Date of Hearing: June 23, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 28 (Umberg) – As Amended June 11, 2026

SENATE VOTE: Not relevant.

SUBJECT: Community Assistance, Recovery, and Empowerment (CARE) court program.

SUMMARY: Makes several changes to the implementation of the CARE Act, including to eligibility criteria, referrals to involuntary treatment under the Lanterman-Petris-Short (LPS) Act, and considerations of alternative treatment programs during the petition review process. Establishes the position of a CARE Court Ombudsperson within the California Health and Human Services Agency (CalHHS). Requires the Governor's office to annually release a list of overperforming and underperforming counties, with respect to CARE implementation, directing additional support to the latter through the CARE Improvement and Coordination Unit. Specifically, **this bill**:

1) Authorizes a conservator to, upon the termination of a conservatorship, request that the court refer the conservatee to CARE court. Requires documentation of the authority for this referral to be signed by a physician or licensed psychologist and to confirm that the conservatee is no longer gravely disabled as a result of mental disorder or impairment by chronic alcoholism and meets, or is likely to meet, criteria to qualify for the CARE process.

2) Authorizes individuals to qualify for the CARE program if they have not been clinically stabilized in ongoing voluntary treatment for more than 90 days prior to the CARE Court filing and if supervision is required to allow for services and supports to be effective and to prevent substantial deterioration or relapse, in addition to current eligibility criteria.

3) States that high utilization of emergency services is strong evidence that a person is not clinically stabilized and that current enrollment in a full-service partnership (FSP) program does not automatically exclude a person from the CARE Act program. Defines "high utilization of emergency services" to mean utilizing 911 or emergency department services 20 times or more in a 12-month period.

4) Allows a CARE petition to include evidence that the respondent was either detained for a minimum of two involuntary holds in the last six months, or that they were referred to an FSP program more than once but were not enrolled due to an inability or unwillingness to engage.

5) Extends the period for an affidavit of a licensed behavioral health professional stating the licensed behavioral health professional or their designee has examined or made multiple unsuccessful attempts to examine the respondent within 60 days of submission of the petition from 60 days to 270 days.

6) Authorizes the county behavioral health agency, their designee, or the court to recommend the respondent be considered for alternative treatment, including, but not limited to, assisted outpatient treatment program (AOT) or a grave disability evaluation under the LPS Act, if the respondent requires a higher level of care than the CARE process. Prohibits a

determination that a respondent requires a higher level of care than the CARE process if they otherwise meet, or are likely to meet, the criteria for CARE Court.

7) Permits a clinical evaluation, required if a CARE agreement is not entered, to be shared with the original petitioner, if the respondent consents.

8) Permits the court to adopt the CARE agreement as a CARE plan if the parties previously entered into a CARE agreement but the respondent stops engaging with the CARE process. Requires the adoption of the CARE agreement as a CARE plan to restart the CARE process timeline, which shall not exceed one year.

9) Requires the county behavioral health agency to request a status hearing to address a change in circumstances and request the court to order an evaluation under the LPS Act of the respondent if prescribed conditions are met, including that the respondent's nonadherence to the CARE plan has resulted in behavior consistent with an established pattern of psychiatric deterioration or symptoms of decompensation and the respondent may be in need of a higher level of care.

10) Requires, if appropriate, rather than permits, the court to order an LPS evaluation to ensure the respondent's safety if the court terminates the respondent's participation in the CARE process. Permits the court to order an LPS evaluation upon termination if the court finds it is in the best interest of the respondent.

11) Deletes the six month limitation on the court considering the respondent's failure of their CARE plan and the reasons for that failure in any subsequent hearings under the LPS Act and creating a presumption that the respondent needs additional intervention beyond the supports and services provided by the CARE plan, thereby requiring the court to consider that evidence at any future LPS Act hearing and extending the presumption indefinitely.

12) Authorizes the court to order a grave disability evaluation on its own motion or by motion from the county if the court finds that involuntary reappointment is unlikely to stabilize the respondent and supervision is necessary, or if the court finds it is in the best interest of the respondent, at the one-year status meeting.

