) resulted in CARE agreements or court-ordered CARE plans. Thirty-nine percent of petitions were dismissed and 229 were still pending at the end of the reporting period. Fifty-five respondents were found ineligible for CARE but received services from a county behavioral health agency, while an additional 90 found ineligible did not receive any county behavioral health services. Most respondents were male (64%) and aged 26–45 (64%), and 37% of respondents were white, 21% Hispanic, 18% Black, and 7% Asian, with 11.6% unknown. The most common petitioner type is personal contacts (such as family and household members) who filed 68% of petitions. County behavioral health agencies and public guardians are unlikely to refer because they may prefer to engage in services without court involvement, as some indicated in the early implementation report.

CARE respondents largely access mental health treatment (93%) and three-quarters of respondents accessed specialized mental health programs like Assertive Community Treatment (ACT) or Full Service Partnership (FSP). Many respondents received stabilizing medications (72%) with 40% of those individuals receiving long-acting injectable medications. Long-acting injectable antipsychotic medications can be given as a shot in the muscle or under the skin and they usually are given every two to four weeks, according to the Mayo Clinic.

The report notes that housing remains a challenge, though the share of respondents in permanent housing increased from 46% at time of petition to 56% in the most current reporting period. The most common unmet need for CARE participants was securing and maintaining permanent housing. Over half of CARE participants did not receive at least one ordered mental health service during their active service period (the most common was peer supports). Sixty-three percent received all three foundational services (medication, treatment, and housing supports) though unmet needs remain. Twenty-five percent had criminal justice involvement during their service period, 21% had emergency visits, and 20% were hospitalized or placed on psychiatric holds. The report notes that only 15 individuals became "elective clients," those who voluntarily engaged with services outside court oversight. These clients generally accessed fewer services, especially medications and housing supports, suggesting disparities in care quality.

Along with the first annual report, the California Health and Human Services Agency (CalHHS) released a companion document to provide an update on implementation. As of May 31, 2025, 2,008 petitions had been filed across California since October 2023.

Since the CARE Act took effect in all counties in December 2024, 1,063 petitions were filed, which is more total petitions than had been filed in the previous 14 months. The update also states that, through 2024, counties "diverted" 1,358 individuals to other services through CARE outreach. *CalMatters* reports that as of January 2026, California courts had received 3,817 petitions on behalf of prospective CARE Court participants and approved just 893 treatment agreements. The first annual report with statewide data is expected in July 2026.

In addition to the early implementation report and annual reporting from DHCS, an independent, research-based entity must be retained by DHCS to develop, in consultation with county behavioral health agencies, county CARE courts, racial justice experts, and other appropriate stakeholders, including providers and CARE court participants, an independent evaluation of the effectiveness of the CARE Act. This will be conducted by the RAND Corporation. The preliminary report is expected to the Legislature by December 31, 2026, and a final report is expected by December 31, 2028.

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. Typically, one first interacts with the LPS Act through a "5150" hold initiated 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.

Throughout this process, existing law requires specified entities to notify family members or others identified by the detained individual of various hearings, where it is determined whether a person will be further detained or released, unless the detained person requests that this information is not provided. Additionally, a person cannot be found to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or others who indicate they are both willing and able to help. SB 43 (Eggman), Chapter 637, Statutes of 2023, expanded the definition of gravely disabled to also include a condition in which a person, as a result of a severe SUD, or a co-occurring mental health disorder and SUD, is unable to provide for their personal safety or necessary medical care, in addition to the inability to provide for basic personal needs of food, clothing, and shelter. SB 43 also defined these additional criteria, but implementation by the counties and consideration of these criteria by hearing officers and the courts will determine how they are interpreted in practice.

Following the release of a white paper earlier this year by Quarter Turn Strategies titled "The Lost Legal Pathway to Mental Health Care," several bills have made reference directly to the mental health evaluation process contained in the LPS Act and described in 3) and 4) of Existing Law above. The CARE Act also currently references this evaluation process and authorizes courts to utilize this existing authority to ensure the respondent's safety. The focus of the white paper is that this existing legal mechanism for evaluating those who may be a danger to self or others or gravely disabled is not often utilized and presents an opportunity to strengthen the continuum of behavioral health care and save money by preventing those with serious mental illness from seeking emergency care and being incarcerated. In drafting this paper, the authors sent Public Records Act requests to all counties regarding their policies for these evaluations, and the paper notes that the responses indicate that these evaluation orders are not currently in use by responding counties and that it is a "legacy" or "antiquated" process. Stakeholders report that is seldom used, but that Humboldt County has successfully referred to LPS out of CARE. Without more information on counties' processes for actually implementing this existing law, it's difficult to evaluate if this will close a gap in treatment or offer more false hope to those filing CARE petitions.

