SENATE THIRD READING
SB 1338 (Umberg and Eggman)
As Amended August 15, 2022
Majority vote

SUMMARY

Establishes the Community Assistance, Recovery, and Empowerment (CARE) Act.

Major Provisions

1) Establishes the CARE Act, which must be implemented by counties representing at least half the population of the state by October 1, 2023, and the other half by December 1, 2024, subject to delays based on a state or local emergency, or discretionary approval by the Department of Health Care Services (DHCS), up until December 1, 2025.

2) Defines, for purposes of the CARE Act, certain terms, including:

   a) "CARE agreement" is a voluntary settlement agreement, which includes the same elements as a CARE plan.

   b) "CARE plan" is an individualized, appropriate range of services and supports consisting of behavioral health care, stabilization medications, housing, and other supportive services, as provided.

   c) "Graduation plan" is a voluntary agreement entered into by the parties at the end of the CARE program that includes a strategy to support a successful transition out of court jurisdiction and may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing services and supports. A graduation plan may not place additional requirements on the local government entities and is not enforceable by the court.

   d) "Parties" are the person who file the petition, respondent and the county behavioral health agency, along with other parties that the court may add if they are providing services to the respondent.

   e) "Petitioner" is the entity who files the CARE Act petition, but if other than the county behavioral health agency, the court is required, at the initial hearing, to substitute the director of county behavioral health agency or their designee as the petitioner, limiting the initial petitioner's rights to potentially receiving ongoing notice of the proceedings, and the right to make a statement at the hearing on the merits of the petition, with broader participation rights only if the respondent consents.

   f) "Respondent" is the person who is subject to the petition for the CARE process.

   g) "Supporter" is an adult who assists the respondent, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE process, including a CARE agreement, a CARE plan, and developing a graduation plan.

3) Provides that a respondent may qualify for the CARE process only if all of the following criteria are met:

   a) The person is 18 years of age or older.

   b) The person is currently experiencing a severe mental illness, as defined, and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Specifically exempts specified others conditions or disorders.

   c) The person is not clinically stabilized in on-going voluntary treatment.

   d) At least one of the following is true:

      i) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

      ii) The person is 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 to others.

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

   f) It is likely that the person will benefit from participation in a CARE plan or agreement.

4) Provides venue provisions for where CARE Act proceedings may be brought.

5) Allows a petition to initiate a CARE proceedings to be brought by one of the following adults:

   a) A person with whom the respondent resides or a spouse, parent, sibling, child, or grandparent of the respondent, or another individual who stands in loco parentis to the respondent.

   b) The director of a hospital, or their designee, in which the respondent is hospitalized, or the director of a public or charitable organization, agency, or home, or their designee, that is currently, or within the previous 30 days, providing behavioral health services to the respondent or in whose institution the respondent resides.

   c) A licensed behavioral health professional, or their designee, who is treating, or has been treating within the last 30 days, the respondent for a mental illness.

   d) 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, as provided, multiple attempts to engage the respondent in voluntary treatment or other repeated efforts to aid the respondent in obtaining professional assistance.

e) The public guardian or public conservator, or their designee (and a respondent may be referred from conservatorship proceedings).

f) The director of a county behavioral health agency of the county in which the respondent reside or is present (and a respondent may be referred from assisted outpatient treatment proceedings).

g) The director of the county Adult Protective Services or their designee.

h) The director of a California Indian health services program, California tribal behavioral health department, or their designee.

i) The judge of a tribal court that is located in California, or their designee.

j) The respondent.

6) Allows a court, if a criminal defendant is found to be mentally incompetent and ineligible for a diversion, to refer the defendant to the CARE program, as provided,

7) Requires the CARE petition, which must be developed as a mandatory form by the Judicial Council (along with other forms necessary for the CARE process) and must be signed under penalty of perjury, to include, among other things:

a) The name of the respondent, their address, if known, and the petitioner's relationship with the respondent.

b) Facts that support petitioner's allegation that the respondent meets the criteria in 3).

c) Either of the following:

i) An affidavit of a licensed behavioral health professional stating that the health professional 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 submission of the petition, and that the licensed behavioral health professional had 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.

ii) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to under the Lanterman-Petris-Short (LPS) Act, the most recent of which must be no longer ago than 60 days from the date of the petition.