13) Limits the current requirement for a court to order a county behavioral health agency to investigate and file a written report when a petition is filed by any entity that is not county behavioral health to only when a petitioner is a cohabitant or family member.

14) Adds the following to the definition of a "licensed behavioral health professional" for the purposes of the CARE Act:

    a) A licensed advance practice provider who renders behavioral health services in accordance with a physician assistant (PA) practice agreement; and,

    b) A licensed nurse practitioner specializing in behavioral health.

15) Adds the director or chief of a governmental agency offering first responder services, or their designee, to the list of people and entities permitted to file a CARE petition.

16) Explicitly authorizes county behavioral health agencies to disclose reports generated by the county behavioral health agency during the CARE process to healthcare providers or covered entities, if necessary to assist with ongoing treatment of the respondent. Provides that the county behavioral health agency will not be held civilly or criminally liable for any disclosure authorized or required by this bill and requires the respondent to be notified of a disclosure by mail at the respondent's last known address, to the respondent's counsel, and including a notification with the next notice of hearing served to the respondent.

17) Adds to the information to be included in a petition, or reported by the county behavioral health agency if not included in the petition, efforts and timeframes of efforts by county and noncounty providers to voluntarily engage the respondent prior to the filing of the petition. Adds documentation regarding how past attempts at voluntary engagement failed, cognitive deficits, and unmet mental health needs were assessed to the information contained in the petition or report.

18) Requires the county behavioral health agency to provide guidelines to facilities providing involuntary treatment on requesting an expedited assessment, where there is concern of imminent discharge and foreseeable challenges with locating the respondent, rather than the current 14 business day window for the county to complete an assessment upon referral from a facility.

19) Requires the court to make findings on the record about the basis for termination of the respondent's participation in the CARE process.

20) Prohibits the court from terminating the respondent's participation in the CARE process due to a failure of the county or other local government entity to properly engage with the CARE process. Requires the court to consider the imposition of fines if the court finds that the respondent is not participating in the CARE process due to a failure of the county or local government entity.

21) Specifies the Assisted Living Waiver program and the Home- and Community-based Services Waiver program as federal housing programs to be considered for the respondent.

22) Establishes the position of a CARE Court Ombudsperson within CalHHS, to be appointed by the Governor and confirmed by the Senate. Requires the ombudsperson to oversee and investigate complaints by petitioners, participants, and governmental agencies involved in the CARE process, including, but not limited to, judges, county staff, first responders, and city staff. Requires the ombudsperson to be funded by the CARE Act Accountability Fund.

23) Requires 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 (CARE ICU).

24) Authorizes all parties and witnesses to appear remotely via technology, though the court retains discretion to mandate in-person appearances if deemed necessary.

25) Requires all counties to establish a process for the electronic submission of CARE Act documents using a secured portal by January 1, 2028.

26) Expands the data compiled from county behavioral health departments and courts to include the number of petitions submitted electronically, the number of individuals successfully enrolled in an FSP program post-referral, the number of petitions dismissed for failure to make a prima facie showing, and the total number of LPS evaluations ordered by the CARE court.

27) Requires the tracking of data for cases involving dismissed respondents.

28) Adds court ordered LPS evaluations and the continuum of housing options to the training and technical assistance that the Department of Health Care Services (DHCS) must provide to county behavioral health agencies. Adds court ordered LPS evaluations to the training and technical assistance provided to judicial officers.

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 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) 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. [WIC § 5976]

11) Provides that all CARE Act hearings are presumptively closed to the public. Allows the respondent to demand that the hearings be public or request the presence of a family member or friend without waiving their right to keep the hearing closed to the general public. A request by another party to make a hearing public may be granted if the court finds that the public interest clearly outweighs the respondent's privacy interest. [WIC § 5976.5]

12) 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, requires the proceedings to be conducted in an

informal, non-adversarial atmosphere with a view to obtaining the maximum cooperation of the respondent, all persons interested in the respondent's welfare, and all other parties, with any provisions that the court may make for the disposition and care of the respondent. [WIC § 5977.4 (a)]

