Supreme Court Case No.

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

DISABILITY RIGHTS CALIFORNIA

PETITIONER,

V.

GAVIN NEWSOM, in his official capacity as Governor of the State of California; and MARK GHALY, in his official capacity as Secretary of the California Health and Human Services Agency.

RESPONDENTS

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Exhibit 1

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Senate Bill No. 1338, CHAPTER 319

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

Senate Bill No. 1338

CHAPTER 319

An act to add Section 1374.723 to the Health and Safety Code, to add Section 10144.54 to the Insurance Code, to amend Section 1370.01 of the Penal Code, and to amend Sections 5801 and 5813.5 of, and to add Part 8 (commencing with Section 5970) to Division 5 of, the Welfare and Institutions Code, relating to courts.

[Approved by Governor September 14, 2022. Filed with Secretary of State September 14, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1338, Umberg. Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(1) Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, requires each county to offer specified mental health programs, unless a county or group of counties opts out by a resolution passed by the governing body, as specified. Existing law, the Lanterman-Petris-Short Act, provides for short-term and longer-term involuntary treatment and conservatorships for people who are determined to be gravely disabled.

This bill, contingent upon the State Department of Health Care Services developing an allocation to provide financial assistance to counties, would enact the Community Assistance, Recovery, and Empowerment (CARE) Act, which would authorize specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. The bill would require the Counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco to implement the program commencing October 1, 2023, and the remaining counties to commence no later than December 1, 2024. The bill would require the Judicial Council to develop a mandatory form for use in filing a CARE process petition and would specify the process by which the petition is filed and reviewed, including requiring the petition to be signed under penalty of perjury, and to contain specified information, including the facts that support the petitioner's assertion that the respondent meets the CARE criteria. The bill would also specify the schedule of review hearings required if the respondent is ordered to comply with an up to one-year CARE plan by the court. The bill would make the hearings in a

CARE Act proceeding confidential and not open to the public, thereby limiting public access to a meeting of a public body. The bill would authorize the CARE plan to be extended once, for up to one year, and would prescribe the requirements for the graduation plan. By expanding the crime of perjury and imposing additional duties on the county behavioral health agencies, this bill would impose a state-mandated local program.

This bill would require the court to appoint counsel for the respondent, unless the respondent has retained their own counsel. The bill would require the Legal Services Trust Fund Commission at the State Bar to provide funding to qualified legal services projects to provide legal counsel in CARE Act proceedings, as specified. The bill would authorize the respondent to have a supporter, as defined. The bill would require the State Department of Health Care Services, in consultation with specified stakeholders, to provide optional training and technical resources for volunteer supporters on the CARE process, community services and supports, supported decisionmaking, and other topics, as prescribed.

This bill would require the California Health and Human Services Agency, or a designated department within that agency, to engage an independent, research-based entity to advise on the development of data-driven process and outcome measures for the CARE Act and to convene a workgroup to provide coordination and support among relevant state and local partners and other stakeholders throughout the phases of county implementation of the CARE Act. The bill also would require the State Department of Health Care Services to provide training and technical assistance to county behavioral health agencies to implement the act and to provide training to counsel, as specified. The bill would require the Judicial Council, in consultation with the department and others, to provide training to judges regarding the CARE process, as specified.

This bill would authorize the court, at any time during the CARE process, if it finds the county or other local government entity not complying with court orders, to report that finding to the presiding judge of the superior court or their designee. If the presiding judge or their designee finds, by clear and convincing evidence, that the local government has substantially failed to comply with the CARE process, the presiding judge may impose a fine of up to $1,000 per day and, if the court finds persistent noncompliance, to appoint a special master to secure court-ordered care for the respondent at the county's cost. The bill would establish the CARE Act Accountability Fund in the State Treasury to receive the fines collected under the Act, which would, upon appropriation, be allocated and distributed by the department to the local government entity that paid the fines to serve individuals who have schizophrenia spectrum or other psychotic disorders who are experiencing or are at risk of homelessness, criminal justice involvement, hospitalization, or conservatorship.

This bill would require the department, in consultation with the Judicial Council, to develop an annual reporting schedule for the submission of CARE Act data from the trial courts and would require the Judicial Council to aggregate the data and submit it to the department. The bill would require

the department, in consultation with various other entities, to develop an annual CARE Act report and would require county behavioral health agencies and other local governmental entities to provide the department with specified information for that report. The bill would require an independent, research-based entity retained by the department to develop an independent evaluation of the effectiveness of the CARE Act and would require the department to produce a preliminary and final report based on that evaluation. By increasing the duties of a local agency, this bill would impose a state-mandated local program.

This bill would exempt a county or an employee or agent of a county from civil or criminal liability for any action by a respondent in the CARE process, except when an act or omission constitutes gross negligence, recklessness, or willful misconduct.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund (MHSF), a continuously appropriated fund, to fund various county mental health programs, including children's mental health care, adult and older adult mental health care, prevention and early intervention programs, and innovative programs.

This bill would clarify that MHSA funds may be used to provide services to individuals under a CARE agreement or a CARE plan.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and insurers to provide coverage for medically necessary treatment of mental health and substance use disorders. Violation of the Knox-Keene Act by a health care service plan is a crime.

This bill would require health care service plans and insurers to cover the cost of developing an evaluation for CARE process services and the provision of all health care services for an enrollee or insured when required or recommended for the person pursuant to a CARE plan, as specified, without cost sharing, except for prescription drugs, and regardless of whether the services are provided by an in-network or out-of-network provider. Because a violation of this requirement by a health care service plan would be a crime, this bill would impose a state-mandated local program.

(3) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning the defendant to competency. Existing law suspends a criminal action pending restoration to competency.

This bill, for a misdemeanor defendant who has been determined to be incompetent to stand trial, would authorize the court to refer the defendant to the CARE process.

(4) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(5) This bill would state that its provisions are severable.

(6) This bill would incorporate additional changes to Section 1370.01 of the Penal Code proposed by SB 1223 to be operative only if this bill and SB 1223 are enacted and this bill is enacted last.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

(b) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. But too often this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

(c) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses and to local governments with the responsibility to provide behavioral health services. California’s civil courts will provide a new process for earlier action, support, and accountability, through a new Community Assistance, Recovery, and Empowerment (CARE) process.

(d) California has made unprecedented investments in behavioral health, housing, and combating homelessness, and the CARE process helps those with the greatest needs access these resources and services. The CARE process provides a framework to ensure counties and other local governments focus their efforts to provide comprehensive treatment, housing, and supportive services to Californians with complex behavioral health care needs so they can stabilize and find a path to wellness and recovery.

(e) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated severe mental illnesses with the provision of legal counsel for CARE proceedings, agreements, and plans, as well as the promotion of supported decisionmaking.

(f) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution to ensure access to comprehensive services and supports for some of the most ill and most vulnerable Californians.

SEC. 2. Section 1374.723 is added to the Health and Safety Code, to read:

1374.723. (a) A health care service plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code, regardless of whether the service is provided by an in-network or out-of-network provider.

(b) (1) A health care service plan shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) A health care service plan may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health care service plan may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The health plan's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) A health care service plan shall provide for reimbursement of prescription drugs provided to an enrollee pursuant to this section at the health care service plan's contracted rate.

(3) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

(e) No later than July 1, 2023, the department may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse a health care service plan from complying with Section 1374.72.

(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(h) This section shall become operative on July 1, 2023.

SEC. 3. Section 10144.54 is added to the Insurance Code, to read:

10144.54. (a) An insurance policy issued, amended, renewed, or delivered on or after July 1, 2023, shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services for an insured when required or recommended for the insured pursuant to a CARE agreement or CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code, regardless of whether the service is delivered by an in-network or out-of-network provider.

(b) (1) An insurer shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) An insurer may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the insurer reasonably determines the insured was not insured at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), an insurer may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) An insurer shall provide for reimbursement of services provided to an insured pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The insurer's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) An insurer shall provide for reimbursement of prescription drugs provided to an insured pursuant to this section at the insurer's contracted rate.

(3) An insurer shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an insured pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the insured, nor seek reimbursement from the insured, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

(e) No later than July 1, 2023, the department may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse an insurer from complying with Section 10144.5.

SEC. 4. Section 1370.01 of the Penal Code is amended to read:

1370.01. (a) If the defendant is found mentally competent, the criminal process shall resume, and the trial on the offense charged or hearing on the alleged violation shall proceed.

(b) If the defendant is found mentally incompetent, the trial, judgment, or hearing on the alleged violation shall be suspended and the court may do either of the following:

(1) (A) Conduct a hearing, pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, and, if the court deems the defendant eligible, grant diversion pursuant to Section 1001.36 for a period not to exceed one year from the date the individual is accepted into diversion or the maximum term of imprisonment provided by law for the most serious offense charged in the misdemeanor complaint, whichever is shorter.

(B) If the court opts to conduct a hearing pursuant to this paragraph, the hearing shall be held no later than 30 days after the finding of incompetence.

If the hearing is delayed beyond 30 days, the court shall order the defendant to be released on their own recognizance pending the hearing.

(C) If the defendant performs satisfactorily on diversion pursuant to this section, at the end of the period of diversion, the court shall dismiss the criminal charges that were the subject of the criminal proceedings at the time of the initial diversion.

(D) If the court finds the defendant ineligible for diversion based on the circumstances set forth in subdivision (b) or (d) of Section 1001.36, the court may, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether to do any of the following:

(i) Order modification of the treatment plan in accordance with a recommendation from the treatment provider.

(ii) Refer the defendant to assisted outpatient treatment pursuant to Section 5346 of the Welfare and Institutions Code. A referral to assisted outpatient treatment may only occur in a county where services are available pursuant to Section 5348 of the Welfare and Institutions Code, and the agency agrees to accept responsibility for treatment of the defendant. A hearing to determine eligibility for assisted outpatient treatment shall be held within 45 days after the date of the referral. If the hearing is delayed beyond 45 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into assisted outpatient treatment, the charges shall be dismissed pursuant to Section 1385.

(iii) Refer the defendant to the county conservatorship investigator in the county of commitment for possible conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. A defendant shall only be referred to the conservatorship investigator if, based on the opinion of a qualified mental health expert, the defendant appears to be gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institution Code. Any hearings required in the conservatorship proceedings shall be held in the superior court in the county of commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the county mental health director or the director's designee and shall notify the county mental health director or their designee of the outcome of the proceedings. Before establishing a conservatorship, the public guardian shall investigate all available alternatives to conservatorship pursuant to Section 5354 of the Welfare and Institutions Code. If a petition is not filed within 60 days of the referral, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending conservatorship proceedings. If the outcome of the conservatorship proceedings results in the establishment of conservatorship, the charges shall be dismissed pursuant to Section 1385.

(iv) Refer the defendant to the CARE program pursuant to Section 5978 of the Welfare and Institutions Code. A hearing to determine eligibility for CARE shall be held within 14 days after the date of the referral. If the hearing is delayed beyond 14 days, the court shall order the defendant, if

confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into CARE, the charges shall be dismissed pursuant to Section 1385.

(2) Dismiss the charges pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the county behavioral health director or the director's designee.

(c) If the defendant is found mentally incompetent and is on a grant of probation for a misdemeanor offense, the court shall dismiss the pending revocation matter and may return the defendant to supervision. If the revocation matter is dismissed pursuant to this subdivision, the court may modify the terms and conditions of supervision to include appropriate mental health treatment.

(d) It is the intent of the Legislature that a defendant subject to the terms of this section receive mental health treatment in a treatment facility and not a jail. A term of four days will be deemed to have been served for every two days spent in actual custody against the maximum term of diversion. A defendant not in actual custody shall otherwise receive day for day credit against the term of diversion from the date the defendant is accepted into diversion. "Actual custody" has the same meaning as in Section 4019.

(e) This section shall apply only as provided in subdivision (b) of Section 1367.

SEC. 4.5. Section 1370.01 of the Penal Code is amended to read:

1370.01. (a) If the defendant is found mentally competent, the criminal process shall resume, and the trial on the offense charged or hearing on the alleged violation shall proceed.

(b) If the defendant is found mentally incompetent, the trial, judgment, or hearing on the alleged violation shall be suspended and the court may do either of the following:

(1) (A) Conduct a hearing, pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, and, if the court deems the defendant eligible, grant diversion pursuant to Section 1001.36 for a period not to exceed one year from the date the individual is accepted into diversion or the maximum term of imprisonment provided by law for the most serious offense charged in the misdemeanor complaint, whichever is shorter.

(B) If the court opts to conduct a hearing pursuant to this paragraph, the hearing shall be held no later than 30 days after the finding of incompetence. If the hearing is delayed beyond 30 days, the court shall order the defendant to be released on their own recognizance pending the hearing.

(C) If the defendant performs satisfactorily on diversion pursuant to this section, at the end of the period of diversion, the court shall dismiss the criminal charges that were the subject of the criminal proceedings at the time of the initial diversion.

(D) If the court finds the defendant ineligible for diversion based on the circumstances set forth in subdivision (b), (c), (d), or (g) of Section 1001.36, the court may, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether to do any of the following:

(i) Order modification of the treatment plan in accordance with a recommendation from the treatment provider.