8) Provides that if a person other than the respondent files a petition for CARE Act proceedings that is unmeritorious or intended to harass or annoy the respondent, and that person had previously filed a petition for CARE Act proceedings that was unmeritorious or intended to harass or annoy the respondent, the petition is grounds to declare the person a vexatious litigant, as provided.

9) 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.

10) Provides that all CARE Act hearings are presumptively closed to the public. Allows the respondent to demand that the hearings be public or allows them to request the presence of a family member or friend without waiving their right to keep the hearing closed to the rest of the 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.

11) 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 respondent's welfare, and all other parties, with any provisions that the court may make for the disposition and care of the respondent.

12) Requires that all reports, evaluations, diagnoses, or other information related to the respondent's health are confidential. Requires that all evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings are confidential.

13) Upon receipt of a CARE Act petition the court shall promptly review the petition to see if it makes a prima facie showing that the respondent is or may be a person described in 3), above.

    a) If the court finds the petitioner has not made a prima facie showing that the respondent is or may be a person described in 3), above, the court shall dismiss without prejudice, subject to 8), above.

    b) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), and the petitioner is the county behavioral health agency, the court shall 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.

    c) If the court finds the petitioner has made a prima facie showing that the respondent is or may be a person described in 3), above, and the petitioner is not the county behavioral health agency, the court shall order the county agency to investigate whether the respondent meets the CARE proceedings criteria and is willing to engage voluntarily with the county, file a written report with the court, and provide notice, as required.

14) If the county agency is making progress to engage the respondent, allows the agency to request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

15) Within five days of the receipt of the report in 13), above, requires the court to review the report and do one of the following:

a) If the court determines that voluntary engagement with the respondent is effective, as provided, requires the court to dismiss the matter.

b) If the court determines that respondent meets, or likely meets, the CARE criteria, and engagement is not effective, requires the court to: i) set an initial hearing within 14 days; ii) appoint counsel, unless the respondent has their own counsel; and iii) provide notice of the hearing, as provided.

c) If the court determines that the individual does not meet, or is likely not to meet the criteria, requires the court to dismiss the matter.

16) At the initial hearing:

a) If the petitioner is not present, allows the court to dismiss the matter.

b) If the respondent elects not to waive their appearance and is not present, allows the court to conduct the hearing in the respondent's absence if the court makes a finding on the record that reasonable attempts to elicit the attendance of the respondent have failed, and conducting the hearing without the participation or presence of the respondent would be in the respondent's best interest.

c) Requires a county behavioral health agency representative to be present, allows a supporter to be appointed, and allows a tribal representative to attend for a respondent who is tribal member, as provided, and subject to the respondent's consent.

d) If the court finds that there is no reason to believe that the facts stated in the petition are true, 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.

e) If the court finds that there is reason to believe that the facts stated in the petition appear to be true, requires the court to order the county behavioral health agency to work with the respondent and the respondent's counsel and CARE supporter to engage in behavioral health treatment. Requires the court to set a case management hearing within 14 days.

f) If the petitioner is other than the county behavioral health director, substitutes the county behavioral health director or their designee for the petitioner, as provided in 2e).

g) Requires the court to shall set a hearing on the merits of the petition, which may be conducted concurrently with the initial appearance on the petition upon stipulation of the petitioner and respondent and agreement by the court.

17) 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.

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.

18) At the case management hearing:

a) If the parties have entered, or are likely to into, 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. Requires the court to set a clinical evaluation hearing.

19) At the clinical evaluation review hearing:

a) Requires the court to 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.

20) At the hearing to review the proposed CARE plan:

a) Either or both parties may present a CARE plan.

b) Requires the court to 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.

c) Allows a court to 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 medication, including antipsychotic 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 contempt or the accountability measures in 29), below.

d) Allows for supplemental information to be provided to the court, as provided.

21) The issuance of any orders in 20), above, begins the up to one-year CARE program timeline.