d) Senate Health and Judiciary Joint Oversight Hearing. On November 13, 2025, the Senate Health and Judiciary Committees held a Joint Oversight Hearing on the first annual CARE Act report. The committees heard from judges, attorneys, representatives from DHCS, CalHHS, the Judicial Council, petitioners, county representatives, behavioral health professionals, and disability rights advocates. At that time, a vast majority of the formalized court arrangements were collaborative, with 620 CARE agreements approved compared to only 19 mandated CARE plans. Judges and public defenders noted that the program is highly effective when participants feel empowered to choose their treatment from a "menu of services" rather than facing forced compliance. Some of the challenges identified by panelists include the following:

i) **Housing Shortages**: A severe lack of appropriate housing, specifically board and care homes or permanent supportive housing, prevents participants from stepping down into safe environments.

ii) **Lack of Coercive Power**: Family members testified that loved ones suffering from anosognosia (lack of insight into their illness) routinely reject voluntary help, leaving families helpless without involuntary treatment options.

iii) **Financial Strain on Counties**: Because 43% of participants have an unknown health insurance status, counties may be forced to absorb the costs of care.

iv) **Service Delivery Gaps**: Preliminary data indicated that 82% of individuals under CARE agreements or plans did not receive at least one court-ordered social service.

v) **Missing Data on Dismissals**: Individuals whose petitions are dismissed or who elect out of the program are not comprehensively tracked, obscuring how many ultimately cycle back into jails or emergency rooms.

Some of the recommendations from panelists include:

i) Promote and enforce the use of the LPS Act for court-ordered psychiatric evaluations when individuals fail in the CARE Court process.

ii) Create a streamlined judicial pathway to transfer individuals directly from CARE Court to AOT or LPS conservatorships when needed.

iii) Establish a statutory mechanism to convert failing CARE agreements into CARE plans without resetting the 12-month procedural clock.

iv) Implement an anonymous petitioning option to protect fragile family relationships from being destabilized when a family petition is filed.

v) Invest more heavily in peer support roles, peer respites, and dedicated support networks for family members.

3) **SUPPORT**. The California State Association of Psychiatrists (CSAP) is the sponsor of this bill and states that the most severely mentally ill are not all receiving the evaluations and help they need through the CARE Act. Those whose illness is so severe that they cannot recognize it or engage with court proceedings remain outside the program's reach. CSAP argues that as of March 2026, over 3,800 CARE petitions have been submitted statewide, yet fewer than 1,851 people have continued through the CARE Court process. The DHCS first Annual CARE Act Report found that among those dismissed in the program's first nine months, 90 received no county behavioral health services at all. These are the people whose severity of illness prevented engagement with the court process; the very population CARE Court was built to reach. CSAP contends that many have anosognosia, a neurological feature of some psychotic disorders that prevents a person from recognizing their own illness. For these patients, CARE Court's current framework provides no workable pathway to evaluation and treatment. CSAP states this bill establishes a pathway for CARE Court respondents who are unwilling or unable to engage to be referred for a court-ordered mental health evaluation under section 5200, allowing the court to access existing legal tools without creating new or duplicative procedures.

   The National Alliance on Mental Illness – California (NAMI-CA) supports this bill stating that CARE Court was established to connect individuals with untreated schizophrenia spectrum and other psychotic disorders to treatment, housing, and supportive services before they experience further deterioration, homelessness, hospitalization, incarceration, or conservatorship. However, early implementation has revealed a significant challenge: some individuals are simply too ill to meaningfully participate in the CARE process because of the severity of their symptoms or a lack of insight into their illness. NAMI-CA argues that when CARE Court is not the appropriate level of intervention, there is currently no reliable pathway to connect individuals to a higher level of clinical evaluation and care. As a result, many people are left cycling through emergency rooms, short-term crisis holds, homelessness, and repeated psychiatric crises without receiving a comprehensive evaluation or a clear treatment pathway. NAMI-CA says this bill helps address this gap by creating a procedural bridge between CARE Court and the existing court-ordered evaluation process and does not create a new involuntary treatment standard. Instead, it helps operationalize an existing pathway that has existed in statute for decades but is often unavailable in practice.