(ii) Refer the defendant to assisted outpatient treatment pursuant to Section 5346 of the Welfare and Institutions Code. A referral to assisted outpatient treatment may only occur in a county where services are available pursuant to Section 5348 of the Welfare and Institutions Code, and the agency agrees to accept responsibility for treatment of the defendant. A hearing to determine eligibility for assisted outpatient treatment shall be held within 45 days after the date of the referral. If the hearing is delayed beyond 45 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into assisted outpatient treatment, the charges shall be dismissed pursuant to Section 1385.

(iii) Refer the defendant to the county conservatorship investigator in the county of commitment for possible conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. A defendant shall only be referred to the conservatorship investigator if, based on the opinion of a qualified mental health expert, the defendant appears to be gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institution Code. Any hearings required in the conservatorship proceedings shall be held in the superior court in the county of commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the county mental health director or the director's designee and shall notify the county mental health director or their designee of the outcome of the proceedings. Before establishing a conservatorship, the public guardian shall investigate all available alternatives to conservatorship pursuant to Section 5354 of the Welfare and Institutions Code. If a petition is not filed within 60 days of the referral, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending conservatorship proceedings. If the outcome of the conservatorship proceedings results in the establishment of conservatorship, the charges shall be dismissed pursuant to Section 1385.

(iv) Refer the defendant to the CARE program pursuant to Section 5978 of the Welfare and Institutions Code. A hearing to determine eligibility for CARE shall be held within 14 days after the date of the referral. If the hearing is delayed beyond 14 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into CARE, the charges shall be dismissed pursuant to Section 1385.

(2) Dismiss the charges pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the county behavioral health director or the director's designee.

(c) If the defendant is found mentally incompetent and is on a grant of probation for a misdemeanor offense, the court shall dismiss the pending revocation matter and may return the defendant to supervision. If the revocation matter is dismissed pursuant to this subdivision, the court may

modify the terms and conditions of supervision to include appropriate mental health treatment.

(d) It is the intent of the Legislature that a defendant subject to the terms of this section receive mental health treatment in a treatment facility and not a jail. A term of four days will be deemed to have been served for every two days spent in actual custody against the maximum term of diversion. A defendant not in actual custody shall otherwise receive day for day credit against the term of diversion from the date the defendant is accepted into diversion. "Actual custody" has the same meaning as in Section 4019.

(e) This section shall apply only as provided in subdivision (b) of Section 1367.

SEC. 5. Section 5801 of the Welfare and Institutions Code is amended to read:

5801. (a) A system of care for adults and older adults with severe mental illness results in the highest benefit to the client, family, and community while ensuring that the public sector meets its legal responsibility and fiscal liability at the lowest possible cost.

(b) The underlying philosophy for these systems of care includes the following:

(1) Mental health care is a basic human service.

(2) Seriously mentally disordered adults and older adults are citizens of a community with all the rights, privileges, opportunities, and responsibilities accorded other citizens.

(3) Seriously mentally disordered adults and older adults usually have multiple disorders and disabling conditions and should have the highest priority among adults for mental health services.

(4) Seriously mentally disordered adults and older adults should have an interagency network of services with multiple points of access and be assigned a single person or team to be responsible for all treatment, case management, and community support services.

(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment, or the client is under a court order for assisted outpatient treatment pursuant to Section 5346 and, prior to the filing of the petition for assisted outpatient treatment pursuant to Section 5346, the client has been offered an opportunity to participate in treatment on a voluntary basis and has failed to engage in that treatment, or the client is under a court order for CARE pursuant to Part 8 (commencing with Section 5970) and, prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so.

(6) Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.

(7) People in local communities are the most knowledgeable regarding their particular environments, issues, service gaps and strengths, and opportunities.

(8) Mental health services should be responsive to the unique characteristics of people with mental disorders including age, gender, minority and ethnic status, and the effect of multiple disorders.

(9) For the majority of seriously mentally disordered adults and older adults, treatment is best provided in the client's natural setting in the community. Treatment, case management, and community support services should be designed to prevent inappropriate removal from the natural environment to more restrictive and costly placements.

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(11) State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered adults and seniors.

SEC. 6. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental

illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison. Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1), and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

SEC. 7. Part 8 (commencing with Section 5970) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 8. THE COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT ACT

Chapter 1. General Provisions

5970. This part shall be known, and may be cited, as Community Assistance, Recovery, and Empowerment (CARE) Act.

5970.5. This part shall be implemented as follows, with technical assistance and continuous quality improvement, pursuant to Section 5983:

(a) A first cohort of counties, which shall include the Counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco, shall begin no later than October 1, 2023, unless the county is provided additional time pursuant to paragraph (2) of subdivision (c).

(b) A second cohort of counties, representing the remaining population of the state, shall begin no later than December 1, 2024, unless the county is provided additional time pursuant to paragraph (2) of subdivision (c).

(c) (1) The department shall issue guidelines under which counties can apply for, and be provided, additional time to implement this part. The guidelines shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The department shall approve implementation delay for the first or second cohort if the county experiences a state or local emergency and the

delay of the provision of the CARE process is necessary as a result of the emergency.

(3) The department shall only grant extensions once and no later than December 1, 2025.

(d) This part shall become operative only upon the department, in consultation with county stakeholders, developing a CARE Act allocation to provide state financial assistance to counties to implement the care process in this act.

5971. Unless the context otherwise requires, the following definitions shall govern the construction of this part.

(a) "CARE agreement" means a voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports.

(b) "CARE plan" means an individualized, appropriate range of community-based services and supports, as set forth in this part, which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services, as appropriate, pursuant to Section 5982.

(c) "CARE process" means the court and related proceedings to implement the CARE Act.

(d) "Counsel" means the attorney representing the respondent, provided pursuant to Section 5980, or chosen by the respondent, in CARE Act proceedings and matters related to CARE agreements and CARE plans.

(e) "County behavioral health agency" means the local director of mental health services described in Section 5607, the local behavioral health director, or both as applicable, or their designee.

(f) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Section 5977.

(g) "Department" means the State Department of Health Care Services.

(h) "Graduation plan" means 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 that may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports. The graduation plan shall not place additional requirements on the local government entities and is not enforceable by the court.

(i) "Homeless outreach worker" means a person who engages people experiencing homelessness to assess for unmet needs, offer information, services, or other assistance, or provide care coordination.

(j) "Indian health care provider" means a health care program operated by the Indian Health Service, an Indian tribe, a tribal organization, or urban Indian organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. Sec. 1603).

(k) "Licensed behavioral health professional" means either of the following:

(1) A licensed mental health professional, as defined in subdivision (j) of Section 4096.

(2) A person who has been granted a waiver of licensure requirements by the department pursuant to Section 5751.2.

(*l*) "Parties" means the petitioner, respondent, the county behavioral health agency in the county where proceedings under this part are pending, and other parties added by the court pursuant to paragraph (4) of subdivision (d) of Section 5977.1.

(m) "Petitioner" means the entity who files the CARE Act petition with the court. Additionally, if the petitioner is a person listed in Section 5974 other than the director of a county behavioral health agency, or their designee, the petitioner shall have the right to file a petition with the court, but at the initial hearing the court shall substitute the director of a county behavioral health agency, or their designee, of the county in which the proceedings are filed as petitioner. The petitioner who filed the petition may, at the court's discretion and in furtherance of the interests of the respondent, retain rights as described in subparagraph (A) of paragraph (7) of subdivision (b) of Section 5977.

(n) "Psychiatric advance directive" means a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions, that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis.

(o) "Respondent" means the person who is subject to the petition for the CARE process.

(p) "Stabilization medications" means medications included in the CARE plan that primarily consist of antipsychotic medications, to reduce symptoms of hallucinations, delusions, and disorganized thinking. Stabilization medications may be administered as long-acting injections if clinically indicated. Stabilization medications shall not be forcibly administered.

(q) "Supporter" means an adult, designated pursuant to Chapter 4 (commencing with Section 5980), who assists the person who is the subject of the petition, 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. A supporter shall not act independently.

Chapter 2. Process

5972. An individual shall 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 in paragraph (2) of subdivision (b) of Section 5600.3 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. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for the CARE process.

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

(d) At least one of the following is true:

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

(2) 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 others, as defined in Section 5150.

(e) Participation in a CARE plan or CARE 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 CARE agreement.

5973. (a) Proceedings under this part may be commenced in any of the following:

(1) The county in which the respondent resides.

(2) The county where the respondent is found.

(3) The county where the respondent is facing criminal or civil proceedings.

(b) If the respondent does not reside in the county in which proceedings are initiated under this subdivision, as determined in accordance with Section 244 of the Government Code, except as provided in subdivision (e) of Section 5982, and this part is operative in the respondent's county of residence, the proceeding shall, with the respondent's consent, be transferred to the county of residence as soon as reasonably feasible. Should the respondent not consent to the transfer, the proceedings shall continue in the county where the respondent was found.

5974. The following adult persons may file a petition to initiate the CARE process:

(a) A person with whom the respondent resides.

(b) A spouse, parent, sibling, child, or grandparent or other individual who stands in loco parentis to the respondent.

(c) The director of a hospital, or their designee, in which the respondent is hospitalized, including hospitalization pursuant to Section 5150 or 5250.

(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 Section 5150, 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 is present or reasonably believed to be present.

(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, or their designee.

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

(*l*) The respondent.

5975. The Judicial Council shall develop a mandatory form for use to file a CARE process petition with the court and any other forms necessary for the CARE process. The petition shall be signed under the penalty of perjury and contain all of the following:

(a) The name of the respondent and, if known, the respondent's address.

(b) The petitioner's relationship to the respondent.

(c) Facts that support the petitioner's assertion that the respondent meets the CARE criteria in Section 5972.

(d) Either of the following:

(1) An affidavit of a licensed behavioral health professional, stating that the licensed behavioral 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 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.

(2) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to Article 4 (commencing with Section 5250) of Chapter 2 of Part 1, the most recent one within the previous 60 days.

5975.1. Notwithstanding Section 391 of the Code of Civil Procedure, if a person other than the respondent files a petition for CARE Act proceedings that is without merit or is intended to harass or annoy the respondent, and the person has previously filed a pleading in CARE Act proceedings that was without merit or was intended to harass or annoy the respondent, the petition shall be grounds for the court to determine that the

person is a vexatious litigant for the purposes of Title 3A (commencing with Section 391) of Part 2 of the Code of Civil Procedure.

5976. The respondent shall:

(a) Receive notice of the hearings.

(b) Receive a copy of the court-ordered evaluation.

(c) Be entitled to be represented by counsel at all stages of a proceeding commenced under this chapter, regardless of the ability to pay.

(d) Be allowed to have a supporter, as described in Section 5982.

(e) Be present at the hearing unless the respondent waives the right to be present.

(f) Have the right to present evidence.

(g) Have the right to call witnesses.

(h) Have the right to cross-examine witnesses.

(i) Have the right to appeal decisions, and to be informed of the right to appeal.

5976.5. (a) Notwithstanding any other law, and except as otherwise provided in this section, a hearing held under this part is presumptively closed to the public.

(b) The respondent may demand that the hearing be public and be held in a place suitable for attendance by the public.

(c) The respondent may request the presence of any family member or friend without waiving the right to keep the hearing closed to the rest of the public.

(d) A request by any other party to the proceeding to make the hearing public may be granted if the judge conducting the hearing finds that the public interest in an open hearing clearly outweighs the respondent's interest in privacy.

(e) All reports, evaluations, diagnoses, or other information related to the respondent's health shall be confidential.

(f) Before commencing a hearing, the judge shall inform the respondent of their rights under this section.

5977. (a) (1) The court shall promptly review the petition to determine if the petitioner has made a prima facie showing that the respondent is, or may be, a person described in Section 5972.

(2) If the court finds that the petitioner has not made a prima facie showing that the respondent is, or may be, a person described in Section 5972, the court may dismiss the case without prejudice subject to consideration of Section 5975.1.

(3) If the court finds that the petitioner has made a prima facie showing that the respondent is, or may be, a person described in Section 5972, the court shall do one of the following:

(A) If the petitioner is the director of a county behavioral health agency, or their designee, the court shall do the following:

(i) Set the matter for an initial appearance on the petition within 14 court days.

(ii) Appoint a qualified legal services project, as defined in Sections 6213 to 6214.5, inclusive, of the Business and Professions Code, to represent the

respondent. If no legal services project has agreed to accept these appointments, a public defender shall be appointed to represent the respondent. Unless replaced by respondent's own counsel, appointed counsel shall represent the respondent in any proceeding under this part, and shall represent the individual, as needed, in matters related to CARE agreements and CARE plans, including appeals.

(iii) Determine if the petition includes all of the following information, or order the county to submit a report within 14 court days that addresses all the following:

(I) A determination as to whether the respondent meets, or is likely to meet, the criteria for the CARE process.

(II) The outcome of efforts made to voluntarily engage the respondent prior to the filing of the petition.

(III) Conclusions and recommendations about the respondent's ability to voluntarily engage in services.

(iv) Order the county behavioral health director or their designee to provide notice to the respondent, the appointed counsel, and the county behavioral health agency in the county where the respondent resides, if different from the county where the CARE process has commenced.

(B) If the petitioner is a person other than the director of a county behavioral health agency, or their designee, the court shall order a county agency, or their designee, as determined by the court, to investigate, as necessary, and file a written report with the court within 14 court days and provide notice to the respondent and petitioner that a report has been ordered. The written report shall include all of the following:

(i) A determination as to whether the respondent meets, or is likely to meet, the criteria for the CARE process.