22) Requires that a status review hearing occur at least every 60 days during the CARE plan implementation.

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.

23) Requires the court, in the 11th month, to hold a one-year status hearing, which is an evidentiary hearing, to determine if the respondent graduates from the CARE plan or should be reappointed for another year.

a) Requires a report by the petitioner before the status conference, as provided. Allows respondent to call witnesses and present evidence.

b) Provides that the respondent may be graduated from the CARE program and may be allowed to enter into a voluntary graduation plan with the county. However, such plan may not place additional requirements on the county and is not enforceable, other than a psychiatric advance directive if included.

c) If the respondent elects to accept voluntary reappointment to the program, the respondent may request to be re-appointed to the CARE program for up to one additional year, subject to meeting certain criteria and court approval.

d) Allows the court to involuntarily reappoint the respondent to the CARE program for up to one year if the court finds, by clear and convincing evidence, that i) the respondent did not successfully complete the CARE process; ii) all of the required services and supports were provided to the respondent; ii) the respondent would benefit from continuation of the CARE process; and iv) the respondent currently meets the requirements in 3).

e) Provides that a respondent may only be reappointed to the CARE program for up to one additional year.

24) Provides mandatory timeframes, as well as continuances for good cause, throughout the CARE court proceedings.

25) Requires hearings to occur in person unless the court allows a party or a witness to appear remotely. Provides the respondent with the right to be in-person for all hearings.

26) Allows the respondent and the county behavioral health agency to appeal an adverse court determination.

27) Requires the Judicial Council to adopt rules to implement the CARE court provisions.

28) 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.

29) Requires that, if a respondent was provided timely with all of the services and supports required by the CARE plan, the fact that the respondent failed to successfully complete their CARE plan, including the reasons for that failure: a) is a fact considered by a court in a subsequent hearing under the LPS Act, provided that hearing occurs within six months of termination of the CARE plan; and b) creates a presumption at that hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan. Prohibits a respondent's failure to comply with any order from resulting in nay penalty outside of this paragraph, including, but not limited to contempt or failure to appear. Prohibits a respondent's failure to comply with a medication order from resulting in any penalty, including under this paragraph.

30) Creates a process for penalizing counties or other local government entities that do not comply with CARE court orders. If the presiding judge of the county finds, by clear and convincing evidence, that a local government entity has substantially failed to comply with an order, the presiding judge may impose a fine of up to $1,000 per day for noncompliance, not to exceed $25,000 for each violation. Requires that any fines be deposited in the CARE Act Accountability Fund and used, upon appropriation, by DHCS to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders and who experience, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship. Allows the presiding judge, if a county is found to be persistently noncompliant, to appoint a receiver to secure court-ordered care for the respondent at the county's cost. In determining the application of the remedies available, requires the court to consider whether there are any mitigating circumstances impairing the ability of the county agency or local government entity to fully comply with the CARE Act requirements.

31) Requires DHCS, in consultation with specified groups, to provide optional training and technical resources for volunteer supporters. Requires that a CARE supporter do the following:

    a) Offer the respondent a flexible and culturally responsive way to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating, and implementing their own informed choices;

b) Strengthen the respondent's capacity to engage in and exercise autonomous decision making and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship; and

c) Assist the respondent with understanding, making, and communicating decisions and expressing preferences throughout the CARE court process.

32) Allows a respondent to have their supporter be in any meeting, judicial proceedings, status hearing, or communication related to an evaluation; creation of the CARE plan; establishing a psychiatric advance directive; and development of a graduation plan.

33) Sets forth the duties and limitations of the supporter. Bounds a supporter by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. Prohibits a supporter from being subpoenaed or called to testify against the respondent in any CARE Act proceeding, and provides that the supporter's presence at any meeting, proceeding, or communication does not waive confidentiality or any privilege.

34) Requires the Legal Services Trust Fund Commission to provide funding to qualified legal services projects to provide appointed legal counsel in CARE proceedings. Allows the Legal Services Trust Fund Commission to enter into no bid contracts.