The San Diego County District Attorney's Office (SDDA) supports this bill stating that it is a thoughtful and urgently needed reform that strengthens California's continuum of care for individuals suffering from severe mental illness. SDDA argues that, for years, their prosecutors, law enforcement partners, and behavioral health clinicians have witnessed the same heartbreaking pattern repeat itself: individuals with the most profound mental illnesses cycle through short-term holds, emergency rooms, jails, and the streets, deteriorating further each time. CARE Court was designed to intervene earlier, and it has undoubtedly helped many. But they have also seen a population whose needs exceed the CARE Court framework, where individuals who are too ill, too disorganized, or too impaired by psychosis or substance use disorders to meaningfully participate. SDDA argues that those individuals, without a clear statutory bridge, fall into the very gap that this bill seeks to close.

4) **SUPPORT IF AMENDED.** Vitus Pius Iunctus Corp supports this bill, if amended, authorizing a limited Judicial Council-administered pilot program to evaluate enhanced case-management procedures in unlawful detainer proceedings involving documented public-safety concerns, repeated nuisance activity, significant property damage, repeated emergency-service responses, or substantial interference with the lawful use and enjoyment of residential property.

5) **OPPOSITION**. A coalition of more than 30 organizations, including Disability Rights California, ACLU California Action, CalVoices, the Corporation for Supportive Housing, Mental Health America of California, and many more opposes this bill, stating that it would make explicit what advocates have long warned: that unwillingness to participate in CARE Court means a fast track to involuntary commitment. Specifically, if someone chooses to not participate in CARE Court, this bill would permit a court to order them to submit to an evaluation or be subjected to an evaluation for involuntary commitment. These evaluations are often conducted in locked facilities, where the individual may be held for days before receiving one. The coalition argues that refusal to participate in CARE Court does not mean that someone would be unwilling to voluntarily participate in a different evidence-based mental health assessment and program. However, if someone is unwilling to participate in CARE Court, they likely would not attend any CARE Court hearings. In such a case, a judge would not be able to independently determine whether they would be willing to voluntarily accept an evaluation. The coalition also argues that this bill would add significant costs to the CARE Court program and lead to a waste of judicial resources.

   A coalition of county entities, including the County Behavioral Health Directors Association of California, Urban Counties of California, California State Association of Counties, Rural County Representatives of California, and the California State Association of Public Administrators, Public Guardians, and Public Conservators oppose this bill. This county coalition argues that the evaluation authority referenced in this bill has historically not been used because counties have more efficient and effective ways to evaluate an individual who is a danger to themselves or others or potentially gravely disabled. Namely, counties have stood up a statewide network of 24/7 community-based mobile crisis teams to help immediately respond and deescalate behavioral health crisis and connect individuals to services. The coalition states that where an individual is considered a danger to themselves or others or gravely disabled, counties typically rely on a 5150 hold to immediately detain and evaluate individuals who are at risk. The coalition notes that since some courts are allowing petitions without substantive documentation of an individual's condition or independent clinical review, and without the county's ability to verify allegations made by petitioners,

counties may be ordered by the court to involuntarily detain and evaluate individuals for whom an involuntary evaluation is not necessary or reasonable. Involuntary detention can be incredibly intrusive, and even traumatic; as such, the existing law attempts to establish a reasonably high bar for exercising this authority. They further argue that this bill gives the Court the authority to weigh in on an individual's motivation and degree of insight into their condition, without appropriate training or evidence, and that it bypasses due process protections required under LPS. The coalition states that this bill introduces involuntary detention into the CARE Act process, thereby changing the voluntary nature of CARE.

6) **DOUBLE REFERRAL.** This bill is double referred; it was heard in the Assembly Judiciary Committee on June 16, 2026 and passed by a vote of 9-1.

