THIRD READING

Bill No: SB 989
Author: Blakespear (D) and Umberg (D), et al.
Amended: 5/14/26
Vote: 21

SENATE HEALTH COMMITTEE: 9-0, 4/15/26
AYES: Weber Pierson, Valladares, Caballero, Durazo, Gonzalez, Grove, Padilla, Rubio, Smallwood-Cuevas
NO VOTE RECORDED: Menjivar, Pérez

SENATE JUDICIARY COMMITTEE: 12-0, 4/21/26
AYES: Umberg, Niello, Allen, Ashby, Caballero, Durazo, Laird, Reyes, Stern, Valladares, Wahab, Wiener
NO VOTE RECORDED: Weber Pierson

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/14/26
AYES: Cervantes, Seyarto, Cabaldon, Dahle, Grayson, Richardson, Wahab

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

SOURCE: California Professional Firefighters

DIGEST: This bill permits a first responder (FR) to request the county behavioral health (CBH) agency file a petition to commence the Community Assistance, Recovery, and Empowerment Act process to investigate a person's eligibility. Requires CBH to complete a review of the request within 30 days and determine whether to file a petition.

ANALYSIS:

Existing law:

1) Establishes Community Assistance, Recovery, and Empowerment (CARE) 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. [Welfare and Institutions Code (WIC) §5970, et seq.]

2) Requires an individual, to qualify as a respondent in the CARE process, to:
    a) Be 18 years of age or older;
    b) Be currently experiencing a serious mental disorder and have a diagnosis of schizophrenia spectrum or other psychotic disorder. Prohibits an individual who has a current diagnosis of substance use disorder, 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]

3) 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 Lanterman-Petris-Short (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) An FR, 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 CBH, 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]

4) Requires the court to review a petition promptly, and after a series of investigations, reports, and hearings that determine if an individual meets CARE criteria, to:
   a) Dismiss the matter if the court determines voluntary engagement with the respondent is effective, and they have enrolled or are likely to enroll in voluntary behavioral health treatment;
   b) Order CBH to work with the respondent, the respondent's counsel, and the supporter ("the parties") to engage the respondent in behavioral health treatment and attempt to enter into a CARE agreement, approve the agreement, and set a progress hearing for 60 days, if voluntary engagement is not effective;
   c) Order CBH, through a licensed behavioral health professional, to conduct a clinical evaluation of the respondent to determine if they meet CARE criteria, if the parties are not likely to enter into a CARE agreement; and,
   d) Order CBH and the parties to jointly develop a CARE plan within 14 days, if the respondent does meet CARE criteria. [WIC §5977(a)(5)(A), §5977 (c)(2), §5977.1(a)(2)(A), §5977.1(b), and §5977.1(c)(3)(A)]

5) Requires the Department of Health Care Services (DHCS) to provide training and technical assistance to CBH 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)]

This bill:

1) Permits an FR, in addition to directly filing a petition to commence the CARE process, to request the CBH of the county in which the respondent resides or is found to file a petition to commence the CARE process if the FR believes that an individual meets or is likely to meet criteria to qualify for the CARE process, Requires the request to include contact information for the individual, including a telephone number and address, if available, and other information as specified by DHCS.

2) Requires CBH, within 30 business days of the request, to complete a review of the request and determine whether to file a petition.

3) Requires CBH, upon completing the review, to notify the FR about the outcome of the review of the request and whether the individual met criteria for the CARE process.

4) Requires DHCS to develop a referral form to be used by an FR and to issue guidance regarding the procedure for an FR to request CBH to file a petition to commence the CARE process, and to include data regarding FR requests made to CBH in the annual CARE Act report.

Comments

According to the author of this bill:

> CARE was created to provide a structured, coordinated pathway to treatment for individuals with severe mental illness who are too often cycling through emergency rooms, jail, and repeated law enforcement encounters. Today, FRs are often the first point of contact for individuals in crisis, but current law makes it difficult for them to file a CARE petition. To do it, they must navigate a complex court filing process, obtain sensitive medical records, and appear in court. This bill creates a more practical and effective pathway by allowing FRs

to request that CBH investigate and file CARE petitions on their behalf. This bill would expand access to CARE and help more Californians with untreated psychotic disorders receive the care they need.

Background

CARE. SB 1338 (Umberg and Eggman, Chapter 319, Statutes of 2022) established CARE to help connect an individual in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides these individuals (referred to as "respondents" in the CARE process) with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent, which includes short-term stabilization medications, wellness and recovery supports, connection to social services, and a housing plan. The California Health and Human Services Agency states that CARE is an upstream diversion to prevent more restrictive conservatorships or incarceration, based on evidence that demonstrates many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer-acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community. The first cohort of counties implemented CARE beginning October 1, 2023, and included Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco. Los Angeles County implemented early and began accepting CARE petitions on December 1, 2023. The second cohort of counties, representing the remaining population of the state, began accepting CARE petitions as of December 1, 2024.