35) Sets forth the provisions of the CARE plan, which may only include:

a) Specified behavioral health services;

b) Medically necessary stabilization medications;

c) Housing resources, as provided;

d) Social services, as provided; and

e) General assistance, as provided.

36) Requires that CARE participants be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program. If the county behavioral health agency elects not to enroll the respondent into a full service partnership, as defined, allows the court to review why not.

37) 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.

38) Sets forth rules by which a county is responsible for the costs of providing services to CARE participants.

39) Requires the Health and Human Services Agency, as provided, to a) engage an independent, research-based entity to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act; (b) convene a working group to provide coordination and on-going engagement with, and support collaboration among, relevant state and local partners and other stakeholders

throughout the phases of county implementation to support the successful implementation of the CARE Act, including during implementation.

40) Requires DHCS to provide training and technical assistance to county behavioral health agencies to support the implementation of the CARE Act, including trainings regarding the CARE statutes, CARE plan services and supports, supported decisionmaking, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives, and data collection.

41) Requires the Judicial Council, in consultation with others, to provide training and technical assistance to judges to support the implementation of the CARE Act.

42) Requires DHCS, in consultation with others, to provide training to counsel on the CARE statutes, and CARE plan services and supports.

43) Allows the Health and Human Services Agency and DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

44) Allows the Health and Human Services Agency and DHCS to implement, interpret, or make specific the CARE Act by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

45) Requires DHCS, in consultation with specified others, to prepare an annual CARE Act report. Requires state or local governmental entities to provide data required by DHCS. Requires DHCS to provide information on the populations served and demographic data, stratified as specified. Requires that the report include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing homelessness, criminal justice involvement, conservatorships, and hospitalization of participants. Requires the annual report to examine data through the lens of health equity to identify racial, ethnic, and other demographic disparities and inform disparity reduction efforts.

46) Requires DHCS to report on court data, as specified.

47) Requires an independent, research-based entity retained by DHCS, in consultation with others, to develop an independent evaluation of the effectiveness of the CARE Act. Requires the independent evaluation to employ statistical research methodology and include a logic model, hypotheses, comparative or quasi-experimental analyses, and conclusions regarding the extent to which the CARE Act model is associated, correlated, and causally related with the performance of the outcome measures included in the annual reports, highlighting racial, ethnic, and other demographic disparities, and including causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts. Requires DHCS to provide a preliminary evaluation of the effectiveness of the CARE Act to the Legislature three years after its implementation and a final report five years after implementation.

48) Requires a health care service plan and an insurance policy, after July 1, 2023, to cover various costs under the CARE program. Sets out requirements for health care services plans and insurance policies, effective July 1, 2023, to cover CARE plans, as provided.

COMMENTS

This bills seeks to implement Governor Newsom's CARE Court program, which would allow civil courts to order those suffering from certain mental illnesses into treatment programs at the community level, similar to today's Assisted Outpatient Treatment under the LPS Act, but with, hopefully, more community-based supports and services, and more court oversight. In support of his proposal, the Governor has stated:

> Sadly, the status quo provides support only after a criminal justice intervention or conservatorship. CARE Court is a paradigm shift, providing a new pathway for seriously ill individuals before they end up cycling through prison, emergency rooms, or homeless encampments." In addition he states that, "CARE Court is about meeting people where they are and acting with compassion to support the thousands of Californians living on our streets with severe mental health and substance use disorders. We are taking action to break the pattern that leaves people without hope and cycling repeatedly through homelessness and incarceration. This is a new approach to stabilize people with the hardest-to-treat behavioral health conditions.

The growing problem of homelessness in California. Beyond simply seeing the growing number of tent encampments and unhoused people living on the streets, the most recent data on homelessness makes clear that California has a massive problem that, despite significant spending and efforts aimed at reducing it, continues to grow. The most recent single-night count from January 2020 (a count was made in 2022, but data has not yet been released) found that California had 28% of the nation's homeless population – over 160,000 – of which 70.4% were unsheltered, both of which are the highest rates in the nation. (California Senate Housing Committee, *Fact Sheet: Homelessness in California* (updated May 2021), *available at* https://shou.senate.ca.gov/sites/shou.senate.ca.gov/files/Homelessness%20in%20CA%202020%20Numbers.pdf.)