13) Upon receipt of a CARE Act petition, requires the court to promptly review the petition to see if it makes a prima facie showing that the respondent is or may be a person eligible for services under the CARE Act. [WIC § 5977 (a)(1)]

    a) If the court finds the petitioner has not made a prima facie showing that the respondent is or may be a person who is eligible for services under the CARE Act, the court must dismiss without prejudice, except if the court finds that the petition is without merit, or intended to harass the respondent. Allows a petition to be refiled with new information. [WIC § 5977 (a)(2)]

    b) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person who is eligible for services under the CARE Act, and the petitioner is the county behavioral health agency, the court must 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. [WIC § 5977 (a)(3)(A)]

    c) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person who is eligible for services under the CARE Act, and the petitioner is not the county behavioral health agency, the court must order the county agency to investigate whether the respondent meets the eligibility criteria of the CARE Act and is willing to engage voluntarily with the county, file a written report with the court, and provide notice, as required by the Act. [WIC § 5977 (a)(3)(B)]

14) Provides 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; and,

    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. Requires notice to the tribe, if applicable. [WIC § 5977 (c)]

15) Provides at the case management hearing:

    a) If the parties have entered, or are likely to enter, 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, as provided. Requires the evaluation to 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.

c) Requires the court to set a clinical evaluation hearing. [WIC § 5977.1]

16) Provides at the clinical evaluation review hearing:

a) The court must consider the evaluation, and other evidence, including calling witnesses, but only relevant and admissible evidence that fully complies with the rules of evidence may be considered by the court.

b) If the court finds, by clear and convincing evidence, after review of the evaluation and other evidence, that the respondent meets the CARE criteria, requires the court to order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan.

c) If the court finds, in reviewing the evaluation, that clear and convincing evidence does not support that the respondent meets the CARE criteria, requires the court to dismiss the petition. [WIC § 5977.1 (c)]

17) Provides at the hearing to review the proposed CARE plan:

a) The parties must present their plan or plans to the court. [WIC § 5977.1 (d)(1)]

b) The court must adopt the elements of a CARE plan that support the recovery and stability of the respondent. Allows the court to issue any orders necessary to support the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding, as provided. These orders are the CARE plan. [WIC § 5977.1 (d)(2)]

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, prohibits the medication from being forcibly administered and the respondent's failure to comply with a medication order may not result in a penalty, including but not limited to a court order of contempt or imposition of accountability measures. [WIC § 5977.1 (d)(3)]

d) Specifies that the above provisions do not prohibit the parties from agreeing to, and the court from approving, amendments to the CARE plan. The court may also approve amendments to the CARE plan upon the finding that those amendments are necessary to support the respondent in accessing appropriate services and supports, following a hearing on the issue. [WIC § 5977.1 (d)(7)]

18) Requires that a status review hearing occur at least every 60 days during the CARE plan implementation. [WIC § 5977.2 (a)(1)]

    a) Requires the petitioner to 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.

    b) Allows the respondent to respond to the report and introduce their own information and recommendations.

    c) Allows the petitioner, the respondent, or the court to request more frequent reviews as necessary to address changed circumstances. [WIC § 5977.2 (a)(1)(A) – (b)]

19) 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. Allows the court to make a referral under the LPS Act, as provided. [WIC § 5979 (a)]

20) 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. [WIC § 5982(d)]

21) 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)]

22) 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]

23) Establishes the Confidentiality of Medical Information Act (CMIA), which establishes protections for the use of medical information. [Civil Code (CIV) § 56, *et seq*.]

24) Prohibits providers of health care, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. [CIV § 56.10]

25) Provides that every provider of health care, health care service plan, pharmaceutical company, or contractor who creates, maintains, preserves, stores, abandons, destroys, or disposes of medical information shall do so in a manner that preserves the confidentiality of the information contained therein. Makes any provider of health care, health care service plan, pharmaceutical company, or contractor who negligently creates, maintains, preserves,

stores, abandons, destroys, or disposes of medical information subject to remedies and penalties, as specified. [CIV § 56.101]

26) Defines "provider of health care," for purposes of CMIA, to mean any person licensed or certified pursuant to the Business and Professions Code, as specified; the Osteopathic Initiative Act or the Chiropractic Initiative Act; the Health and Safety Code, as specified; or any licensed clinic, health dispensary, or health facility, as specified. The term does not include insurance institutions, as defined. [CIV § 56.05 (o)]