(ii) The outcome of efforts made to voluntarily engage the respondent during the 14-day report period.

(iii) Conclusions and recommendations about the respondent's ability to voluntarily engage in services.

(4) If, upon a request by the county, the court finds that the county agency is making progress to engage the respondent, the court may, in its discretion, grant the county no more than 30 additional days to continue to work with, engage, and enroll the individual in voluntary treatment and services. The county shall provide notice to the respondent and petitioner that an extension for filing a report has been granted.

(5) Upon receipt of the report described in subparagraph (B) of paragraph (3), the court shall, within five days, take one of the following actions:

(A) If the court determines that voluntary engagement with the respondent is effective, and that the individual has enrolled or is likely to enroll in voluntary behavioral health treatment, the court shall dismiss the matter.

(B) If the court determines that county's report does not support the petition's prima facie showing that the respondent is a person described in Section 5972, the court shall dismiss the matter. This section shall not prevent a county behavioral health agency from continuing to voluntarily

engage with individuals who do not meet CARE criteria, but who are in need of services and supports.

(C) If the court determines that county's report does support the petition's prima facie showing that the respondent is, or may be, a person described in Section 5972, and engagement with the county was not effective, the court shall do all of the following:

(i) Set an initial appearance on the petition within 14 court days.

(ii) Appoint a qualified legal services project, as defined in Sections 6213 to 6214.5, inclusive, of the Business and Professions Code or, if no legal services project has agreed to accept these appointments, a public defender to represent the respondent for all purposes related to this part, including appeals, unless the respondent has retained their own counsel. Unless replaced by respondent's own counsel, appointed counsel shall represent the respondent in any proceeding under this part, and shall represent the individual, as needed, in matters related to CARE agreements and CARE plans.

(iii) Order the county to provide notice of the hearing to the petitioner, the respondent, the appointed counsel, the county behavioral health agency in the county where the respondent resides, and, if different, the county where the CARE court proceedings have commenced.

(b) At the initial appearance on the petition, all of the following shall apply:

(1) The court shall permit the respondent to substitute their own counsel.

(2) Petitioner shall be present. If the petitioner is not present, the matter may be dismissed.

(3) Respondent may waive personal appearance and appear through counsel. If the respondent does not waive personal appearance and does not appear at the hearing, and the court makes a finding on the record that reasonable attempts to elicit the attendance of the respondent have failed, the court may conduct the hearing in the respondent's absence if the court makes a finding on the record that conducting the hearing without the participation or presence of the respondent would be in the respondent's best interest.

(4) A representative from the county behavioral health agency shall be present.

(5) A supporter may be appointed.

(6) If the respondent self-identifies that they are enrolled in a federally recognized Indian tribe or otherwise receiving services from an Indian health care provider, a tribal court, or a tribal organization, a representative from the program, the tribe, or the tribal court shall be allowed to be present, subject to the consent of the respondent. The tribal representative shall be entitled to notice by the county of the initial appearance.

(7) (A) If the petitioner is a person described in Section 5974 other than the director of a county behavioral health agency, or their designee, the court shall issue an order relieving the petitioner and appointing the director of the county behavioral health agency or their designee as the substitute petitioner.

(B) If the petitioner who is relieved pursuant to this paragraph is described in subdivision (a) or (b) of Section 5974, all of the following apply:

(i) The petitioner shall have the right to participate in the initial hearing to determine the merits of the petition, pursuant to subparagraphs (A) and (B) of paragraph (8).

(ii) The court may, in its discretion, assign ongoing rights of notice.

(iii) The court may, additionally, allow for participation and engagement in the respondent's CARE proceedings if the respondent consents.

(iv) The petitioner may file a new petition with the court, pursuant to Section 5974, if the matter is dismissed and there is a change in circumstances.

(C) If the petitioner who is relieved pursuant this paragraph is described in Section 5974, other than persons described in subparagraph (a) or (b) of that section, the court shall not assign ongoing rights to the entity that originally filed the CARE petition, other than the right to make a statement at the hearing on the merits of the petition as provided in subparagraphs (A) and (B) of paragraph (8).

(8) (A) The court shall set a hearing on the merits of the petition within 10 days, at which time the court shall determine by clear and convincing evidence if the respondent meets the CARE criteria in Section 5972. In making this determination, the court shall consider all evidence properly before it, including the report from the county required pursuant to paragraph (3) of subdivision (a) and any additional evidence presented by the parties, including the petition submitted by the petitioner who is relieved.

(B) The hearing on the merits of the petition may be conducted concurrently with the initial appearance on the petition upon stipulation of the petitioner and respondent and agreement by the court.

(c) (1) If, at the hearing on the merits of the petition, the court finds, by clear and convincing evidence, that the respondent does not meet the CARE criteria in Section 5972, the court shall dismiss the case without prejudice, unless the court makes a finding, on the record, that the initial petitioner's filing was not in good faith.

(2) If, at the hearing on the merits of the petition, the court finds that the petitioner has shown by clear and convincing evidence that the respondent meets the CARE criteria in Section 5972, the court shall 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. The court shall set a case management hearing within 14 days.

(3) If the respondent is enrolled in a federally recognized Indian tribe, the respondent shall provide notice of the case management hearing to the tribe, subject to the consent of the respondent.

5977.1. (a) (1) At the case management hearing, the court shall hear evidence as to whether the parties have entered, or are likely to enter, into a CARE agreement.

(2) If the court finds that the parties have entered, or are likely to enter, into a CARE agreement, the court shall do both of the following:

(A) Approve the terms of the CARE agreement or modify the terms of the CARE agreement and approve the agreement as modified by the court.

(B) Continue the matter and set a progress hearing for 60 days.

(b) If the court finds that the parties have not entered into a CARE agreement, and are not likely to enter into a CARE agreement, the court shall order the county behavioral health agency, through a licensed behavioral health professional, to conduct a clinical evaluation of the respondent, unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation. The evaluation shall address, at a minimum, the following:

(1) A clinical diagnosis of the respondent.

(2) Whether the respondent has the legal capacity to give informed consent regarding psychotropic medication.

(3) Any other information as ordered by the court or that the licensed behavioral health professional conducting the evaluation determines would help the court make future informed decisions about the appropriate care and services the respondent should receive.

(4) An analysis of recommended services, programs, housing, medications, and interventions that support the recovery and stability of the respondent.

(c) (1) The court shall set a clinical evaluation hearing to review the evaluation within 21 days. The court shall order the county to file the evaluation with the court and provide the evaluation to the respondent's counsel no later than five days prior to the scheduled clinical evaluation hearing. The clinical evaluation hearing may be continued for a maximum of 14 days upon stipulation of the respondent and the county behavioral health agency, unless there is good cause for a longer extension.

(2) At the clinical evaluation review hearing, the court shall review the evaluation and any other evidence from the county behavioral health agency and the respondent. The county behavioral health agency and the respondent may present evidence and call witnesses, including the person who conducted the evaluation. Only relevant and admissible evidence that fully complies with the rules of evidence may be considered by the court.

(3) At the conclusion of the hearing, the court shall make orders as follows:

(A) If the court finds by clear and convincing evidence, after review of the evaluation and other evidence, that the respondent meets the CARE criteria, the court shall order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan within 14 days.

(B) If the court finds, in reviewing the evaluation, that clear and convincing evidence does not support that the respondent meets the CARE criteria, the court shall dismiss the petition.

(4) If the respondent is a self-identified American Indian or Alaska Native individual, as defined in Sections 1603(13), 1603(28), and 1679(a) of Title 25 of the United States Code, has been determined eligible as an Indian under Section 136.12 of Title 42 of the Code of Federal Regulations, or is

otherwise receiving services from an Indian health care provider or tribal court, the county behavioral health agency shall use best efforts to meaningfully consult with and incorporate the Indian health care provider or tribal court available to the respondent to develop the CARE plan.

(5) The evaluation and all reports, documents, and filings submitted to the court shall be confidential.

(6) The date for the hearing to review and consider approval of the proposed CARE plan shall be set not more than 14 days from the date of the order to develop a CARE plan, unless the court finds good cause for an extension. The party requesting an extension of time for the CARE plan review hearing shall provide notice to the opposing party and their counsel of the request for extension of time, and the court's order if the request is granted.

(d) (1) At the CARE plan review hearing, the parties shall present their plans to the court. The county behavioral health agency or the respondent, or both, may present a proposed CARE plan.

(2) After consideration of the plans proposed by the parties, the court shall adopt the elements of a CARE plan that support the recovery and stability of the respondent. The court may 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 pursuant to Section 5982. These orders shall constitute the CARE plan.

(3) 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 the court orders medically necessary stabilization medication, the medication shall not be forcibly administered and the respondent's failure to comply with a medication order shall not result in a penalty, including, but not limited to, contempt or termination of the CARE plan pursuant to Section 5979.

(4) If the proposed CARE plan includes services and supports, such as housing, provided directly or indirectly through another local governmental entity, that local entity may agree to provide the service or support, or the court may consider a motion by either of the parties to add the local entity as a party to the CARE proceeding. If the local entity agrees to provide the service or support, it may request to be added as a party by the court.

(5) If, after presentation of the CARE plan or plans, the court determines that additional information is needed, including from a licensed behavioral health professional, the court shall order a supplemental report to be filed by the county behavioral health agency for which the court may grant a continuance of no more than 14 days, unless there is good cause for a longer extension.

(6) If there is no CARE plan because the parties have not had sufficient time to complete it, the court may grant a continuance of no more than 14 days, unless there is good cause for a longer extension.

(e) The issuance of an order approving a CARE plan pursuant to paragraph (2) of subdivision (d) begins the CARE process timeline, which shall not exceed one year.

5977.2. (a) (1) At intervals set by the court, but not less frequently than 60 days after the court orders the CARE plan, the court shall hold a status review hearing. The county behavioral health agency shall file with the court and serve on the respondent, and the respondent's counsel and supporter, a report not fewer than five court days prior to the review hearing with the following information:

(A) Progress the respondent has made on the CARE plan.

(B) What services and supports in the CARE plan were provided, and what services and supports were not provided.

(C) Any issues the respondent expressed or exhibited in adhering to the CARE plan.

(D) Recommendations for changes to the services and supports to make the CARE plan more successful.

(2) The respondent shall be permitted to respond to the report submitted by the county behavioral health agency and to the county behavioral health agency's testimony. The respondent shall be permitted to introduce their own information and recommendations.

(3) Subject to applicable law, intermittent lapses or setbacks described in this section of the report shall not impact access to services, treatment, or housing.

(b) The county behavioral health agency or the respondent may request, or the court upon its own motion may set, a hearing to occur at any time during the CARE process to address a change of circumstances.

5977.3. (a) (1) In the 11th month of the program timeline, the court shall hold a one-year status hearing. Not fewer than five court days prior to the one-year status hearing, the county behavioral health agency shall file a report with the court and shall serve the report on the respondent and the respondent's counsel and supporter. The report shall include the following information:

(A) Progress the respondent has made on the CARE plan including a final assessment of the respondent's stability.

(B) What services and supports in the CARE plan were provided, and what services and supports were not provided, over the life of the program.

(C) Any issues the respondent expressed or exhibited in adhering to the CARE plan.

(D) Recommendations for next steps, including what ongoing and additional services would benefit the respondent that the county behavioral health agency can facilitate or provide.

(2) At an evidentiary hearing, the respondent shall be permitted to respond to the report submitted by the county behavioral health agency and to the county behavioral health agency's testimony. Respondent shall be permitted to introduce their own information and recommendations. The respondent shall have the right at the hearing to call witnesses and to present evidence

as to whether the respondent agrees with the report. The respondent may request either to be graduated from the program or to remain in the program.

(3) The court shall issue an order as follows:

(A) If the respondent elects to be graduated from the program, the court shall order the county behavioral health agency and the respondent to work jointly on a graduation plan. The court shall schedule a hearing in the 12th month after adoption of the CARE plan for presentation of the graduation plan. The court shall review the voluntary graduation plan and recite the terms on the record. The graduation plan shall not place additional requirements on local government entities and is not enforceable by the court, except that the graduation plan may, at respondent's election, include a psychiatric advance directive, which shall have the force of law. Upon completion of the hearing, the respondent shall be officially graduated from the program.

(B) If the respondent elects to remain in the CARE process, respondent may request any amount of time, up to and including one additional year. The court may permit the ongoing voluntary participation of the respondent if the court finds both of the following:

(i) The respondent did not successfully complete the CARE plan.

(ii) The respondent would benefit from continuation of the CARE plan.

(C) The court shall issue an order permitting the respondent to continue in the CARE plan or denying respondent's request to remain in the CARE plan, and state its reasons on the record.

(b) The respondent may be involuntarily reappointed to the program only if the court finds, by clear and convincing evidence, that all of the following conditions apply:

(1) The respondent did not successfully complete the CARE process.

(2) All services and supports required through the CARE process were provided to the respondent.

(3) The respondent would benefit from continuation in the CARE process.

(4) The respondent currently meets the requirements in Section 5972.

(c) A respondent may only be reappointed to the CARE process once, for up to one additional year.

5977.4. (a) In all CARE Act proceedings, the judge shall control the proceedings during the 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 when there is a contested issue of fact or law, the proceedings shall be conducted in an informal nonadversarial 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. All evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings shall be confidential.

(b) The hearings described in this chapter shall occur in person unless the court, in its discretion, allows a party or witness to appear remotely

through the use of remote technology. The respondent shall have the right to be in person for all hearings.