While there are many causes of homelessness, the high cost of housing in California is a significant contributor. (Legislative Analyst's Office, *California's Homelessness Challenges in Context*, Presentations to Assembly Budget Subcommittee No. 6 (Feb. 13, 2020).) Wages have not kept pace with housing costs, particularly for low-income households. (*Ibid.*)

According to the 2019 annual point-in-time count, 23% of California's homelessness population is severely mentally ill and 17% has a chronic substance abuse disorder. (Legislative Analyst's Office, *California's Homelessness Challenges in Context*, *supra*, citing the United States (U.S.) Department of Housing and Urban Development's 2019 point-in-time homelessness.)

California's mental health crisis. Mental illness is pervasive in California. About one in six Californians experience mental illness and one in 25 experience a serious mental illness. (California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (March 2020).) These rates are higher among people of color and those living below the poverty line. (*Ibid.*) Among those experiencing homelessness, one in four individuals report having a serious mental illness. (*Ibid.*)

The pandemic exacerbated mental illness rates in California, and the state continues to face a shortage of facilities, services, and workers to appropriately care for its mentally ill population. For example, since 1995, the number of inpatient psychiatric beds in California has been decreasing, despite population growth and increased rates of mental illness. (California Hospital

Association, *California Psychiatric Bed Annual Report* (Aug. 2018).) The state is projected to continue to face a shortfall of thousands of psychiatric beds for adult inpatient and residential care. (McBain, *et al., Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California* (2021) RAND Corporation.) Despite the high rates of mental illness among individuals experiencing homelessness, there is a dire shortage of supportive housing and wrap-around services to adequately treat mental illness within this population. The behavioral health workforce is insufficient to meet the growing demand for mental healthcare. One report projected that, if current trends continue, by 2028 California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, therapists, and social workers than are likely to be needed. (Coffman, *et al., California's Current and Future Behavioral Health Workforce* (Feb. 2018) Healthforce Center at the University of California – San Francisco, p. 55.) The growing mental health crisis has led to calls for reforming the mental healthcare system in California, including reforming existing law providing for involuntary detentions and treatment due to mental illness. Less attention has been paid, however, to the lack of services and support given to individuals who are involuntarily detained pursuant to standards now in place under existing law.

Constitutional and federal limitations on depriving individuals of liberty though involuntary confinement or forced treatment. Federal and state constitutional law prohibits individuals from being deprived of their liberty without due process of law. The 14th Amendment to the U.S. Constitution provides that no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The California Constitution provides: "A person may not be deprived of life, liberty, or property without due process of law or denied equal protection of the laws. (Cal. Constitution, Art. I, Sec 7.) In the 1975 United States Supreme Court case *O'Connor v. Donaldson*, the Court declared that a person had to be a danger to themselves or to others for confinement to be constitutional. (*O'Connor v. Donaldson* (1975) 422 U.S. 563.) In *O'Connor,* the plaintiff was confined to a mental hospital in Florida for 15 years, received a minimal amount of psychiatric care, and challenged his confinement numerous times before successfully suing his attending physician for violating his 14th Amendment right to liberty. The Court upheld the verdict in favor of the plaintiff:

> The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. . . . Nor is it enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if, in fact, it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed. (*O'Connor v. Donaldson* (1975) 422 U.S. at 574-75)

In the specific facts presented in *O'Connor*, the Court held that a person could not be placed on a conservatorship if others were willing to care for that person, holding that a state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." (*Id.* at 576.) While the Court recognized that the government might subject a mentally ill person to involuntary holds and treatments when necessary to prevent harm to that person or others, the government's power to do so is not unlimited and must respect the due process and liberty interests protected by the 14th Amendment. Understandably, the Court has not drawn any bright lines or offered up any neat "factor" test for identifying the precise conditions that would justify treating mentally ill persons against their will. Most states, including California, have statutes setting forth the requisite conditions in purposefully general language, and those statutes,

and the manner in which they are implemented, are subject to judicial review. In addition to baseline constitutional requirements, the Supreme Court has determined that the federal Americans with Disabilities Act (ADA) prohibits the segregation of individuals with disabilities. In *Olmstead v. L.C.*, the Court held that placing individuals with mental illness in institutions "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment" (*Olmstead v. L.C.* (1999) 527 U.S. 581, 601), and unjustified institutionalization constitutes discrimination under the ADA. (*Id.* at 597-98.) Integrated services in the community should be provided instead.