FISCAL EFFECT: Unknown. As recently amended, this bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill addresses major gaps in the original CARE Court process. Now that CARE Court has been active for nearly three years, there is clear data and evidence of unintended implementation issues such as high numbers of dismissed participants and lack of CARE Plans. The author states this bill creates numerous, urgently needed, commonsense CARE Court reforms in order to increase accessibility and accountability. Implementation data and other evidence shows that accountability tools in CARE Court are not being used. Public reporting and data have revealed that the number of court-supervised CARE Plans is unusually low relative to the number of CARE Agreements, with some counties having only a few or no CARE Plans at all. Some counties have even stated their intention publicly and privately to not use the CARE Plan process at all, despite the program having substantial public support. Additionally, the author notes, not a single county has been fined under CARE Court's enforcement provision. In fact, not a single fine has even been considered despite widespread reporting on several individuals and families claiming that CARE Court failed them. Although CARE Court was designed as an intervention before conservatorship is necessary, implementation data showcases an ongoing gap between CARE Court and higher levels of care. The author contends that there is no evidence that any CARE Court respondent has ever been referred into conservatorship despite a high number of dismissals for respondents needing a "higher level of care." The author says that, according to the DHCS Annual CARE Act Report, participants who required a "higher level of care" accounted for a significant portion of dismissals. The author states that in Los Angeles County, 29 of 130 dismissals (22%) were classified as "needs higher level of care," raising concerns about how to assist those who may be too ill for CARE Court, but are not ultimately placed under conservatorship. Another unintentional gap in CARE Court is in the eligibility process where it is obvious certain individuals are eligible, but, for technical reasons, the individual is denied access to CARE Court. Some of this can be attributed to lack of data on the potential CARE court enrollee, lack of consideration of longer-term patterns of psychiatric deterioration, previous rejection of voluntary services, high utilization of emergency services, and excessive service of process requirements.

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. The author reports that 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 agreement v. CARE plan. The author notes that there are counties that choose not to seek CARE plans and rely on agreements. In training and technical assistance provided by DHCS, the CARE agreement is referred to as a "voluntary settlement agreement" that all parties have agreed to. The CARE agreement is presented to the court for approval at the case management hearing. A CARE agreement specifically outlines behavioral health services, medications, and other housing and community services that the participant agrees to follow, and the county agrees to provide. With a focus on supporting autonomy and recovery, many counties prioritize CARE agreements, recognizing that participants are more likely to engage when actively involved in the decision-making process. If a CARE agreement is reached, there will be at least one court

review hearing within 60 days, although many courts and county behavioral health agencies have chosen to continue progress review hearings.

A CARE plan occurs after it is determined that a CARE agreement cannot be reached. The court will order the county behavioral provider to complete a clinical evaluation, which will include a specific assessment of capacity to provide consent to psychotropic medication. If the respondent is still found to meet eligibility requirements for CARE at the clinical evaluation hearing, the court will order the parties to present recommended elements for the CARE plan. Rather than coming to the court with an agreed course of action, the county behavioral agency, the participant, or both may present elements of a CARE plan to the court during the CARE plan review hearing. During this hearing, the court will decide which elements submitted will be included in the CARE plan and will adopt the elements that support the recovery and stability of the participant.

The CARE Act stipulates that the county is also court ordered to provide these services to the respondent. The respondent is ordered to follow the CARE plan as well, but because this is a civil case, there will be no criminal penalties if they don't engage. However, information of non-participation in a CARE plan may inform a future LPS Act proceeding. Like a CARE agreement, the intent of a CARE plan is to promote the individual's stability and recovery. And, also like a CARE agreement, a CARE plan should include behavioral health services, medications, housing, and community support. After a CARE plan is ordered, the court will continue to conduct progress review hearings every 60 days (but may hold the hearing sooner, if necessary). This bill proposes that a CARE agreement may be converted into a CARE plan if an individual is not participating. This change would create a more direct path from CARE agreement to an LPS proceeding, which opponents argue will disincentivize respondents from engaging in the CARE process.

c) **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 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, 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.

d) 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.

e) **Licensed Behavioral Health Professional**. The current definition of "licensed behavioral health professional" in the CARE Act includes a licensed physician, a licensed psychologist, a licensed clinical social worker, a licensed marriage and family therapist,

or a licensed professional clinical counselor. It also includes social workers, marriage and family therapists, professional clinical counselors who are registered with their licensing board and working toward licensure, and psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors recruited from out of state that would otherwise meet the criteria to gain admission to a licensing examination.