7) **RELATED LEGISLATION**.

a) SB 28 (Umberg) would make several changes to the implementation of the CARE Act, including to eligibility criteria, referrals to involuntary treatment under the LPS Act, and considerations of alternative treatment programs during the petition review process. Would establish the position of a CARE Court Ombudsperson within the California Health and Human Services Agency. Would require the Governor's office to annually release a list of overperforming and underperforming counties, directing additional support to the latter through the CARE Improvement and Coordination Unit. SB 28 is pending in the Assembly Judiciary Committee.

b) SB 989 (Blakespear) would authorize a first responder to contact the county behavioral health agency in the county in which the respondent resides to request the agency file a petition to commence the CARE process. Would require the agency to review the request and determine whether to file a petition within 30 business days and, upon completion of the review, to notify the first responder that made the referral of specified information, including whether or not a petition was filed. SB 989 is pending in the Assembly Appropriations Committee.

c) SB 1242 (Choi) would permit an original petitioner in a CARE Court action who is a family member of the respondent to remain involved in the respondent's CARE proceedings, for the purpose of assisting in care coordination and providing relevant information to the CARE team, unless the court finds that the participation is likely to be detrimental to the respondent's treatment or wellbeing. SB 1242 is pending in the Assembly Judiciary Committee.

8) **PREVIOUS LEGISLATION**.

a) SB 27 added Bipolar I Disorder with psychotic features to the disorders eligible under the CARE Act, and authorizes nurse practitioners and physician assistants to prepare an affidavit supporting a CARE petition. Defines the phrase "clinically stabilized in ongoing voluntary treatment," which is a status considered when determining eligibility for the CARE Act. Authorizes a court to refer an individual from felony proceedings to the CARE Act program and authorizes a CARE court to consider a referral as a petition for participation in the CARE program if certain requirements are met. Revises additional court processes relative to the CARE Act.

b) SB 42 (Umberg), Chapter 640, Statutes of 2024, among other things, clarifies what evidence may establish a respondent's eligibility for CARE proceedings; reduces a CARE court's obligation to inform the respondent of their rights; and, gives the original petitioner the right to notice of ongoing CARE proceedings unless the court specifically finds it would be detrimental to the respondent.

c) SB 1323 (Menjivar), Chapter 646, Statutes of 2024, among other things, requires the court, when the defendant is found to be incompetent to stand trial and not eligible for diversion, or diversion is terminated early, to do various things, including referring the defendant to assisted outpatient treatment, to the county conservatorship investigator for possible conservatorship proceedings, or to CARE.

d) SB 1400 (Stern), Chapter 647, Statutes of 2024, among other things, requires, rather than permits, the court to hold a hearing to determine whether the defendant would be referred to outpatient treatment, conservatorship, or CARE, or if the defendant's treatment plan would be modified. SB 1400 also expanded the data to be compiled and reported to the Judicial Council, and expanded the information compiled from county behavioral health departments to include information on all active and former participants for a period of time after the conclusion of CARE services.

e) AB 102 (Ting), Chapter 38, Statutes of 2023, required DHCS, in consultation with the Judicial Council of California, to provide an early implementation report by December 1, 2024 to the Joint Legislative Budget Committee and the Budget Committees of each house of the Legislature, on key data for each trial court implementing CARE.

f) SB 35 (Umberg), Chapter 283, Statutes of 2023, made various revisions and clarifications to the CARE process, including to the obligations and responsibilities of CARE petitioners and county behavioral health agencies; provisions relating to a respondent's privacy and the circumstances their health information may be shared with the county; and, the level of participation in CARE proceedings a petitioner who is an eligible family member or a person who lives with the respondent may maintain if the court grants privileges.

g) SB 43 (Eggman) expanded the definitions of "gravely disabled" and "basic personal needs" in relation to a person's mental health disorder.

h) SB 1338 (Umberg), Chapter 319, Statutes of 2022, establishes the CARE Act.

9) POLICY COMMENTS.

a) Program updates without robust data. As noted above, since the passage of the CARE Act in 2022, there have been annual legislative updates to the process, reporting, eligibility, and more. While continued monitoring of implementation and the ability to course correct are crucial to ensuring program success, it must be noted that all of these changes have happened in the absence of a single statewide annual report. The early implementation report, first annual report on early implementation counties, and the update provided by CalHHS in July 2025 have provided valuable insight into the operation of the program, however this committee may wish to consider additional changes to the CARE Act in the context of pending statewide reporting and the

preliminary evaluation by an independent, research-based entity due December 31 this year.

Current law requires the annual the report to include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing disparities, homelessness, criminal justice involvement, conservatorships, and hospitalization of participants. The annual report must include process measures to examine the scope of impact and monitor the performance of 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. The report must include outcome measures to assess the effectiveness of the CARE Act model, such as improvement in housing status, including 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 reductions in substance use. The annual report also must examine these data through the lens of health equity to identify racial, ethnic, and other demographic disparities and inform disparity reduction efforts.