This bill. This bill does not seek to refine or better coordinate existing programs for those with mental illness. Instead, it seeks to create and implement throughout California a new program for identifying those with mental illness who need treatment – the CARE program. While the details of how the CARE program will operate are set forth in the *SUMMARY*, above, the basic premise is that a broad range of individuals – including family members, behavioral health professionals, and first responder--with knowledge of a person suffering from severe mental illness and a current diagnosis of schizophrenia spectrum or other psychotic disorder, could petition the civil court to have the person either enter into a voluntary CARE agreement, or be court-ordered into a treatment plan. The person would only qualify for the CARE program if, among other things, the person is currently experiencing a severe mental illness and has a current diagnosis of schizophrenia spectrum or other psychotic disorder.

The bill sets out the evidence that must be presented and timeframes for all court hearings. The individual (called the respondent, but the analysis will use the term participant once the person has a CARE plan) is provided with an attorney and, perhaps, a supporter for the duration of the process. They choose their own counsel and supporter, or the court will appoint an attorney for them. If the petitioner sets forth a prima facie case (sufficient initial evidence) that the respondent qualifies for the CARE program, the court must provide the participant and the county behavioral health agency with the opportunity to arrive at a voluntary CARE plan for the treatment of the participant, with the supports and services necessary, including housing, subject to many limitations, including availability and available funding.

The bill is designed to provide opportunities for the respondent to voluntarily agree to participate in a CARE agreement and to get the supports and services set forth in the agreement. However, if an agreement cannot be reached, and an evaluation proves that the respondent meets the CARE Act criteria, the bill directs the respondent and the county behavioral health agency to develop a CARE plan, which is then brought back to court for review, approval, or modification. Once the plan is approved, the bill provides for ongoing status hearings so the court can stay abreast of the progress being made and take corrective action, if necessary. To ensure that both the court is informed of the progress and to help the participant navigate the labyrinth of support and services, the bill requires that county behavioral health reports to the court at each status hearing. The plan can last up to a year, but can be extended for an additional year if certain criteria were met.

While housing with supportive or wrap-around services would clearly be required for any unhoused participant to be successful in the CARE program, the bill does not require that housing be provided, but instead prioritizes the participant for certain housing. It is hoped that that the CARE program will have sufficient resources to provide housing, with wrap-around services, to those in the program who lack stable housing.

The bill contains a number of "accountability" measures designed to keep participants and counties on track. If a participant fails to complete the program, they may be dropped from the program; and their failure 1) is a fact that must be considered by a court in a subsequent LPS hearing, provided that the hearing occurs within six months of termination of the CARE plan; and 2) creates a presumption at that hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan. Further, if the presiding judge finds that a county is not complying with a court order, the judge may fine the county up to $1,000 for each day of noncompliance, up to $25,000 per incident; and if the county is consistently noncompliant, the presiding judge may, at the county's cost, appoint a receiver to secure the county's compliance. These penalties are subject to due process protections and mitigating factors and any penalty collected must be used to support county activities serving individuals with serious mental illness.

Being a brand new program, the CARE Act program appropriately requires an evaluation of the program so that the Legislature can learn how the CARE Act is working and what, if any, changes need to be made in order to make the program more successful. The report would be required to include demographic information about participants; services ordered and services provided to participants; success rates; participant involvement with the LPS system and the criminal justice system; and a survey of participants themselves. An interim report is due to the Legislature three years after the program begins, with a final report due in five years.