(c) Consistent with its constitutional rulemaking authority, the Judicial Council shall adopt rules to implement the policies and provisions in this section and in Sections 5977, 5977.1, 5977.2, and 5977.3 to promote statewide consistency, including, but not limited to, what is included in the petition form packet, the clerk's review of the petition, and the process by which counsel will be appointed.

5978. (a) A court may refer an individual from assisted outpatient treatment, as well as from conservatorship proceedings pursuant Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 (LPS conservatorship) to CARE Act proceedings. If the individual is being referred from assisted outpatient treatment, the county behavioral health director or their designee shall be the petitioner. If the individual is being referred from LPS conservatorship proceedings, the conservator shall be the petitioner pursuant to Section 5974.

(b) A court may refer an individual from misdemeanor proceedings pursuant to Section 1370.01 of the Penal Code.

Chapter 3. Accountability

5979. (a) (1) If, at any time during the proceedings, the court determines by clear and convincing evidence that the respondent is not participating in the CARE process, after the respondent receives notice, or is not adhering to their CARE plan, after the respondent receives notice, the court may terminate the respondent's participation in the CARE process.

(2) To ensure the respondent's safety, the court may utilize existing legal authority pursuant to Article 2 (commencing with Section 5200) of Chapter 2 of Part 1. The court shall provide notice to the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority.

(3) If the respondent was timely provided 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 reasons for that failure, shall be a fact considered by the court in a subsequent hearing under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)), provided that the hearing occurs within six months of the termination of the CARE plan and shall create a presumption at that hearing that the respondent needs additional intervention beyond the supports and services provided by the CARE plan.

(4) The respondent's failure to comply with an order shall not result in a penalty outside of this section, including, but not limited to, contempt or a failure to appear.

(5) The respondent's failure to comply with a medication order shall not result in any penalty, including under this section.

(b) (1) If, at any time during the CARE process, the court finds that the county or other local government entity is not complying with court orders, the court shall report that finding to the presiding judge of the superior court or their designee.

(2) (A) The presiding judge or their designee shall issue an order to show cause why the local government entity should not be fined as set forth in this section. The time set for hearing shall be no earlier than 15 days after the date of the order. The scheduled date of the hearing shall allow adequate time for notice of the hearing to be served upon the local government entity.

(B) The presiding judge, or their designee, shall consider the matter on the record established at the hearing. If the presiding judge or their designee finds, by clear and convincing evidence, that the local government entity has substantially failed to comply with this part, or with lawful orders issued by a court under this part, the presiding judge or their designee may issue an order imposing a fine under this section.

(C) A fine under this section shall be in an amount of up to one thousand dollars ($1,000) per day, not to exceed $25,000 for each individual violation identified in the order imposing fines.

(D) (i) Funds collected pursuant to this subdivision shall be deposited in the CARE Act Accountability Fund, which is hereby created in the State Treasury. Upon appropriation, the department shall administer the funds annually, and shall issue guidance, as necessary, to local government entities, pursuant to subdivision (b) of Section 5984, regarding the distribution and conditions associated with the administered funds.

(ii) All moneys in the fund shall be allocated and distributed to the local government entity that paid the fines, to be used by that entity to serve individuals who have schizophrenia spectrum or other psychotic disorders and who are experiencing, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship.

(3) If, after notice and hearing as set forth in paragraph (2), the presiding judge or their designee finds, by clear and convincing evidence, that the local government entity is persistently noncompliant with this part, or with lawful orders issued by a court under this part, the presiding judge or their designee may appoint a special master to secure court-ordered care for the respondent at the local government entity's cost. The presiding judge, or their designee, shall not make an order under this paragraph unless they have received five or more reports under paragraph (1) pertaining to the same local government entity within a one-year period.

(4) In determining the application of the remedies available under this section, the court shall consider whether there are any mitigating circumstances impairing the ability of the local government entity to fully comply with the requirements of this part, or with court orders issued under this part. The court may consider whether the local government entity is making a good faith effort to come into substantial compliance or is facing substantial undue hardships.

(c) Either the respondent or the county behavioral health agency may appeal an adverse court determination.

Chapter 4. Supporter and Counsel

5980. (a) Subject to appropriation, the department, in consultation with disability rights groups, county behavioral health and aging agencies, individuals with lived expertise, families, racial justice experts, and other appropriate stakeholders, shall provide optional training and technical resources for volunteer supporters on the CARE process, community services and supports, supported decisionmaking, people with behavioral health conditions, trauma-informed care, family psychoeducation, and psychiatric advance directives. The department may consult with other state and national public and nonprofit agencies and organizations and the Judicial Council to align supported decisionmaking training with best practices for persons with mental illnesses, intellectual and developmental disabilities, other disabilities, and older adults. The department may enter into a technical assistance and training agreement for this purpose, pursuant to Section 5984.

(b) The supporter shall do all of the following:

(1) 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.

(2) Strengthen the respondent's capacity to engage in and exercise autonomous decisionmaking and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship.

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

5981. (a) Notwithstanding any other provision of this part, the respondent may have a supporter present in any meeting, judicial proceeding, status hearing, or communication related to any of the following:

(1) An evaluation.

(2) Development of a CARE agreement or CARE plan.

(3) Establishing a psychiatric advance directive.

(4) Development of a graduation plan.

(b) A supporter is intended to do all the following:

(1) Support the will and preferences of the respondent to the best of their ability and to the extent reasonably possible.

(2) Respect the values, beliefs, and preferences of the respondent.

(3) Act honestly, diligently, and in good faith.

(4) Avoid, to the greatest extent possible, and disclose to the court, the respondent, and the respondent's counsel, minimize, and manage, conflicts of interest. A court may remove a supporter because of any conflict of interest with the respondent, and shall remove the supporter if the conflict cannot be managed in such a way to avoid any possible harm to the respondent.

(c) Unless explicitly authorized by the respondent with capacity to make that authorization, a supporter shall not do either of the following:

(1) Make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury.

(2) Sign documents on behalf of the respondent.

(d) In addition to the obligations in this section, a supporter shall be bound 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. This section does not limit a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion, or mistreatment, including liability under the Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600) of Part 3 of Division 9), including, but not limited to, Sections 15656 and 15657.

(e) The supporter shall not be subpoenaed or called to testify against the respondent in any proceeding relating to this part, and the supporter's presence at any meeting, proceeding, or communication shall not waive confidentiality or any privilege.

5981.5. (a) The Legal Services Trust Fund Commission at the State Bar shall provide funding to qualified legal services projects, as defined in Sections 6213 to 6214.5, inclusive, of the Business and Professions Code, to be used to provide legal counsel appointed pursuant to subdivision (c) of Section 5976, for representation in CARE Act proceedings, matters related to CARE agreements and CARE plans, and to qualified support centers, as defined in subdivision (b) of Section 6213 of, and Section 6215 of, the Business and Professions Code, for training, support, and coordination.

(b) For purposes of implementing this part, the Legal Services Trust Fund Commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, or award grants, provided that they make a finding that both of the following are satisfied:

(1) The state agency will retain control over the distribution of funds to the contractor or grantee.

(2) The contract or grant includes provisions to ensure transparency, accountability, and oversight in delivering the services, including measurement of outcomes established pursuant to Sections 5984, 5985, and 5986.

Chapter 5. CARE Plan

5982. (a) The CARE plan may include only the following:

(1) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, health care plans and insurers, and services supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800).

(2) Medically necessary stabilization medications, to the extent not described in paragraph (1).

(3) Housing resources funded through the No Place Like Home Program (Part 3.9 (commencing with Section 5849.1) of Division 5 of the Welfare

and Institutions Code); California Housing Accelerator (Chapter 6.6 (commencing with Section 50672) of Part 2 of Division 31 of the Health and Safety Code); the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2 of Division 31 of the Health and Safety Code); the Homeless Housing, Assistance, and Prevention Program (Chapter 6 (commencing with Section 50216) of Part 1 of Division 31 of the Health and Safety Code); the Encampment Resolution Funding Program (Chapter 7 (commencing with Section 50250) of Part 1 of Division 31 of the Health and Safety Code); the Project Roomkey and Rehousing Program pursuant to Provision 22 of Item 5180-151-0001 of the Budget Act of 2021 (Ch. 21, Stats. 2021); the Community Care Expansion Program (Chapter 20 (commencing with Section 18999.97) of Part 6 of Division 9 of the Welfare and Institutions Code); the CalWORKs Housing Support Program (Article 3.3 (commencing with Section 11330) of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code); the CalWORKs Homeless Assistance pursuant to clause (i) of subparagraph (A) of paragraph (2) of subdivision (f) of Section 11450 of Article 6 of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code; the Housing and Disability Advocacy Program (Chapter 17 (commencing with Section 18999) of Part 6 of Division 9 of the Welfare and Institutions Code); the Home Safe Program (Chapter 14 (commencing with Section 15770) of Part 3 of Division 9 of the Welfare and Institutions Code); the Bringing Families Home Program (Article 6 (commencing with Section 16523) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code); the Transitional Housing Placement program for nonminor dependents (Article 4 (commencing with Section 16522) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code); the Transitional Housing Program-Plus pursuant to subdivision (s) of Section 11400 and paragraph (2) of subdivision (a) of Section 11403.2 of Article 5 of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code and Article 4 (commencing with Section 16522) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code; the Behavioral Health Continuum Infrastructure Program (Chapter 1 (commencing with Section 5960) of Part 7 of Division 5 of the Welfare and Institutions Code); the Behavioral Health Bridge Housing Program; HUD-Veterans Affairs Supportive Housing Program (Section 8(o)(19) of the United States Housing Act of 1937 [42 U.S.C. Section 1437f(o)(19)]); Supportive Services for Veteran Families (Section 604 of the Veterans' Mental Health and Other Care Improvements Act of 2008 [38 U.S.C. Sec. 2044]); HUD Continuum of Care program (Section 103 of the McKinney-Vento Homeless Assistance Act [42 U.S.C. Sec. 11302]); the Emergency Solutions Grant (Subtitle B of Title IV of the McKinney-Vento Homeless Assistance Act [42 U.S.C. Secs. 11371-11378]); HUD Housing Choice Voucher program (Section 8 of the United States Housing Act of 1937 [42 U.S.C. Sec. 1437f]); the Emergency Housing Vouchers (Section 3202 of the American Rescue Plan Act of 2021 [Public Law 117-2]; Section 8(o) of the United States Housing Act of 1937 [42 U.S.C. Sec. 1437f(o)]); HOME Investment Partnerships Program (Title II of the Cranston-Gonzalez

National Affordable Housing Act [42 U.S.C. Sec. 12721 et seq.]); the Community Development Block Grant Program (Title 1 of the Housing and Community Development Act of 1974 [42 U.S.C. Sec. 5301 et seq.]); housing supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800); community development block grants; and other state and federal housing resources.

(4) Social services funded through Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), CalWORKs, California Food Assistance Program, In-Home Supportive Services program, and CalFresh.

(5) Services provided pursuant to Part 5 (commencing with Section 17000) of Division 9.

(b) Individuals who are CARE process participants shall be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

(c) If the county behavioral health agency elects not to enroll the respondent into a full service partnership, as defined in Section 3620 of Title 9 of the California Code of Regulations, the court may request information on the reasons for this and any barriers to enrollment.

(d) All CARE plan services and supports ordered by the court are subject to available funding and all applicable federal and state statutes and regulations, contractual provisions, and policy guidance governing initial and ongoing program eligibility. In addition to the resources funded through programs listed in subdivision (a), the State Department of Health Care Services may identify other adjacent covered Medi-Cal services, including, but not limited to, enhanced care management and available community supports, which may be suggested, although not ordered, by the court, subject to all applicable federal and state statutes, regulations, contractual provisions, and policy guidance.

(e) This section does not prevent a county or other local government entity from recommending their own services that are their own responsibility not listed in subdivision (a) or (c). Any such recommendation is not required by this section and shall be made at the request of the county for the purposes of Section 6 of Article XIII B, and Sections 6 and 36 of Article XIII of the California Constitution.

(f) (1) For respondents who are Medi-Cal beneficiaries, the county in which the respondent resides is the county of responsibility as defined in Section 1810.228 of Title 9 of the California Code of Regulations.

(2) If a proceeding commences in a county where the respondent is found or is facing criminal or civil proceedings that is different than the county in which the respondent resides, the county in which the respondent is found or is facing criminal or civil proceedings shall not delay proceedings under this part and is the responsible county behavioral health agency for providing or coordinating all components of the CARE agreement or CARE plan.

(3) The county in which the respondent resides, as defined in paragraph (1), shall be responsible for the costs of providing all CARE agreement or

CARE plan behavioral health services, as defined in paragraph (1) of subdivision (a).

(4) In the event of a dispute over responsibility for any costs of providing components of the CARE agreement or CARE plan, the impacted counties shall resolve the dispute in accordance with the arbitration process established in Section 1850.405 of Title 9 of the California Code of Regulations for county mental health plans, including for respondents who are not Medi-Cal beneficiaries, and pursuant to any related guidance issued pursuant to subdivision (b) of Section 5984.

Chapter 6. Technical Assistance and Administration

5983. (a) The California Health and Human Services Agency, or a designated department within the agency, shall do both of the following:

(1) Engage an independent, research-based entity, as described in Section 5986, to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act pursuant to this part.