CARE Act 2025 first annual report. As reported by DHCS in its initial annual report, data from the first nine months of CARE implementation demonstrate that, even in its early stages, the CARE process is connecting people with schizophrenia and other psychotic disorders with evidence-based treatments and housing plans. This reflects a meaningful shift in helping the state's most vulnerable populations towards long-term recovery, lasting wellness, and housing stability. Relative to this bill, the report states that 556 CARE petitions had been received by the courts as of June 30, 2024 (the first nine months of CARE implementation). Of the filed CARE petitions, 217 (39%) were dismissed. There were 101 approved CARE agreements or ordered CARE plans. The remainder of filed CARE petitions were still in the court review process at the time of this report development and were pending disposition assignment, as reported by DHCS. Of the total 556 petitions submitted

to the court, 497 CARE petitions were received by CBH during the first nine months of CARE implementation (representing 490 unique CARE respondents, given that some respondents were petitioned more than once). CBH are only aware of, and able to track, CARE petitions they file themselves or those they are ordered to investigate by the courts. Petitions may also be pending court determination at the end of the reporting period covered in the report. Of the 490 unique CARE respondents that were sent to CBH, 101 had a CARE agreement approved, or CARE plan ordered by the court as their first CARE disposition; 160 were dismissed by the court; and 229 did not yet have a court disposition assigned. Among the 160 dismissed respondents, 15 became elective clients, 55 were found to be ineligible for CARE but received CBH services, and 90 were found to be ineligible for CARE and did not receive any CBH services. The report further notes that of the 490 CARE respondents that were sent to CBHs, 334 (68%) were petitioned by someone with a personal relationship to the respondent (referred to as a personal petition); 107 (22%) by a system partner (defined as a hospital director, licensed behavioral health professional treating client, public guardian, or conservator); 34 (7%) by an FR; and 14 (3%) by the respondent themselves.

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

According to the Senate Appropriations Committee:

- Unknown costs to county behavioral health agencies for administration. Costs to counties would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

- Unknown General Fund costs to the Department of Health Care Services (DHCS), potentially tens of thousands, for state administration to develop a referral form and issue guidance.

SUPPORT: (Verified 5/14/26)

California Professional Firefighters (source)
City of Oceanside
City of San Diego

OPPOSITION: (Verified 5/14/26)

Cal Voices
California Peer Watch
Disability Rights California
Mental Health America of California

ARGUMENTS IN SUPPORT: The California Professional Firefighters (CPF) as sponsor argue California's firefighters are on the front lines of delivering emergency medical services throughout the state, including to patients who are experiencing a mental health crisis, leading in evolving the local response framework to improve patient care. For example, CPF cosponsored legislation in 2020 that established community paramedicine and triage to alternate destination programs, including allowing a paramedic to triage a patient and take them to an appropriate behavioral health facility to get the services they need at the right time. Moreover, many jurisdictions have developed mobile mental health units, bringing together a suite of public safety and medical professionals to improve care in the field. CPF argues despite that work more needs to be done. Firefighters in the field see patients daily who are in desperate need of robust care, but gaps in the system lead to patients not receiving the right kind of care at the right time. While firefighters are well-situated to identify individuals who may be eligible for CARE given their presence and engagement in the community, barriers, such as general lack of information, training, and support for CARE still exist throughout California, leaving many firefighters unable to participate or even unaware that they are able to begin the petition process. Additionally, firefighters and other first responders are responsible for hundreds of emergency calls and may lack the local resources needed to complete petitions and appear in the court process as required. Those who are able to begin the petition process may not have access to the required medical records or other documentation required by the court.

ARGUMENTS IN OPPOSITION: Disability Rights California (DRC) and California Peer Watch argue that they share first responders' concerns, but streamlining processes for referring people into CARE is not the solution. DRC argues people with CARE agreements or plans are placed on the same waitlists for services as anyone seeking services on their own, like one respondent who was placed on a waitlist for medication services that was three months long. The CARE First Annual Report noted 56.4% of CARE participants did not receive at least one ordered behavioral health service—including peer support, medication supports, and therapy—and 82.2% of CARE participants did not receive at least one ordered social service or support. CARE is also failing to achieve its goal of preventing crises or stopping people from cycling through emergency services, and coercive treatment interferes with the therapeutic relationship and is counter to sound public health policy. The quality of the therapeutic relationship is critical for a client's engagement in treatment, adherence to a medication plan, management of symptoms, overall treatment outcomes, and quality of life. California should be working to improve, not destroy, the therapeutic relationship. DRC says the state

should be investing in community-based services, including: peer-led hotlines and warmlines that answer calls and texts that would otherwise go to 911; mobile crisis response teams that respond to mental health calls that would otherwise receive a police, fire, or ambulance response; peer respites that offer a space for healing for individuals who might otherwise find themselves in an emergency room; and full-service partnerships that actually connect people with whatever they need: housing, food, case management, medical, or mental health care. Cal Voices argues this bill complicates the CARE process and could worsen the already coercive conditions faced by respondents. Mental Health of America California argues the right to appeal is a right exclusively given to respondents in CARE. Other petitioners may refile if their petition is dismissed. FRs should not be given the power to appeal the county's decision when that decision is in favor of the respondent, particularly when the respondent is unaware of any assessment or investigation occurring, as such appeals will create further unnecessary burdens for the counties.

Prepared by: Reyes Diaz / HEALTH / (916) 651-4111
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