According to the Author

> County behavioral health departments provide Medi-Cal specialty mental health services to those who are enrolled in Medi-Cal and have severe mental illness. However, many of the most impaired and vulnerable individuals remain under or un-served because a) the individual is so impaired they do not seek out services, b) the necessary services are not available at the right time due to administrative complexities and/or legal barriers, c) client care lacks coordination among providers and services, resulting in fragmentation among provided services, and d) little accountability at various levels of the system results in poor outcomes for the client, who is often living on the streets. This legislation seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.

Arguments in Support

In support of this bill, local governments from San Diego, including the City and County of San Diego County, write:

> The creation of CARE Courts by SB 1338 represents a thoughtful approach to addressing the behavioral health crisis we are witnessing on our streets and getting people connected with the care they need earlier. It appropriately recognizes the continuum of care that this small but highly visible segment of the population with significant mental health disorders deserve. As with local agencies throughout the State, San Diego's communities are facing a daunting homelessness crisis. However, the unsheltered population is as diverse as the general population, all who come to their housing situation with different backgrounds, upbringings, and traumas. It is imperative that we provide multi-faceted solutions to help the myriad situations our fellow Californians face. Some unsheltered individuals recently lost a job and need quick and focused assistance; some have serious mental health and substance use disorder issues that have developed over many years resulting in an inability to care for themselves. . . .

CARE Court will provide a new and focused civil justice alternative to those struggling with schizophrenia spectrum or psychotic disorders and who lack medical decision-making capacity. The CARE plan envisioned by SB 1338 provides numerous safeguards to ensure personal civil liberties are respected and protected. Distinct from the Lanterman Petris Short (LPS) conservatorship process, this bill requires the County Health and Human Services Agency to establish a cadre of "supporters" who have the obligation to advocate for each person enrolled or potentially enrolled in CARE Court. Further, CARE Court enrollment is time-limited and is intended to last only one year, although it can be extended for one additional year. During the enrolled period, CARE plans can provide the needed time and intensive care to assist those more seriously ill on our streets.

Arguments in Opposition
A coalition of over 40 advocacy organizations, including Disability Rights California, writes in opposition:

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction. The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services. . . .

Instead of allocating vast sums of money towards establishing an unproven system of court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to homelessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing is proven to reduce utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing homelessness. . . .

Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court sets up a system of coerced, involuntary outpatient civil commitment that deprives people with mental health disabilities of the right to make self-determined decisions about their own lives. Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment provided in accordance with evidence-based practices. Conversely, evidence shows that involuntary, coercive treatment is harmful.

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face homelessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court. (Footnotes omitted.)

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) Costs (General Fund (GF)) in the tens of millions of dollars to Judicial Council of California (JCC) for courts to operate the CARE Act. The 2022 Budget allocates $39.5 million from the GF in fiscal year (FY) 2022-23 and $37.7 million ongoing for the courts to conduct CARE court hearings and provide resources for self-help centers. According to the Administration, it is continuing to work with the JCC and counties to estimate costs associated with this new process. JCC estimates costs of approximately $40 million to $50 million related to conducting additional hearings, expanding self-help centers, and updating court case management systems.

2) Possibly reimbursable costs (GF and local funds) in the hundreds of millions of dollars to low billions of dollars to counties, including local behavioral health departments, to provide services to CARE court participants. According to the California State Association of Counties (CSAC), costs include as much as $40,000 per participant for at least 12,000 participants (although county offices believe the number of participants could be much higher - as high as 50,000 participants), court-ordered investigations, evaluations, and reporting requirements, and one-time start-up costs. Costs to the GF will depend on whether the duties imposed by this bill constitute a reimbursable state mandate, as determined by the Commission on State Mandates.

3) Possible cost pressure (GF) to the California Department of Health and Human Services (CHHSA), possibly in the millions of dollars to engage in an independent, research-based entity to advise on the development of data-drive processes and outcome measure for the CARE Act and provide support and coordination between stakeholders during the implementation process.