Under the CARE Act, a licensed behavioral health professional is able to:

i) File a CARE petition [WIC § 5974 (e)];

ii) Sign an affidavit stating they 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 the petition, and that they have 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. [WIC § 5975 (d)(1)];

iii) Testify as an expert concerning whether the respondent meets the CARE criteria provided that the court finds that the professional has special knowledge, skill, experience, training, or education sufficient to qualify as an expert. [WIC § 5977 (b)(7)(A)];

iv) Conduct a clinical evaluation of a respondent, including a clinical diagnosis, whether the respondent has the legal capacity to give informed consent regarding psychotropic medications, any other information they feel is appropriate for the evaluation, and an analysis of recommended services, programs, housing, medications, and interventions that support the recovery and stability of the respondent. This would be on behalf of the county behavioral health department, at the direction of the court, if there is no CARE agreement. [WIC § 5977.1 (b)]; and,

v) Authorize referrals to CARE from an individual on an LPS hold. [WIC § 5978.1].

This bill would add nurse practitioners (NPs) specializing in behavioral health and PAs who render behavioral health services to the definition of "Licensed Behavioral Health Professional" under the CARE Act. SB 27 (Umberg), Chapter 528, Statutes of 2025, added NPs and PAs specifically to ii) above, allowing them to sign an affidavit. This bill would allow them to carry out all of the activities above.

PAs are health care providers who can provide a wide range of medical services under the supervision of a physician, including prescribing, when authorized by a supervising physician under a document known as a practice agreement. They can make clinical decisions and provide a broad range of diagnostic, therapeutic, preventative, and health maintenance services. The practice agreement outlines what a PA may or may not do based on the PA's competence and the level of physician supervision required. A physician is authorized to supervise more than one PA, but no more than four at a time, other than in limited circumstances for PAs providing limited home health evaluations.

An NP is a registered nurse (RN) who has additionally earned a postgraduate nursing degree, such as a Master's or Doctorate, and obtained a certificate from a certifying body.

As RNs, NPs generally have the same base scope of practice as non-NP RNs, although their additional education and training allows them to perform more advanced functions under standardized procedures. NPs can meet additional requirements to practice independently without standardized procedures.

f) Clinically stabilized in ongoing voluntary treatment. One of the requirements to be eligible under the CARE Act is that a respondent not be clinically stabilized in ongoing voluntary treatment. That term was not originally defined and last year SB 27 defined the term to mean that the person's condition is stable and not deteriorating and that the person is currently engaged in treatment and managing symptoms through medication or other therapeutic interventions. The definition specifies that enrollment in treatment alone shall not be considered clinically stabilized in ongoing voluntary treatment. This bill proposes adding a time frame to the eligibility criteria, allowing a person to be eligible for CARE if they have not been clinically stabilized for the prior 90 days. Under this change, a person could be clinically stabilized for 89 days and considered eligible. Further, when the court is determining whether voluntary engagement with a respondent is effective, this bill would permit the court, rather than require it, to dismiss the petition even when an individual has stabilized.

Taken together, it's unclear how requiring respondents to continue in the CARE process even when they are stable and voluntarily engaging is consistent with the original intent of the Act.