(2) 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. The working group shall meet no more than quarterly. The working group shall meet during the implementation and shall end no later than December 31, 2026.

(b) The department shall provide training and technical assistance to county behavioral health agencies to support the implementation of this part, including training regarding the CARE process, CARE agreement and plan services and supports, supported decisionmaking, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives, family psychoeducation, and data collection.

(c) The Judicial Council, in consultation with the department, other relevant state entities, and the County Behavioral Health Directors Association, shall provide training and technical assistance to judges to support the implementation of this part, including training regarding the CARE process, CARE agreement and plan services and supports, working with the supporter, supported decisionmaking, the supporter role, the family role, trauma-informed care, elimination of bias, best practices, and evidence-based models of care for people with severe behavioral health conditions.

(d) The department, in consultation with other relevant state departments and the California Interagency Council on Homelessness, shall provide training to counsel regarding the CARE process and CARE agreement and plan services and supports.

5984. (a) For purposes of implementing this part, the California Health and Human Services Agency and the department may enter into exclusive

or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this part shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the California Health and Human Services Agency and the department may implement, interpret, or make specific this part, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

5985. (a) The department shall 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. The department shall post the annual report on its internet website.

(b) County behavioral health agencies and any other state or local governmental entity, as identified by the department, shall provide data related to the CARE Act participants, services, and supports to the department. The department shall determine the data measures and specifications, and shall publish them via guidance issues pursuant to subdivision (b) of Section 5984.

(c) Each county behavioral health department and any other state and local governmental entity, as identified by the department, shall provide the required data to the department, in a format and frequency as directed by the department.

(d) (1) In consultation with the Judicial Council, the department shall develop an annual reporting schedule for the submission of CARE Act data from the trial courts.

(2) Data from the trial courts shall be submitted to the Judicial Council, which shall aggregate the data and submit it to the department consistent with the reporting schedule developed pursuant to paragraph (1).

(3) On an annual basis to be determined by the Judicial Council and consistent with the annual reporting schedule developed pursuant to paragraph (1), the trial courts shall report to the Judicial Council the following data related to CARE Act petitions:

(A) The number of petitions submitted pursuant to Section 5975.

(B) The number of initial appearances on the petition set pursuant to paragraph (3) of subdivision (a) of Section 5977.

(C) The total number of hearings held pursuant to this part.

(e) The annual report shall include process measures to examine the scope of impact and monitor the performance of CARE Act model implementation. The report shall include, at a minimum, all of the following:

(1) The demographics of participants, including, but not limited to, the age, sex, race, ethnicity, disability, languages spoken, sexual orientation, gender identity, housing status, veteran status, immigration status, health coverage status, including Medi-Cal enrollment status, and county of residence, to the extent statistically relevant data is available.

(2) The services and supports ordered, the services and supports provided, and the services and supports ordered but not provided.

(3) The housing placements of all participants during the program and at least one year following the termination of the CARE plan, to the extent administrative data are available to report the latter. Placements include, but are not limited to, transition to a higher level of care, independent living in the person's own house or apartment, community-based housing, community-based housing with services, shelter, and no housing.

(4) Treatments continued and terminated at least one year following termination of the CARE plan, to the extent administrative data are available.

(5) Substance use disorder rates and rates of treatment among active CARE plan participants and former participants at least one year following termination of the CARE plan, to the extent administrative data are available to report the latter.

(6) Detentions and other Lanterman-Petris-Short Act involvement for participants with an active CARE plan and for former participants at least one year following termination of the CARE plan, to the extent administrative data are available to report the latter.

(7) Criminal justice involvement of participants with an active CARE plan and for former participants at least one year following termination of the CARE plan, to the extent administrative data are available to report the latter.

(8) Deaths among active participants and for former participants at least one year following termination of the CARE plan, along with causes of death, to the extent administrative data are available.

(9) The number, rates, and trends of petitions resulting in dismissal and hearings.

(10) The number, rates, and trends of supporters.

(11) The number, rates, and trends of voluntary CARE agreements.

(12) The number, rates, and trends of ordered and completed CARE plans.

(13) Statistics on the services and supports included in CARE plans, including court orders for stabilizing medications.

(14) The rates of adherence to medication.

(15) The number, rates, and trends of psychiatric advance directives created for participants with active CARE plans.

(16) The number, rates, and trends of developed graduation plans.

(17) 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.

(18) A health equity assessment of the CARE Act to identify demographic disparities based on demographic data in paragraph (1), and to inform disparity reduction efforts.

(f) (1) The report shall 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 shall 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 shall 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 shall examine these data through the lens of health equity to identify racial, ethnic, and other demographic disparities and inform disparity reduction efforts.

(2) Data shall be stratified by age, sex, race, ethnicity, languages spoken, disability, sexual orientation, gender identity, housing status, veteran status, immigration status, health coverage source, and county, to the extent statistically relevant data is available. Information released or published pursuant to this section shall not contain data that may lead to the identification of respondents or information that would otherwise allow an individual to link the published information to a specific person. Data published by the department shall be deidentified in compliance with Section 164.514(a) and (b) of Title 45 of the Code of Federal Regulations.

(g) The outcomes shall be presented to relevant state oversight bodies, including, but not limited to, the California Interagency Council on Homelessness.

5986. (a) An independent, research-based entity shall be retained by the department 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. The independent evaluation shall 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. The independent evaluation shall include results from a survey conducted of program participants. The independent evaluation shall highlight racial, ethnic, and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts.

(b) The department shall provide a preliminary report to the Legislature three years after the implementation date of the CARE Act and a final report to the Legislature five years after the implementation date of CARE Act. The department shall post the preliminary and final reports on its internet website.

(c) Each county behavioral health department, each county CARE court, and any other state or local governmental entity, as determined by the department, shall provide the required data to the department, in a format and frequency as directed by the department.

(d) A report to be submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

5987. A county, or an employee or agent of a county, shall not be held civilly or criminally liable for any action by a respondent in the CARE process, except when the act or omission of a county, or the employee or agent of a county, constitutes gross negligence, recklessness, or willful misconduct. This section does not limit any immunity provided under any other law.

SEC. 8. The Legislature finds and declares that Section 7 of this act, which adds Sections 5976.5 and 5977.1 to the Welfare and Institutions Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

This act protects the sensitive medical information of the respondent in a CARE Act proceeding, including medical and psychological records.

SEC. 9. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 10. Section 4.5 of this bill incorporates amendments to Section 1370.01 of the Penal Code proposed by both this bill and SB 1223. That section shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2023, (2) each bill amends Section 1370.01 of the Penal Code, and (3) this bill is enacted after SB 1223, in which case Section 4 of this bill shall not become operative.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this

act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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Exhibit 2

Pages: RJN-0039 through RJN-0088

Assembly Bill No. 179, CHAPTER 249

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

Assembly Bill No. 179

CHAPTER 249

An act to amend the Budget Act of 2022 (Chs. 43 and 45, Stats. 2022) by amending Items 0250-001-0001, 0250-101-0001, 0250-101-0932, 0250-111-0001, 0250-162-8506, 0250-301-0001, 0509-001-0001, 0509-101-0001, 0509-102-3398, 0509-104-0001, 0509-112-0001, 0511-001-0001, 0521-001-0042, 0521-001-0044, 0521-001-0046, 0521-001-0890, 0530-001-0001, 0540-001-0001, 0540-101-0001, 0540-490, 0540-492, 0540-495, 0650-001-0001, 0650-001-0890, 0650-101-0001, 0690-001-0001, 0690-003-0001, 0690-004-0001, 0690-012-0001, 0690-101-0001, 0890-001-0001, 0954-101-0001, 0985-220-0001, 2240-001-0001, 2240-102-0001, 2240-104-0001, 2240-110-0001, 2240-111-0001, 2240-121-0001, 2240-122-0001, 2240-124-0001, 2240-125-0001, 2240-126-0001, 2660-490, 3340-001-0001, 3340-003-0001, 3360-001-0465, 3360-001-0890, 3360-001-3062, 3360-002-0001, 3360-102-0001, 3480-001-3046, 3480-101-0001, 3480-491, 3480-492, 3540-001-0001, 3540-003-0001, 3540-101-0001, 3560-001-0001, 3600-001-0001, 3600-006-0001, 3600-007-0001, 3720-001-0001, 3790-001-0001, 3790-101-0263, 3790-101-3001, 3790-301-0001, 3790-301-3312, 3790-491, 3790-493, 3790-496, 3810-103-0001, 3835-101-0001, 3860-001-0001, 3860-001-3398, 3860-101-0001, 3900-001-0001, 3900-001-3228, 3900-002-3228, 3900-101-0001, 3900-101-3228, 3900-102-3228, 3930-001-0001, 3940-001-0001, 3970-001-0001, 3970-001-0133, 3970-101-0001, 3970-101-0133, 3970-101-3228, 4140-101-0001, 4140-101-3085, 4170-001-0001, 4170-101-0001, 4260-001-0001, 4260-101-0001, 4260-116-0890, 4265-001-0001, 4265-021-3398, 4265-111-0001, 4265-491, 4300-001-0890, 4300-101-0890, 4440-003-0001, 5180-001-0001, 5180-101-0001, 5180-101-0890, 5180-141-0001, 5180-151-0001, 5225-008-0001, 5225-018-0001, 5225-019-0001, 5225-022-0001, 5227-001-0001, 5227-119-0001, 6100-001-0001, 6100-004-0001, 6100-006-0001, 6100-009-0001, 6100-107-0001, 6100-112-0890, 6100-134-0890, 6100-137-0890, 6100-161-0890, 6100-195-0890, 6100-203-0001, 6100-296-0001, 6100-491, 6120-161-0001, 6360-001-0001, 6360-001-0408, 6440-001-0001, 6440-005-0001, 6870-101-0001, 6870-201-0001, 7120-001-0001, 7120-001-0890, 7350-001-0001, 7350-001-0890, 7502-001-9730, 7760-001-0001, 8260-001-0001, 8570-001-0001, 8570-002-0001, 8570-102-0001, 8570-490, 8660-001-0462, 8660-001-0890, 8660-101-0464, 8660-101-0470, 8955-001-0001, and 9210-104-0001 of Section 2.00 of, adding Items 0509-492, 0540-103-0001, 0820-101-0001, 2667-001-0046, 2720-301-0660, 3125-101-0001, 3340-002-0001, 3360-001-3228, 3360-004-0001, 3360-005-0001, 3360-007-0001, 3360-101-3228, 3360-104-0001, 3360-107-0001, 3480-103-0001, 3480-494, 3540-102-0001, 3600-102-0001, 3600-495, 3640-002-0001, 3640-103-0001,

3760-001-0001, 3760-103-0001, 3760-106-0001, 3810-001-0001, 3810-104-0001, 3825-001-0001, 3825-102-0001, 3830-101-0001, 3845-001-0001, 3845-101-0001, 3850-101-0001, 3850-495, 3855-102-0001, 3875-101-0001, 3940-002-0001, 3940-493, 3970-001-3408, 3970-011-0133, 3970-492, 5225-496, 6440-492, 6610-490, 6870-302-6087, 6870-492, 7350-002-0001, 7502-011-0890, 7600-011-0001, 8260-491, 8570-102-3228, and 8660-001-0001 to Section 2.00 of, repealing Item 0775-001-3085 of Section 2.00 of, amending Sections 8.75, 11.96, 15.14, 19.56, 39.00, and 99.50 of, adding Sections 19.58 and 39.10 to, and repealing Section 19.55 of, that act, relating to the state budget, and making an appropriation therefor, to take effect immediately, budget bill.

[Approved by Governor September 6, 2022. Filed with Secretary of State September 6, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 179, Ting. Budget Act of 2022.

The Budget Act of 2022 made appropriations for the support of state government for the 2022–23 fiscal year.

This bill would amend the Budget Act of 2022 by amending, adding, and repealing items of appropriation and making other changes.

This bill would declare that it is to take effect immediately as a Budget Bill.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Item 0250-001-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-001-0001—For support of Judicial Branch.....	774,970,000
Schedule:	
(1) 0130-Supreme Court.....	53,756,000
(2) 0135-Courts of Appeal.....	265,433,000
(3) 0140-Judicial Council.....	449,954,000
(4) 0155-Habeas Corpus Resource Center.....	17,625,000
(5) Reimbursements to 0140-Judicial Council.....	−11,598,000
(6) Reimbursements to 0135-Courts of Appeal.....	−200,000
Provisions:	
1. Of the funds appropriated in this item, $5,800,000 is available for the defense and indemnity of the Judicial Council, the appellate courts, the trial courts or the	

officers, judicial officers, and employees of these entities including government claims, litigation related matters, labor and employment related matters, and matters requiring specialized legal advice. The funds may be used for prelitigation and litigation fees, and costs from the Attorney General or other outside legal counsel, fees for legal advice in specialized areas of law, and any judgment, stipulated judgment, offer of judgment, or settlement. This amount is for use in connection with (a) matters arising from the actions of appellate courts, appellate court judicial officers, appellate court employees, or court contractors, or (b) matters arising from the actions of the Judicial Council, council members, council employees or agents, or Judicial Council contractors, or (c) matters arising from the actions of trial courts, trial court judicial officers, trial court employees, or court contractors. The Judicial Council, an appellate court, trial court, or an officer, judicial officer, or employee of these entities must be named as a defendant or alleged to be the responsible party, or be the responsible party pursuant to a contractual provision, memorandum of understanding, or intrabranch agreement. Any funds not used for this purpose shall revert to the General Fund. The amount allocated shall be available for encumbrance or expenditure until June 30, 2024.

