Date of Hearing: August 5, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 28 (Umberg) – As Amended July 2, 2026

Policy Committee:	Health	Vote:	14 - 0
	Judiciary		11 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: Yes

SUMMARY:

This bill makes numerous changes to the Community Assistance, Recovery, and Empowerment (CARE) Act. The bill expands eligibility for referral to the CARE Act, expands the scope of evidence a court may consider as part of a CARE petition, requires the Department of Health Care Services (DHCS) develop a model exit plan for individuals who need a higher level of care than is available through the CARE process, and establishes a CARE Court ombudsperson to oversee complaints regarding the program, among many other changes.

Please refer to the Assembly Judiciary Committee analysis for an enumeration of the provisions of this bill.

FISCAL EFFECT:

1) DHCS estimates costs of $3.86 million (General Fund (GF)) for fiscal year (FY) 2027-28 and $340,000 GF for FY 2028-29 and ongoing for state operations, as follows: $3.5 million for FY 2027-28 in contract resources to augment its existing contract for CARE Act implementation, training and technical assistance (TTA), data collection, reporting, and operationalizing a process to receive, aggregate, and report CARE Act documentation for up to 58 separate electronic portals. The contract resources would also support development of: a new model exit plan; revision of CARE Act policies, the data dictionary and reporting specifications; statewide training curricula and technical assistance resources; modification of data collection systems, reporting tools, and quality assurance processes; development of new reporting methodologies and statewide performance measures; stakeholder engagement activities; and coordination with county behavioral health agencies (CBHAs) and the Judicial Council (Council). The contracted vendor would also be required to deliver retraining statewide to implement changes to eligibility criteria, petition processes, data reporting, confidentiality and information sharing rules, diversion processes, and court-related procedures. DHCS will help the California Health and Human Services Agency (CalHHS) support underperforming counties.

   DHCS will also require $358,000 (GF) in FY 2027-28 and $340,000 (GF) in FY 2028-29 and ongoing for two permanent full-time staff positions to lead cross-system coordination efforts with CBHAs, the Council, CalHHS, the CARE Act Ombudsperson, and other state and local partners, among other activities.

2) DHCS estimates local costs could reach the low tens of millions of dollars (GF) initially and up to $10 million annually ongoing. A coalition of the County Behavioral Health Directors

Association (CBHDA); Urban Counties of California; California State Association of Counties; California State Association of Public Administrators, Public Guardians, and Public Conservators; and Rural County Representatives of California estimates costs of $67.6 million to $150.9 million annually, which would be reimbursable by the state (GF). CBHAs' CARE Act workload would increase due to additional referrals; new data reporting; monitoring of individuals with dismissed petitions related to the new exit plans; providing notices of disclosures of protected information; increased court reporting time; and additional data gathering, tracking, and reporting.

3) CalHHS estimates costs of $3.76 million as follows: $1.76 million for eight staff positions and $2 million in contracts and grants, including $1.5 million annually to contract for capacity and subject matter expertise to provide training and technical assistance to address common complaints or grievances to improve overall CARE Act implementation and $500,000 in mini-grants for local agencies to adopt improvements identified through technical assistance (GF).

4) The Council estimates cost pressures between $4.8 million and $7.8 million in the first year of implementation and $1.7 million to $3.7 million in the second year and annually thereafter. All years will include additional staffing needs at the Council and for the courts, as well as increased hearing workload and calendaring cost pressures. The first year also includes the cost to update the case management systems to add the additional data elements as well as the technology upgrades needed to ensure all 58 courts can accept electronic filing of CARE petitions. The Council states that if funding is not provided for the new workload created by this bill, delays and prioritization of court cases may impact access to justice (Trial Court Trust Fund, GF).

COMMENTS:

1) **Purpose.** According to the author:

> 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. [This bill] creates numerous, urgently needed, commonsense CARE Court reforms in order to increase accessibility and accountability.

2) **Background.** SB 1338 (Umberg), Chapter 319, Statutes of 2022, established the CARE Act to provide community-based behavioral health services and supports, by means of a civil court process, to Californians living with untreated schizophrenia spectrum or other psychotic disorders who meet certain health and safety conditions. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent more restrictive alternatives, including psychiatric hospitalizations, incarceration, and conservatorship under the Lanterman-Petris-Short Act. The CARE Act has been in effect statewide since December 1, 2024.

   The CARE Act process begins when a person ("petitioner") files a petition with the court seeking services for a qualifying person with a serious mental disorder ("respondent"). The court orders a clinical evaluation and appoints a public defender and a support person to

represent the respondent in legal proceedings and help the respondent navigate the CARE court process. If the court finds that the respondent meets the statutory criteria, the court orders the parties and the CBHA to develop a proposed CARE treatment plan for the respondent. Once the court approves the plan, it becomes a court-ordered treatment plan that requires the respondent to participate in specified clinically appropriate, community-based services for a set period of time. If a respondent fails to complete their CARE treatment plan, a future court may consider that fact when determining whether to place the respondent under a conservatorship.

3) **Support.** The California State Association of Psychiatrists (CSAP) writes in support that this bill will result in individuals leaving conservatorship who continue to need intensive community support being more likely to receive ongoing treatment and supervision. CSAP adds that this bill recognizes that frequent use of emergency services is strong evidence that a person is not successfully stabilized in the community. CSAP argues that allowing prior Section 5150 holds and inability to enroll in the Full Service Partnership program to serve as evidence supporting eligibility for the CARE Act, this bill provides city agencies with documentation that can support CARE Act petitions, making CARE Court more accessible. CSAP also argues SB 28 improves care coordination and reduces barriers to treatment by authorizing sharing of CARE Act information among behavioral health professionals.

4) **Opposition.** Among many organizations opposing this bill, a coalition of CBHDA, Urban Counties of California, California State Association of Counties, California State Association of Public Administrators, Public Guardians, and Public Conservators, and Rural County Representatives of California, write that while they appreciate the amendments taken in both Assembly Health and Judiciary committees, SB 28 still proposes significant and concerning changes to the CARE Act, including the requirement for counties to share confidential health information, which could create exposure related to the federal Health Insurance Portability and Accountability Act (HIPAA) violations, and the establishment of new vague and non-clinically sound thresholds for an expedited CARE assessment. The Drug Policy Alliance argues California should invest in accessible, voluntary, and evidence-based behavioral health services that people can choose to engage with, and that lasting recovery is best supported through trust, autonomy, and meaningful access to care—not through court-based processes that increase coercion and involvement in the legal system.

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