g) 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) supports this bill stating that it helps avoid the unfortunate scenario in which a conservatorship is terminated, and an individual is left without adequate care in the community. CSAP argues that this bill recognizes that frequent utilization of emergency medical services is strong evidence that an individual is not successfully stabilized in the community. This population is often primarily served by city first responders, law enforcement agencies, and homeless outreach workers, many of whom struggle to connect individuals to the county behavioral health continuum of care. Because these agencies generally lack access to information regarding an individual's legal status during inpatient psychiatric hospitalization, and often do not employ or contract with behavioral health professionals, identifying individuals who meet CARE eligibility criteria can be difficult. CSAP also contends that by allowing prior 5150 holds and an inability to enroll in an FSP program to serve as evidence supporting CARE Act eligibility, this bill provides city agencies with practical documentation that can support CARE petitions. This change will make CARE Court more accessible to individuals who are chronically gravely disabled and repeatedly cycle through emergency departments, psychiatric hospitals, jails, homelessness, and other acute settings. CSAP states that these reforms strengthen CARE Court's ability to identify, engage, and support individuals with the most serious mental illnesses while improving accountability, continuity of care, and coordination across systems. CSAP concludes that this bill recognizes that individuals with the most severe mental illnesses often require coordinated interventions across multiple systems and levels of care, and it ensures that CARE Court functions as a bridge to treatment rather than a dead end.

4) **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 transforms CARE Court into a pipeline to involuntary commitment, eroding civil liberties and furthering racial disparities. The coalition argues that the LPS evaluations proposed in this bill take place in locked facilities and may result in someone being held for up to 71

hours against their will before the evaluation takes place. As a result, CARE Court respondents would face the ongoing threat of involuntary commitment throughout their time in CARE Court, creating a more coercive environment that undermines voluntary engagement and trust and is not conducive to long-term recovery. The coalition notes that this bill significantly broadens CARE Court eligibility by allowing people to be subject to CARE Court even if they are currently participating in voluntary treatment, including individuals already receiving intensive services, such as FSPs. Subjecting individuals to court oversight while they are actively participating in treatment risks disrupting their progress and undermining therapeutic relationships, particularly when participation requires attending court hearings and complying with court orders. Rather than improving access to care, these provisions risk disruption and destabilization. The coalition argues that instead of respecting a person's decision about their own care, the bill allows the court to impose a mandatory CARE plan if engagement falters, turning what is meant to be a voluntary pathway into a coercive one. This dynamic creates pressure to comply out of fear of escalation, rather than fostering genuine engagement in services, and undermines trust in both providers and the system as a whole. On the recent June 11 amendments, the coalition argues that these sweeping changes late in the legislative process deprive stakeholders and impacted communities of a full opportunity to evaluate this bill's significant civil rights or budget implications. This late-stage gut-and-amend approach continues a troubling pattern of advancing major CARE Court expansions without adequate opportunity for public input.

The California Public Defenders Association (CPDA) opposes this bill, stating that the sweeping and dramatic changes that this bill proposes to CARE Court cannot be adequately evaluated and debated this late in the legislative session. CPDA argues this bill would change CARE eligibility criteria, investigation timelines, reporting requirements, privacy protections, remote appearances, and information sharing. Most troubling and drastically at odds with the promise of CARE Court, these changes constitute a significant shift in emphasis from CARE's foundational principles. Instead of focusing on holding behavioral health care providers accountable for the quality of care that they provide to CARE participants, this bill shifts its focus to the consequences participants may face for inadequate or unsatisfactory participation in treatment. CPDA contends the cumulative impact of these changes is to draw the court's attention away from the current condition and current needs of a potential CARE participant, and to instead invite decisions based on information that is 6 months, 9 months, or a year old. CPDA concludes that these changes to CARE Court are too sweeping to be adequately evaluated and refined at this stage in the legislative process. Just as CARE Courts are finding their footing throughout the state, it is not time to rush through changes this fundamental.

The County Behavioral Health Directors Association (CBHDA) opposes this bill stating that it proposes significant changes to both the CARE and LPS Acts, and does so while foregoing the necessary time for analysis and input by the Legislature or relevant stakeholders such as county behavioral health departments providing these services, conservators and public guardians that administer LPS conservatorships, as well as judicial officers that would be involved in CARE proceedings. CBHDA argues this bill grants courts the authority to order an involuntary LPS evaluation for an individual if the courts terminate the individual's participation in the CARE process. While the CARE process is fundamentally a voluntary program, there are still measures in place for courts to determine when an individual is not participating in the CARE process and can terminate participation altogether. CBHDA notes that existing law already allows a court to order an evaluation under LPS. This bill would