2. Notwithstanding any other law, upon approval and order of the Director of Finance, the amount appropriated in this item shall be reduced by the amount transferred in Item 0250-011-0001 to provide adequate resources to the Judicial Branch Workers' Compensation Fund to pay workers' compensation claims for judicial branch employees and justices, and administrative costs pursuant to Section 68114.10 of the Government Code.
3. Of the funds appropriated in Schedule (2), $76,944,000 is available for the Court-Appointed Counsel Program and shall be used solely for that program. Any funds for the program not expended by June 30, 2023, shall revert to the General Fund.
4. Of the amount appropriated in this item, up to $325,000 is available to reimburse the California State Auditor for the costs of audits incurred by the California State Auditor pursuant to subdivision (c) of Section 19210 of the Public Contract Code.
5. Of the funds appropriated in Schedule (3), $1,500,000 shall be available for administrative costs related to

the management and claiming of federal reimbursements for court-appointed dependency counsel. To the extent these administrative costs are able to be reimbursed, any excess funding shall revert to the General Fund.

6. Of the amount appropriated in Schedule (3), $27,100,000 shall be expended to address a facility modification in the San Diego County Superior Court's Hall of Justice. The amount allocated shall be available for encumbrance or expenditure until June 30, 2025.
7. Of the amount appropriated in Schedule (3), $24,326,000 shall be expended to address facility modifications to accommodate new superior court judgeships. The amount allocated shall be available for encumbrance or expenditure until June 30, 2024.
8. Upon approval of the Administrative Director, the Controller shall increase this item by an amount sufficient to allow for the expenditure of any transfer of this item made pursuant to Provision 16 of Item 0250-101-0001.
9. Of the amount appropriated in Schedule (3), $15,000,000 is appropriated for the purpose of providing court users access to a lactation room in any courthouse in which a lactation room is also provided to court employees. The lactation room shall be located in a publicly accessible area within the court facility or a location that is reasonably accessible to the public using the court facility, in compliance with the requirements of Section 1031 of the Labor Code. A court may comply with this provision by designating a lactation room for court users without complying with subdivision (d) of Section 1031 of the Labor Code, if due to operational, financial, or space limitations.

9.5. Upon approval by the Administrative Director, the controller shall transfer up to 5 percent of the amount in Provision 9 for administrative costs of the Judicial Council.

10. In establishing the judicial training program on water, environment, and climate change, the Judicial Council shall seek judicial participation from all parts of the state, particularly counties that do not have complex litigation departments. For the water law training program, the Judicial Council shall seek to collaborate in developing a common training program with the judicial branches in states that share river basins with California.

11. Of the amount appropriated in Schedule (3), $40,000,000 shall be allocated to the Judicial Council to support a court-based firearm relinquishment program to ensure the consistent and safe removal of firearms from individuals who become prohibited from owning or possessing firearms and ammunition pursuant to court order. This funding shall be available for encumbrance or expenditure until June 30, 2025. Any unspent funds shall revert to the General Fund.
12. Of the amount appropriated in Provision 11, $36,000,000 shall be allocated to the Judicial Council to support a firearm relinquishment program. The Judicial Council shall select the courts and determine specific allocation amounts, ensuring that there is diversity in geographic location and court size. The Judicial Council, at minimum, shall prioritize those courts with higher numbers of domestic violence restraining orders or gun violence restraining orders. The Judicial Council may also consider prioritizing counties with higher rates of gun ownership or higher increases in gun ownership since March 2020.
13. The amount allocated in Provision 12 may be used to support court and law enforcement costs to ensure that firearms and ammunition have actually been removed pursuant to court order. Priority shall be given to activities related to domestic violence restraining orders, gun violence restraining orders, or any other civil court order. Permissible activities include, but are not limited to, the following:
    (a) Processing cases, providing assistance with competing forms, conducting compliance hearings, making referrals to prosecuting agencies and law enforcement, and coordinating the relinquishment of firearms and weapons pursuant to criminal or civil court orders.
    (b) Processing and serving court orders, informing individuals how they may relinquish their firearms and ammunition, investigating whether they have been relinquished, and removing them where necessary.
    (c) Consulting and updating firearms-related systems, including the Automated Firearms System, as well as reporting firearm disposition information to the Department of Justice.
    (d) Collecting data and reporting information as required by the Judicial Council.

(e) Regional planning, coordination, or collaboration with neighboring courts, law enforcement, or other partners.
(f) Any activities associated with implementing Chapter 685 of the Statutes of 2021.

14. Each court that receives funding pursuant to Provision 12 shall contract with at least one law enforcement agency located within the county for activities that cannot reasonably and safely be conducted by the court. Law enforcement agency is defined as probation departments, sheriff's offices, police department, or multiagency teams including some or all of these agencies in a jurisdiction. Such activities include, but are not limited to, investigating whether firearms and ammunition have been relinquished, removing them if necessary, and reporting firearm disposition information to the Department of Justice. At least 30 percent of the funding allocated to each court shall be available for court contracts with law enforcement agencies.
15. The Judicial Council shall determine the process and criteria used to allocate the funding available in Provision 12. Each court seeking funding, at minimum, shall provide the following information: a description of the activities that shall be supported, the proportion that will be used for activities pursuant to civil versus criminal proceedings, the number of staff that will be supported, any entity with which the court may contract to provide a service, and a copy of the contract with one or more law enforcement agencies.
16. Of the amount appropriated in Provision 11, up to $4,000,000 shall be retained by the Judicial Council for costs associated with supporting, conducting oversight, collecting data, and evaluating the firearms relinquishment program. The Judicial Council shall contract with the University of California Firearm Violence Research Center at the University of California, Davis, or an equivalent entity to conduct the evaluation of the firearm relinquishment program and submit a report to the Legislature pursuant to Section 9795 of the Government Code, no later than March 1, 2025. Any funds unspent for this purpose may be allocated to the courts that receive funding from the Judicial Council pursuant to Provision 12 for the uses specified in Provision 13.
17. Each court and their contractors who are granted funding from the Judicial Council shall report funding,

outcome, and any other data required by the Judicial Council. The Judicial Council's reporting requirements shall include, to the extent permitted by law, the information required by the University of California Firearm Violence Research Center at the University of California, Davis, or equivalent entity.

18. By October 1 of each year, beginning in 2023 and ending in 2025, the Judicial Council shall provide a report to the Joint Legislative Budget Committee describing how the funding has been allocated, how the funding has or will be used by each court, the structure of the program at each court, the roles and responsibilities of the court and its contractors, any implementation challenges or other challenges faced, and key data outcomes by each court. Such outcomes, at minimum, shall include: the number of filings addressed by type of order, the number of firearm-related background checks conducted, the range and average number of days from the firearm and ammunition prohibition by the court to removing or confirming relinquishment, the number of individuals who relinquish firearms voluntarily, the number relinquished, to whom the firearms were relinquished, and the number of firearms removed by law enforcement and their disposition.
19. Of the funds appropriated in Schedule (3), $3,048,000 is available for the implementation of the Community Assistance, Recovery, and Empowerment Act. These funds are contingent upon adoption of statutory changes codifying the Community Assistance, Recovery, and Empowerment Act.

SEC. 2. Item 0250-101-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-101-0001—For local assistance, Judicial Branch.....		181,603,000
Schedule:		
(1) 0150010-Support for Operation of Trial Courts.....	78,551,000	
(2) 0150051-Child Support Commissioner Program (AB 1058).....	59,082,000	
(3) 0150055-California Collaborative and Drug Court Projects.....	5,748,000	
(4) 0150075-Grants—Other.....	18,495,000	
(5) 0150083-Equal Access Fund.....	85,642,000	
(6) Reimbursements to 0150051-Child Support Commissioner Program (AB 1058).....	−59,082,000	

(7) Reimbursements to 0150055-California Collaborative and Drug Court Projects..... −4,588,000
(8) Reimbursements to 0150075-Grants—Other..... −1,995,000

Provisions:

1. In order to improve equal access and the fair administration of justice, $35,392,000 of the funds appropriated in Schedule (5) are to be distributed by the Judicial Council through the Legal Services Trust Fund Commission to qualified legal services projects and support centers as defined in Sections 6213 to 6215, inclusive, of the Business and Professions Code, to be used for legal services in civil matters for indigent persons. The Judicial Council shall approve awards made by the commission if the council determines that the awards comply with statutory and other relevant guidelines. Up to 10 percent of the funds appropriated for purposes of this provision shall be for joint projects of courts and legal services programs to make legal assistance available to pro per litigants and not less than 90 percent of the funds appropriated for purposes of this provision shall be distributed consistent with Sections 6216 to 6223, inclusive, of the Business and Professions Code. Any funding not allocated for joint projects shall be redistributed consistent with Sections 6216 to 6223, inclusive, of the Business and Professions Code. The Judicial Council may establish additional reporting or quality control requirements consistent with Sections 6213 to 6223, inclusive, of the Business and Professions Code. Of the amount appropriated for purposes of this provision, not more than 2.5 percent shall be available, upon order of the Department of Finance, for administrative costs of the Judicial Council and the State Bar.
2. In order to improve equal access and the fair administration of justice, $5,000,000 shall be annually appropriated in Schedule (5) by the Judicial Council to the California Access to Justice Commission for grants to civil legal aid nonprofits, including qualified legal services projects and support centers as defined in Sections 6213 to 6215, inclusive, of the Business and Professions Code, to be used to support the infrastructure and innovation needs of legal services in civil matters for indigent persons. Of this amount, not more than 2.5 percent shall be available for administrative

costs of the California Access to Justice Commission associated with distributing and monitoring the grants.

3. The California Access to Justice Commission shall make award determinations for grants described in Provision 2. In awarding these grants, preference shall be given to qualified legal aid agencies' proposals that focus on services to rural or underserved immigrant communities regardless of citizenship status and proposals that are innovative or that involve partnership with community-based nonprofits. Any funding not allocated in a given fiscal year shall be reallocated pursuant to Provision 1.
4. The grant process described in Provision 2 shall ensure that any qualified legal service project and support center demonstrates a high need for infrastructure and innovation to ensure that funding is distributed equitably among qualified legal service projects and support centers. The qualified legal service project or support center shall demonstrate that funds received under this provision will not be used to supplant existing resources.
5. The funds described in Provisions 1 and 2 are available for encumbrance or expenditure until June 30, 2024.
6. The amount appropriated in Schedule (1) is available for reimbursement of court costs related to the following activities: (a) payment of service of process fees billed to the trial courts pursuant to Chapter 1009 of the Statutes of 2002, (b) payment of the court costs payable under Sections 4750 to 4755, inclusive, and Section 6005 of the Penal Code, and (c) payment of court costs of extraordinary homicide trials.
7. Of the amount appropriated in Schedule (4), $16,500,000 shall be provided to county law libraries to backfill the decline in civil filing fee revenue.
8. Of the amount appropriated in Schedule (1) $70,000,000 shall be allocated to the Judicial Council to fund local assistance to each superior court based on each county's relative proportion of the state population that is 18 through 25 years of age. These resources may be used for the following:
   (a) Costs associated with judicial officer pretrial release decisions prior to or at arraignment.
   (b) Costs for technology to facilitate information exchange and process automation between courts and county departments.
   (c) Costs for implementation and improvement of court date reminder programs.

(d) Costs associated with assessments of defendants' ability to pay a financial condition in cases where the court determines that such a condition is necessary to ensure public safety and return to court.
(e) Costs associated with providing services to and monitoring of individuals released pretrial. The pretrial services agencies shall implement evidence-based monitoring practices of defendants released prearraignment and pretrial with the least restrictive interventions and practices necessary to enhance public safety and ensure the defendants' return to court. Electronic monitoring that is funded under this program may only be used in limited cases after other less restrictive interventions are deemed insufficient to enhance public safety and to ensure the defendant's return to court.
(f) Other programs and practices related to pretrial decisionmaking that address public safety, appearance in court, and the efficient and fair administration of justice.

9. Courts shall contract with any county department, including county probation departments, to provide pretrial services, except those departments or agencies that have primary responsibility for making arrests or prosecuting criminal offenses.
10. The Superior Court of California, County of Santa Clara, may contract with the Office of Pretrial Services in that county. The Superior Court of California, County of San Francisco, may contract with the Sheriff's Office and the existing not-for-profit entity that is performing pretrial services in the city and county for pretrial assessment and supervision services.
11. The county department with which the court has contracted is not precluded from contracting with community-based organizations to provide complementary or supportive services in furtherance of the county department's pretrial release services if all of the following conditions have been satisfied:
(a) The contractor adheres to the same transparency, accountability, and outcome measure standards that apply to county probation departments.
(b) The contractor has a proven record of providing culturally competent and responsive rehabilitative services.
(c) The contract will not result in the displacement of county employees or a reduction in the provi-

sion of services by county probation department employees.

(d) The contractor pays wages and benefits to its nonsupervisory employees that are commensurate with or greater than the wages and benefits paid to public employees in similar job classifications.

(e) The contractor does not pay wages and benefits to its most highly compensated executive and managerial employees that are significantly higher than the rates that would be paid to public employees performing similar job duties.

(f) The county has consulted with the court prior to entering into a contract for the provision of these services.