All of this is information that would be valuable and relevant when considering further changes to the CARE Act.

b) **This bill may diminish the voluntary nature of the CARE Act.** There is disagreement across the spectrum of stakeholders about which aspects of the CARE Act are working and which are not. The author argues that people who are dismissed from CARE because they need a higher level of services are falling through the cracks, and the proposed solution is to further integrate CARE with involuntary treatment. However, this bill may have the impact of discouraging those respondents with significant behavioral health issues, individuals that may be truly engaging with treatment for the first time, from participating at all if the threat of involuntary treatment is hanging over the process. Additionally, while the Judicial Council has not formally adopted a position on this bill at this time, it has identified concerns that the bill places courts in a challenging position when attempting to engage with respondents due to the potential for involuntary treatment. Under current law, if a person is gravely disabled or a danger to self or others as a result of a mental disorder, they are eligible to be detained for evaluation and treatment under LPS, regardless of their enrollment in CARE. The CARE Act also provides a mechanism for a court to use existing legal authority to pursue an LPS evaluation to protect a respondent's safety.

c) **Conflicts with SB 28 (Umberg).** Several sections of this bill conflict with SB 28, as amended on June 25, 2026. Both bills currently amend several of the same sections of WIC. The current version of this bill contains similar provisions to SB 28 that this committee requested be stricken from SB 28 when heard and passed on June 23, 2026. This bill also has one conflicting section with SB 1242. Should all the bills move forward, the authors may wish to coordinate on addressing these conflicts.

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

a) Strike Section 1 from the bill which allows for the bypassing of the county prepetition process. Strike Section 8 to conform with this change.

b) Strike the language permitting a petitioner to request, at the time of the petition, that an LPS mental health evaluation be considered if a person is unable or unwilling to participate, and the requirement that Judicial Council include the option on a petition form to request the court to order an LPS mental health evaluation.

c) Strike the inclusion in the county report or the petition of whether there is probable cause to believe that the respondent is, as a result of a mental disorder, a danger to themselves or others, or gravely disabled as defined in LPS, and whether the respondent will agree voluntarily to receive crisis intervention services or an evaluation in their own home or in a facility designated by the county.

d) Strike the requirement for the court to refer to LPS for evaluation if the court believes there is probable cause to believe the person meets LPS criteria and will not voluntarily receive evaluation, consistent with this committee's amendments to SB 28. Permit the court to refer to the county prepetition process, consistent with existing law, if the petition is dismissed because the respondent needs a higher level of services.

e) Strike the "actively participating" requirement for the court to dismiss the petition with voluntary engagement.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists (sponsor)
Alameda County Families Advocating for the Seriously Mentally Ill
City of San Jose Office of the City Attorney
Family Advocates for Individuals with Serious Mental Illness (FAISMI) of Sacramento
NAMI-California
National Shattering Silence Coalition
National Shattering Silence Coalition
San Diego County District Attorney's Office
Treatment Advocacy Center
Numerous individuals

Opposition

ACLU California Action
All People's Health Collective
Anti Police-Terror Project
Antiracist MD
Black Men Speak
Cal Voices
California Advocates for Nursing Home Reform
California Alliance for Retired Americans

California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Behavioral Health Planning Council
California Consortium of Addiction Programs and Professionals
California Peer Watch
California State Association of Counties
California State Association of Public Administrators, Public Guardians, and Public Conservators
Centro Legal De LA Raza
Corporation for Supportive Housing
County Behavioral Health Directors Association
Disability Community Resource Center
Disability Rights California
Drug Policy Alliance
Food Not Bombs
Gray Panthers of San Francisco
Homeless Union for Friendship and Freedom
Homeless United for Friendship and Freedom
Housing Is a Human Right
Justice Teams Network
Kelechi Ubozoh Consulting
LA Street Care & Mutual Aid
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Mental Health America of California
National Alliance to End Homelessness
National Coalition for Mental Health Recovery
National Mental Health Consumers' Self-help Clearinghouse
People's Budget Orange County
Racial and Ethnic Mental Health Disparities Coalition
Rural County Representatives of California
Sacramento Homeless Union
Serf City Times
Urban Counties of California
Venice Justice Committee
Western Regional Advocacy Project

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