remove clinical and judicial discretion by requiring courts to pursue this pathway if the court finds it in the best interest of the individual. This further undermines the voluntary nature of CARE court, instituting involuntary practices bypassing an individual's legal protections under existing law as well as the requirement to treat individuals at the least restrictive level of care. CBHDA also shares serious concerns with the requirement to develop an "expedited assessment" as an alternative to a 14 day assessment when receiving a CARE referral from a facility, which would add significant new costs to CARE. In the alternative, facilities sending CARE petitions should ensure sufficient lead time for CARE petitions and robust, quality discharge planning processes to ensure individuals do not fall through the cracks upon discharge. CBHDA has significant concerns with the determination of CARE Champions and CARE ICU counties as this was not based on a valid measure of success under CARE. CBHDA encourages the Legislature to work with subject matter experts to develop independent and valid measures of quality and success under CARE, to be overseen by the Department of Health Care Services.

5) **DOUBLE REFERRAL**. This bill has been double referred; upon passage in this committee, it will be referred to the Assembly Judiciary Committee.

6) **RELATED LEGISLATION**.

   a) SB 989 (Blakespear) would authorize a first responder to contact the county behavioral health agency in the county in which an individual 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 Judiciary Committee.

   b) SB 1016 (Blakespear) would authorize a petitioner of a CARE Act petition to request that the court order a mental health evaluation under the LPS Act under certain conditions and would authorize 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. SB 1016 is pending in the Assembly Health 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.

7) **PREVIOUS LEGISLATION**.

   a) SB 27 adds 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, makes 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.

8) POLICY COMMENTS.

a) Pattern of late amendments. Of the many CARE Act bills since the passage of SB 1338, several have followed a pattern of significant amendments very late in the legislative process. SB 35 had 19 sections added with amendments on June 12, 2023. SB 42 had 11 sections added on August 19, 2024. SB 27 had seven sections added on June 17, 2025. This bill was "gutted and amended" (when amendments to a bill remove the current contents in their entirety and replace them with different provisions) on June 11,

2026, with 17 sections added. While amendments to all bills are standard throughout the year, advocates have identified the pattern of these amendments to bills regarding the CARE Act. Advocates have contacted the committee about this pattern, stating that it is "bypassing public engagement and limiting time to properly discern the impacts of the bill," and argue that legislation "that can take people's rights away, must face public opinion, and members of the Legislature must be given the chance to engage in public debate on concerns raised." Further, some of the most significant changes proposed by this bill were mentioned in the November 2025 oversight hearing noted above and conducted by the author, but were not included in this bill until the most recent amendments. Many stakeholders have shared their displeasure with another CARE Act bill being amended this late in the process. This is not just an issue for members of the public and impacted populations: it also severely diminishes this committee's ability to understand fully the author's intent and the practical implications of each provision, making it difficult for committee members to be informed about the policy they are considering.

b) **Program updates without robust data.** As noted above, since the passage of the CARE Act in 2022, there have been annual 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. While 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, 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.

c) **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 notes 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. As noted by CPDA, 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. 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.

d) **Conflicts with other bills.** This bill includes a blanket conflict section stating that if there are conflicts between provisions of this bill and SB 989, SB 1016, or SB 1242, the provisions of those bills would take effect. As currently drafted, this bill does conflict with all three and would need to address those conflicts to avoid chaptering out issues.

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

a) Reduce the proposed extension of the period for an affidavit of a licensed behavioral health professional stating the licensed behavioral health professional or their designee has examined or made multiple unsuccessful attempts to examine the respondent within 60 days of submission of the petition from the 270 days currently proposed to 120 days.

b) Authorize the court to order the county to develop an exit plan, rather than a grave disability evaluation, if the petition is dismissed because the respondent needs a higher level of services. Require DHCS to convene stakeholders to develop a model exit plan.

c) Strike the requirement that the CARE Act Accountability Fund be used to fund the ombudsperson.

d) Limit new information in the petition or report containing documentation regarding how past attempts at voluntary engagement failed to 120 days prior to the petition, rather than indefinite.