4) Costs (GF) possibly in the tens of millions of dollars to the Department of Health Care Services (DHCS) to provide training to support to people enrolled in CARE court. Costs include providing technical assistance to counties and contractors, overseeing stakeholder engagement on the CARE Court model, developing guidance for counties on CARE Court responsibilities; implementing processes to support ongoing data collection and reporting; analyzing data and developing an annual legislative report; and, publishing an independent evaluation. Costs may also result from increased Medi-Cal utilization rates by individuals referred to the CARE court program, who otherwise may not have been existing beneficiaries. Possible cost savings to state public health systems to the extent that peer support services provide support and assistance to Medi-Cal beneficiaries with mental illness and reduce the need for more expensive downstream services, such as inpatient hospitalizations or incarceration.

5) Possibly reimbursable costs (GF and local funds) in the millions of dollars to counties for public defender services. This bill requires a person to receive counsel before ruling on a CARE court petition. Section 5977, subdivision (a)(5)(A)(ii)(II) requires a court to appoint a qualified legal services project to represent any person in the CARE court program that does not already have counsel. If a legal services project declines representation, the public defender is appointed. Only 14 counties have legal services organizations and most do not have enough attorneys to handle even their existing workload. Therefore, it seems far more

likely this bill will result in increased duties on county public defenders. Existing law already requires public defenders to represent individuals in LPS and other conservatorships.

6) Cost pressure (GF), possibly in the hundreds of millions of dollars on state and local housing programs, to the extent this bill increases utilization of the specified housing programs, including the Bridge Housing program, HOME Investment Partnership Program, Housing and Urban Development (HUD) Continuum of Care program, and emergency housing vouchers, among other programs identified in this bill. In addition, as this bill reprioritizes CARE plan program participants in the Behavioral Health Bridge Housing program, it does not increase the funding for Bridge Housing in this bill. The 2021 Budget Act allocated a $12 billion multi-year investment for local governments to build housing and provide critical supports and homelessness services. The 2022 Budget Act includes an additional $3.4 billion GF over three years to continue the state's efforts by investing in immediate behavioral health housing and treatment, as well as encampment cleanup grants, and extends for an additional year support for local government efforts. It is unknown whether existing allocations for housing will be sufficient.

7) Costs (GF) to the Department of Insurance (CDI) of $17,000 in FY 2022-23 and $12,000 FY 2023-24.

8) California Department of Social Services (CDSS) reports no costs. However, this bill may result in considerable cost pressures, possibly in the millions of dollars, downstream to local county welfare departments. The Care Act will likely result in increased use of several programs such as the CalWORKS Housing Support Program, SSI/SSP, Cash Assistance Program for immigrants, CalWORKs, CalFresh, and homeless housing assistance and prevention. This bill may generate costs in the form of local assistance, as county welfare departments will have to conduct participant eligibility, redetermination, and screening for programs. While the bill would be implemented on a county-level, the workload for CDSS to provide technical assistance, program monitoring, and to issue new or updated guidance or all county letters to implement the bill may result in the need for GF money.

9) Department of Managed Health Care (DMHC) reports costs (GF) to draft regulations and provider technical assistance will be minor and absorbable.

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Archuleta, Atkins, Bates, Becker, Borgeas, Bradford, Caballero, Cortese, Dahle, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hueso, Hurtado, Jones, Kamlager, Laird, Leyva, Limón, McGuire, Melendez, Min, Newman, Nielsen, Ochoa Bogh, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener, Wilk
ABS, ABST OR NV: Hertzberg

ASM JUDICIARY: 9-1-0
YES: Stone, Cunningham, Bloom, Davies, Haney, Kiley, Maienschein, Reyes, Robert Rivas
NO: Kalra

ASM HEALTH: 14-0-1
YES: Wood, Waldron, Aguiar-Curry, Arambula, Carrillo, Flora, Maienschein, Mayes, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Akilah Weber
ABS, ABST OR NV: Bigelow

ASM APPROPRIATIONS: 13-0-3
YES: Holden, Calderon, Arambula, Davies, Mike Fong, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, McCarty
ABS, ABST OR NV: Bigelow, Bryan, Megan Dahle

UPDATED

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CONSULTANT: Leora Gershenzon / JUD. / (916) 319-2334 FN: 0003507