15. Of the amount allocated in Provision 9, superior courts may retain up to 30 percent of the funding for costs associated with these programs and practices. The superior courts shall contract with a county department as described in Provision 12 and shall provide the county department with the remainder of the funds to be used for costs outlined in Provision 11, as appropriate.

16. The Judicial Council shall retain up to 5 percent of the amount available to the superior courts in Provision 15 for costs associated with implementing, supporting, and evaluating pretrial programs in courts, including, but not limited to:

(a) Providing technical assistance to courts on practices and programs related to pretrial decisionmaking.

(b) Providing judicial education.

(c) Evaluating pretrial programs and practices funded through this program.

(d) Providing administrative services on programs related to pretrial decisionmaking.

17. To receive the funding allocated in Provision 9, courts and county departments and their contractors shall collaborate with local justice system partners in reporting to the Judicial Council on pretrial programs and practices, including information on expenditure of funds, as required by the Judicial Council, for evaluation of the programs and practices, pursuant to Provision 16.

18. Commencing July 1, 2023, the Judicial Council shall provide an annual report to the Legislature providing an evaluation of pretrial programs and practices, as required in Provision 16.

19. Notwithstanding Section 77203 of the Government Code, trial courts may carry any unexpended balances of the $70,000,000 ongoing funding that was specifically appropriated in Item 0250-101-0001 and identified in Provisions 9 and 10 of that item for pretrial services, to June 30, 2023. Any unexpended funds shall revert to the General Fund.
20. Of the amount appropriated in Schedule (5), $15,000,000 shall be distributed by the Judicial Council, through the Legal Services Trust Fund Commission, of the State Bar as grants to qualified legal services projects and support centers, as defined in Section 6213 to 6215, inclusive, of the Business and Professions Code, to provide civil legal services for indigent persons related to consumer debt matters affected by the COVID-19 pandemic.
21. Upon approval by the Administrative Director, the Controller shall transfer up to 5 percent of the amount in Provision 20 to Item 0250-001-0001, for administrative costs of the Judicial Council or the State Bar. The balance of funds after the deduction of administrative costs shall be allocated through a competitive grant process developed by the Legal Services Trust Fund Commission, which shall award grants to qualified legal services projects and support centers to provide consumer debt civil legal services to low-income and underserved communities.
22. The grant process described in Provision 20 shall ensure that any qualified legal services project or support center receiving funds demonstrates that the funds received will not be used to supplant existing resources. The Legal Services Trust Fund Commission shall make the grant award determinations. In awarding these grants, preference shall be given to qualified legal service projects or support centers that serve rural or underserved communities. Any funding not allocated pursuant to this competitive grant process shall be distributed to qualified legal services projects and support centers pursuant to the formula set forth in Section 6216 of the Business and Professions Code.
23. Funds appropriated in Provision 20 are available for encumbrance or expenditure through December 31, 2025.
24. Of the amount appropriated in Schedule (5), $30,000,000 shall be distributed by the Judicial Council through the Legal Service Trust Fund Commission of the State Bar of California pursuant to this

provision to qualified legal services projects and support centers to provide eviction defense, other tenant defense assistance in landlord-tenant rental disputes, or services to prevent foreclosure for homeowners, including pre-eviction and eviction legal services, counseling, advice, and consultation, mediation, training, renter education, and representation, and legal services to improve habitability, increasing affordable housing, ensuring receipt of eligible income or benefits to improve housing stability, legal help for persons displaced because of domestic violence, and homelessness prevention. Upon approval by the Administrative Director, the Controller shall transfer up to 5 percent of the amount in provision 24 to Item 0250-001-0001, for administrative costs of the Judicial Council and the State Bar of California, provided that funds spent shall not exceed the actual costs of administration. Unspent administrative funds shall be redistributed to qualifying grantees as prescribed by the Legal Services Trust Fund Commission.

25. After the allocation of funds pursuant to Provision 24, any remaining funds from the amount appropriated for purposes of that provision shall be allocated through a competitive grant process developed by the Legal Services Trust Fund Commission of the State Bar to award grants to qualified legal service projects and support centers to provide eviction defense, other tenant defense assistance in landlord-tenant rental disputes, or services to prevent foreclosures for homeowners, as set forth in this provision. The Commission shall make the grant award determinations. In awarding these grants in order to enhance the reach of the services provided, preference shall be given to qualified legal aid agencies that serve rural or underserved communities or to qualified legal aid agencies partnered with or subgranting to community-based organizations or local jurisdictions, provided the partnerships or subgrants were in effect as of June 30, 2022.
26. The funds described in Provisions 24 and 25 are available for encumbrance or expenditure until June 30, 2024.
27. Of the amount appropriated in Schedule (5), $250,000 shall be distributed by the Judicial Council through the Legal Service Trust Fund Commission of the State Bar of California to qualified legal services projects and support centers as defined in Sections 6213 to

6215, inclusive, of the Business and Professions Code, to be used for training, support, and coordination of the Community Assistance, Recovery, and Empowerment (CARE) Act. These funds are contingent upon the adoption of statutory changes codifying the CARE Act.

SEC. 3. Item 0250-101-0932 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-101-0932—For local assistance, Judicial Branch, payable from the Trial Court Trust Fund..... 3,199,758,000

Schedule:

(1) 0150010-Support for Operation of Trial Courts.....	2,558,817,000
(2) 0150019-Compensation of Superior Court Judges.....	422,654,000
(3) 0150028-Assigned Judges.....	30,505,000
(4) 0150037-Court Interpreters.....	135,502,000
(5) 0150067-Court Appointed Special Advocate (CASA) program.....	22,713,000
(6) 0150071-Model Self-Help Program.....	957,000
(7) 0150083-Equal Access Fund.....	5,482,000
(8) 0150087-Family Law Information Centers.....	345,000
(9) 0150091-Civil Case Coordination.....	832,000
(10) 0150095-Expenses on Behalf of the Trial Courts.....	21,952,000
(11) Reimbursements to 0150010-Support for Operation of Trial Courts.....	−1,000

Provisions:

1. Of the funds appropriated in Schedule (1), $25,300,000 shall be available for support of services for self-represented litigants, and any unexpended funds shall revert to the General Fund.
2. The funds appropriated in Schedule (2) shall be made available for costs of the workers' compensation program for trial court judges.
3. The amount appropriated in Schedule (3) shall be made available for all judicial assignments. Schedule (3) expenditures for necessary support staff shall not exceed the staffing level that is necessary to support the equivalent of three judicial officers sitting on assignments. Prior to utilizing funds appropriated in Schedule (3), trial courts shall maximize the use of judicial officers who may be available due to reductions in court services or court closures.

5. Upon order of the Director of Finance, the amount available for expenditure in this item may be augmented by the amount of any additional resources available in the Trial Court Trust Fund, which is in addition to the amount appropriated in this item. Any augmentation shall be approved in joint determination with the Chairperson of the Joint Legislative Budget Committee and shall be authorized not sooner than 30 days after notification in writing to the chairpersons of the committees in each house of the Legislature that consider appropriations, the chairpersons of the committees and appropriate subcommittees that consider the State Budget, and the chairperson of the joint committee, or not sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may determine. When a request to augment this item is submitted to the Director of Finance, a copy of that request shall be delivered to the chairpersons of the committees and appropriate subcommittees that consider the State Budget. Delivery of a copy of that request shall not be deemed to be notification in writing for purposes of this provision.
6. Notwithstanding any other law, upon approval and order of the Director of Finance, the amount appropriated in this item shall be reduced by the amount transferred in Item 0250-115-0932 to provide adequate resources to the Judicial Branch Workers' Compensation Fund to pay workers' compensation claims for judicial branch employees and judges, and administrative costs pursuant to Section 68114.10 of the Government Code.
7. Upon approval by the Administrative Director of the Courts, the Controller shall transfer up to $11,274,000 to Item 0250-001-0932 for recovery of costs for administrative services provided to the trial courts by the Judicial Council.
8. In order to improve equal access and the fair administration of justice, the funds appropriated in Schedule (7) are available for distribution by the Judicial Council through the Legal Services Trust Fund Commission in support of the Equal Access Fund Program to qualified legal services projects and support centers as defined in Sections 6213 to 6215, inclusive, of the Business and Professions Code, to be used for legal services in civil matters for indigent persons. The Judicial Council shall approve awards made by the commission if the council determines that the awards

comply with statutory and other relevant guidelines. Upon approval by the Administrative Director of the Courts, the Controller shall transfer up to 5 percent of the funding appropriated in Schedule (7) to Item 0250-001-0932 for administrative expenses. Ten percent of the funds remaining after administrative costs shall be for joint projects of courts and legal services programs to make legal assistance available to pro per litigants and 90 percent of the funds remaining after administrative costs shall be distributed, consistent with Sections 6216 to 6223, inclusive, of the Business and Professions Code. The Judicial Council may establish additional reporting or quality control requirements, consistent with Sections 6213 to 6223, inclusive, of the Business and Professions Code.

9. Funds available for expenditure in Schedule (7) may be augmented by order of the Director of Finance by the amount of any additional resources deposited for distribution to the Equal Access Fund Program in accordance with Sections 68085.3 and 68085.4 of the Government Code. Any augmentation under this provision shall be authorized not sooner than 30 days after notification in writing to the chairpersons of the committees in each house of the Legislature that consider appropriations, the chairpersons of the committees and appropriate subcommittees that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may determine.
10. Sixteen (16.0) subordinate judicial officer positions are authorized to be converted to judgeships in the 2021–22 fiscal year in the manner and pursuant to the authority described in subparagraph (B) of paragraph (1) of subdivision (c) of Section 69615 of the Government Code, as described in the notice filed by the Judicial Council under subparagraph (B) of paragraph (3) of subdivision (c) of Section 69615 of the Government Code.
11. Notwithstanding any other law, and upon approval of the Director of Finance, the amount available for expenditure in Schedule (1) may be increased by the amount of any additional resources collected for the recovery of costs for court appointed dependency counsel services.
12. Upon approval of the Administrative Director of the Courts, the Controller shall transfer up to $556,000 to

Item 0250-001-0932 for administrative services provided to the trial courts in support of the court appointed dependency counsel program.

13. Of the amounts appropriated in Schedule (1), $325,000 shall be allocated by the Judicial Council in order to reimburse the California State Auditor for the costs of trial court audits incurred by the California State Auditor pursuant to Section 19210 of the Public Contract Code.
14. Upon approval of the Administrative Director of the Courts, the Controller shall transfer up to $500,000 of the funding appropriated in Schedule (10) of this item to Schedule (1) of Item 0250-001-0932 for administrative services provided by the Judicial Council to implement and administer the Civil Representation Pilot Program.
15. Upon approval of the Administrative Director of the Courts, the amount available for expenditure in Schedule (10) may be augmented by the amount of resources collected to support the implementation and administration of the Civil Representation Pilot Program.
16. Of the amount appropriated in this item, up to $540,000 is available to reimburse the Controller for the costs of audits incurred by the Controller pursuant to subdivision (h) of Section 77206 of the Government Code.
18. Upon order of the Department of Finance, the amount available for expenditure in Schedules (1) and (4) may be augmented by an amount sufficient to fund trial court employee benefit increases in the 2022–23 fiscal year.
19. Notwithstanding any other law, and upon approval of the Director of Finance, the amount available for expenditure in Schedule (10) may be increased by the amount of any additional resources collected to support programs pursuant to the Sargent Shriver Civil Counsel Act (Chapter 2.1 (commencing with Section 68650) of Title 8 of the Government Code).
23. Of the amount appropriated in Schedule (1), up to $660,000 shall be available to fund trial court security costs for the new Shasta courthouse. To the extent the courthouse is opened at a later date, the funding available shall be proportionally reduced based on the month the courthouse begins operations.
24. The funds appropriated in Schedule (4) shall be for payments to contractual court interpreters and certified

and registered court interpreters employed by the courts for services provided during court proceedings and other services related to pending court proceedings, including services provided outside a courtroom. Those funds are also available for the following court interpreter coordinator positions: 1.0 each in counties of the 1st through the 15th classes, 0.5 each in counties of the 16th through the 31st classes, and 0.25 each in counties of the 32nd through the 58th classes. For the purposes of this provision, "court interpreter coordinators" may be full- or part-time court employees, and shall be concurrently certified and registered court interpreters in good standing under existing law.

25. The Judicial Council shall set statewide or regional rates and policies for payment of court interpreters, not to exceed the rate paid to certified interpreters in the federal court system.
26. The Judicial Council shall adopt appropriate rules and procedures for the administration of these funds. The Judicial Council shall report to the Legislature and the Director of Finance annually regarding expenditure of the funds appropriated in Schedule (4).
27. Of the funds appropriated in Schedule (1), $7,000,000 shall be available for the Judicial Council to establish a methodology to allocate a share of resources to all courts to cover the costs associated with the increased transcript rates.
28. Of the amount appropriated in this item, $100,000,000 shall be allocated by the Judicial Council to increase equity in funding between trial courts by allocating these funds to the lowest funded trial courts so that all trial courts have at least 84.5 percent of their workload formula identified need.
29. The Judicial Council shall annually report to the Legislature on the operations of each trial court that includes various operational and budgetary metrics. These metrics shall include, but are not limited to, all of the following: time to disposition and case clearance rates by case type, backlogs by case type, court hours of operations including public counter hours, staff vacancy rates by classification, fund balance detail from the prior fiscal year, calculated funding level of each court and the percent of funding actually provided to each court, and funding level of each trial court as measured by the Judicial Council-approved workload formula. This report shall be submitted no later than

February 1 and reflect metrics from the prior fiscal year.