e) Limit the following information to the 120 days prior to a petition: evidence that the respondent was either detained for a minimum of two involuntary holds, or that they were referred to an FSP program more than once but were not enrolled due to an inability or unwillingness to engage.

f) Clarify a court may not terminate a respondent's participation solely for the county's failure to engage.

g) Modify the CARE Champion/ICU section to state the intent of the Legislature to require CalHHS to identify those counties performing well and those not rather than the Governor, and to provide counties with technical assistance and support. Appropriate metrics to be determined should the bill move forward.

h) Permits the court to adopt the CARE agreement as a CARE plan if certain conditions are met, including that the respondent was provided with all services required in the CARE

agreement and that respondent has stopped engaging for 60 days or more with documented attempts to engage them. Prohibits the adoption of the CARE agreement as a CARE plan from restarting the CARE process timeline.

i) Strike the following provisions from the bill:

i) Requires the county behavioral health agency to request a status hearing to address a change in circumstances, only if necessary to ensure the respondent's safety, and remove the requirement that they use legal authority for an LPS evaluation.

ii) Deletes the 6 month limitation on the court considering the respondent's failure of their CARE plan and the reasons for that failure in any subsequent hearings under the LPS Act and creating a presumption that the respondent needs additional intervention beyond the supports and services provided by the CARE plan, thereby requiring the court to consider that evidence at any future LPS Act hearing and extending the presumption indefinitely.

iii) Authorizes individuals to qualify for the CARE program if they have not been clinically stabilized in ongoing voluntary treatment for more than 90 days prior to the CARE Court filing and if supervision is required to allow for services and supports to be effective and to prevent substantial deterioration or relapse, in addition to current eligibility criteria.

iv) States that high utilization of emergency services is strong evidence that a person is not clinically stabilized and that current enrollment in a full-service partnership (FSP) program does not automatically exclude a person from the CARE Act program. Defines "high utilization of emergency services" to mean utilizing 911 or emergency department services 20 times or more in a 12-month period.

v) Authorizes, during the petition review phase, the county behavioral health agency, their designee, or the court to recommend the respondent be considered for alternative treatment, including, but not limited to, assisted outpatient treatment program (AOT) or a grave disability evaluation under the LPS Act, if the respondent requires a higher level of care than the CARE process. Prohibits a determination that a respondent requires a higher level of care than the CARE process if they otherwise meet, or are likely to meet, the criteria for CARE Court.

vi) Permits the court to order an LPS evaluation upon termination if the court finds it is in the best interest of the respondent.

vii) States that if a court dismisses a petition because the person does not meet the criteria by clear and convincing evidence, this is a termination pursuant to another section of the law, which could lead to an LPS evaluation.

viii) Limits the current requirement for a court to order a county behavioral health agency to investigate and file a written report when a petition is filed by any entity that is not county behavioral health to only when a petitioner is a cohabitant or family member.

ix) Adds NPs and PAs to the definition of a "licensed behavioral health professional" for the purposes of the CARE Act.

x) Adds the director or chief of a governmental agency offering first responder services, or their designee, to the list of people and entities permitted to file a CARE petition.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists (CSAP)
One individual

Opposition

All People's Health Collective
Anti Police-terror Project
Antiracist MD
Black Men Speak, Inc.
Buccola Family Homeless Advocacy Clinic
Cal Voices
California Alliance for Retired Americans (CARA)
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Coalition for Women Prisoners
California Peer Watch
California Public Defenders Association
California United for a Responsible Budget (CURB)
CD11 Coalition for Human Rights
Center for Independent Living Berkeley
Centro Legal De LA Raza
Community Lead Advocacy Program Clap
Corporation for Supportive Housing (CSH)
County Behavioral Health Directors Association
Disability Community Resource Center
Disability Rights California
Disability Rights Education & Defense Fund (DREDF)
Drug Policy Alliance
Food Not Bombs
Independent Defense Counsel Office, County of Santa Clara
Kelechi Ubozoh Consulting
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Mental Health America of California
National Alliance to End Homelessness
Painted Brain
People's Homeless Task Force Orange County
Project Return Peer Support Network
Senior & Disability Action
Venice Justice Committee
Western Regional Advocacy Project

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