30. Of the amount appropriated in Schedule (1), $30,000,000 shall be allocated by the Judicial Council in a manner that ensures all courts are allocated funds to be utilized to increase the number of official court reporters in family and civil law cases. This funding may be used for recruitment and retention purposes, filling existing vacancies, converting part-time positions to full-time positions, increasing salary schedules, and providing signing and retention bonuses to enable trial courts to compete with private employers in the labor market. This funding shall not supplant existing trial court expenditures on court reports in family law and civil law cases. Any unspent funds shall revert to the General Fund.
31. Of the amount appropriated in Schedule (5), $16,000,000 shall be allocated to the California Court Appointed Special Advocate Association to provide funding to the local court-appointed special advocate (CASA) programs to expand capacity, recruitment, and training and to stabilize local budgets and staffing.
32. Of the amount appropriated in Schedule (5), $4,000,000 shall be allocated to the California Court Appointed Special Advocate Association to be used statewide for volunteer recruitment initiatives, shared resources and infrastructure, development of statewide training curriculum, collection of data on program implementation and outcomes to support the report to the Legislature, and other uses to expand court-appointed special advocate (CASA) services in the state.
33. Of the amount appropriated in Schedule (5), $20,000,000 shall be available for expenditure for an encumbrance period of two years ending June 30, 2024.
34. The Judicial Council shall annually report to the Legislature on the court-appointed special advocate (CASA) program implementation and outcomes. The initial report shall be due on July 1, 2023, and will describe funding allocations and program development.
35. Upon approval by the Administrative Director, the Controller shall transfer up to $100,000 appropriated in Schedule (5) to Item 0250-001-0001 for administrative costs of the Judicial Council for implementing development of the programs described in Provisions 31 and 32.

36. Of the funds appropriated in Schedule (1), $2,828,000 is available for the implementation of the Community Assistance, Recovery, and Empowerment Act. These funds are contingent upon adoption of statutory changes codifying the Community Assistance, Recovery, and Empowerment Act.

SEC. 4. Item 0250-111-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-111-0001—For transfer by the Controller to the Trial Court Trust Fund..... 1,753,999,000
Provisions:
1. Upon order of the Department of Finance, the amount available for transfer in this item may be increased by an amount sufficient to fund trial court employee benefit increases in the 2022–23 fiscal year.
2. Of the funds appropriated in this item, $2,828,000 is available for the implementation of the Community Assistance, Recovery, and Empowerment Act. These funds are contingent upon adoption of statutory changes codifying the Community Assistance, Recovery, and Empowerment Act.

SEC. 5. Item 0250-162-8506 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-162-8506—For local assistance, Judicial Branch, payable from the Coronavirus Fiscal Recovery Fund of 2021..... 20,000,000
Schedule:
(2) 0150083-Equal Access Fund..... 20,000,000
Provisions:
1. The funding in Schedule (2) shall be distributed by the Judicial Council through the Legal Services Trust Fund Commission of the State Bar of California pursuant to this provision to qualified legal services projects and support centers to provide eviction defense, other tenant defense assistance in landlord-tenant rental disputes, or services to prevent foreclosure for homeowners, including pre-eviction and eviction legal services, counseling, advice and consultation, mediation, training, renter education, and representation, and legal services to improve habitability, increasing affordable housing, ensuring receipt of eligible income or benefits to improve housing stability, legal help for persons displaced because of domestic violence, and homelessness prevention. Of this amount,

no more than 5 percent shall be available, upon order of the Department of Finance, for administrative costs of the Judicial Council and the State Bar of California, provided that funds spent shall not exceed the actual costs of administration. Unspent administrative funds shall be redistributed to qualifying grantees as prescribed by the commission.

2. The funds, after covering administrative costs as described in Provision 1, shall be used to provide funds during the 2022–23 fiscal year pursuant to homelessness prevention grants already awarded by the Legal Services Trust Fund Commission to qualified legal services projects and support centers pursuant to Item 0250-162-8506, Budget Act of 2021 (Chs. 21, 69, and 240, Stats. 2021).
3. Funds appropriated in Schedule (2) are available for encumbrance or expenditure until December 31, 2024.
4. The State Bar of California shall annually provide to the Judicial Council a report that includes funding allocations, annual expenditures, and program outcomes by service area, and service provider for all Equal Access Fund and federal funding. Data shall be reported using the established reporting framework in the Equal Access Program including applicable outcome measures reported in Legal Services standardized reporting, state level performance measures, and main benefits scores. The Judicial Council shall provide the report to the Department of Finance by January 1 of each year for the prior fiscal year.

SEC. 6. Item 0250-301-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0250-301-0001—For capital outlay, Judicial Branch.....		175,527,000
Schedule:		
(1) 0000089-Los Angeles County: New Santa Clarita Courthouse.....	53,050,000	
(a) Acquisition.....	41,749,000	
(b) Performance criteria.....	11,301,000	
(2) 0000099-Plumas County: New Quincy Courthouse.....	7,063,000	
(a) Acquisition.....	3,961,000	
(b) Performance criteria.....	3,102,000	
(2.5) 0000111-Shasta County: New Redding Courthouse	10,000,000	

Schedule:
(1) 0270-Administration of Transportation Agency..... 3,814,000
(2) 0275-California Traffic Safety Program..... 795,000

SEC. 15. Item 0521-001-0044 of Section 2.00 of the Budget Act of 2022 is amended to read:

0521-001-0044—For support of Secretary of Transportation, payable from the Motor Vehicle Account, State Transportation Fund..... 1,456,000
Schedule:
(1) 0270-Administration of Transportation Agency..... 1,195,000
(2) 0275-California Traffic Safety Program..... 261,000

SEC. 16. Item 0521-001-0046 of Section 2.00 of the Budget Act of 2022 is amended to read:

0521-001-0046—For support of Secretary of Transportation, payable from the Public Transportation Account, State Transportation Fund..... 1,513,000
Schedule:
(1) 0270-Administration of Transportation Agency..... 1,255,000
(2) 0275-California Traffic Safety Program..... 252,000
(3) 0276-Transit and Intercity Rail Capital Program..... 6,000

SEC. 17. Item 0521-001-0890 of Section 2.00 of the Budget Act of 2022 is amended to read:

0521-001-0890—For support of Secretary of Transportation, payable from the Federal Trust Fund..... 8,143,000
Schedule:
(1) 0275-California Traffic Safety Program..... 8,143,000

SEC. 18. Item 0530-001-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0530-001-0001—For support of Secretary of California Health and Human Services..... 96,813,000

Schedule:

(1) 0280-Secretary of California Health and Human Services	77,207,000
(2) 0286-Office of Youth and Community Restoration	17,200,000
(2.3) 0296-Center for Data Insights and Innovations	275,000
(2.5) 0290-Office of Systems Integration	2,889,000
(3) 0297-Office of Surgeon General	1,793,000
(4) Reimbursements to 0280-Secretary of California Health and Human Services	−2,551,000

Provisions:

1. Of the amount appropriated in Schedule (1), $2,197,000 shall be available for encumbrance or expenditure until June 30, 2024, for consulting resources related to generic drug manufacturing.
2. Notwithstanding any other law, grants awarded or contracts entered into or amended pursuant to Provision 1 shall be exempt from the personal services contracting requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and from the Public Contract Code and the State Contracting Manual, and shall not be subject to the approval of the Department of General Services.
3. Of the amount appropriated in Schedule (1), $20,000,000 shall be available for encumbrance or expenditure until June 30, 2026, for the California Health and Human Services Agency to provide subject matter expertise and evaluation for the Children and Youth Behavioral Health Initiative.
4. Of the amount appropriated in Schedule (1), $1,000,000 shall be available for encumbrance or expenditure until June 30, 2025, for contracts related to the Healthy California for All Commission followup work.
10. Of the amount appropriated in this item, $500,000 shall be used toward the creation of an Equity Strategic Plan. The California Health and Human Services Agency shall consult with health and human services policy and fiscal legislative staff at regular intervals and at least biannually, beginning in the fall of 2022, on the programs, areas of inequities and disparities, and outcomes being considered toward the development of the plan. Once the Equity Strategic Plan is complete, the agency shall conduct a legislative

briefing with those legislative staff to review its contents, recommendations, and objectives.

11. Of the amount appropriated in Schedule (2.5), $2,889,000 shall be used for the Office of the Agency Information Officer and Office of Systems Integration and Enterprise Capabilities. The California Health and Human Services Agency shall report to the Legislature at regular intervals and at least on an annual basis, beginning January 10, 2023, on the benefits to participants and beneficiaries of impacted government programs, and which specific programs in the agency improved as a result of the resources provided in the Budget Act of 2022.
12. Of the funds appropriated in Schedule (2), $10,000,000 shall be available to the Office of Youth and Community Restoration for, including, but not limited to, providing technical assistance, disseminating best practices, and issuing grants to counties and probation departments for the purpose of transforming the juvenile justice system to improve outcomes for justice involved youth.
13. Of the funds appropriated in Schedule (1), $5,000,000 is available for encumbrance and expenditure until June 30, 2027, to support the Community Assistance, Recovery, and Empowerment Act. The availability of the funds for this purpose is contingent on the adoption of statutory changes codifying the Community Assistance, Recovery, and Empowerment Act.

SEC. 19. Item 0540-001-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

0540-001-0001—For support of Secretary of the Natural Resources Agency..... 61,757,000

Schedule:

(1) 0320-Administration of Natural Resources Agency..... 61,757,000

Provisions:

1. Of the amounts appropriated in this item, $50,000,000 shall be available to the Ocean Protection Council for grants or expenditures for resilience projects that conserve, protect, and restore marine wildlife and healthy ocean and coastal ecosystems.
2. Of the amounts appropriated in this item, up to $500,000 is allocated to support the California Carbon Sequestration and Climate Resiliency Project Registry

cess. The department shall publish the recipient, amount, and purpose of each grant on its public internet website.

7. Of the funds appropriated in this item, $12,500,000 in Schedule (2) shall be available for encumbrance or expenditure until June 30, 2026, to support a competitive grant pilot program for qualified nonprofit organizations to hire registered nurses and community health care workers to provide health education, navigation, coaching, and care to residents of senior citizen housing developments, as described in Sections 51.2 and 51.3 of the Civil Code, in the Counties of Contra Costa, Fresno, Orange, Riverside, Sacramento, San Diego, Shasta, and Sonoma. Upon completion of the pilot program, the department shall publish provide an evaluation of participation in the program, services utilized by participants, and participant outcomes to the Legislature upon completion of the pilot program. The department shall also publish this information on its public internet website. Of the amount described in this provision, no more than $1,900,000 may be utilized by the department for state operations purposes to support the administration of this program.

8. Notwithstanding any other law, the Department of Finance, upon request by the California Department of Aging, may transfer the amounts available to support state operations pursuant to Provisions 3 through 7 of this item between this item and Item 4170-001-0001. The amounts so transferred shall be available for encumbrance or expenditure for the same period specified by the respective provisions.

SEC. 134. Item 4260-001-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

4260-001-0001—For support of State Department of Health Care Services..... 528,306,000
Schedule:
(1) 3960-Health Care Services..... 553,385,000
(2) Reimbursements to 3960-Health Care Services..... −25,079,000
Provisions:
1. The State Department of Health Care Services shall provide a quarterly accounting of expenditures associated with the 8.0 audit positions for the Targeted Case Management Program identified in the Budget Act of

2010 (Ch. 712, Stats. 2010). The department shall make the quarterly accounting of expenditures available to designated representatives of the local government agencies not later than the last day of the third quarter of the 2010–11 fiscal year, and on the last day of each subsequent quarter thereafter.

2. (a) The State Department of Health Care Services shall withhold 1 percent of reimbursements to local educational agencies (LEAs) for the purpose of funding the work and related administrative costs associated with the audit resources approved in the Budget Act of 2010 (Ch. 712, Stats. 2010) to ensure fiscal accountability of the LEA Medi-Cal Billing Option Program and to comply with the Medi-Cal State Plan. The withheld percentage shall be applied to funds paid to LEAs for health services based upon the date of payment, and excluding cost settlement payments. Moneys collected as a result of the reduction in federal Medicaid payments allocable to LEAs shall be deposited into a special deposit fund account, which shall be established by the department. The department shall return all unexpended funds in the special deposit fund account proportionately to all LEAs that contributed to the account, during the second quarter of the subsequent fiscal year. The annual amount withheld shall not exceed $1,000,000, but may be adjusted with approval of the LEA Medi-Cal billing entities.

   (b) The State Department of Health Care Services shall provide a quarterly accounting of expenditures made from the special deposit fund account. The department shall make the quarterly accounting of expenditures available to the public not later than the last day of the third quarter of the 2010–11 fiscal year, and on the last day of each subsequent quarter thereafter.

3. The State Department of Health Care Services, in coordination with other state entities involved in the Medi-Cal Enterprise Systems modernization project efforts, shall provide the appropriate fiscal and policy committees of the Legislature, the Legislative Analyst's Office, the Department of Technology, and the California State Auditor with quarterly project status updates, including newly executed contracts, their purpose, and cost.

4. Of the funds appropriated in this item, $620,000 is to reimburse the State Department of Public Health for lease-revenue bond base rental payments associated with the State Department of Health Care Services' occupancy in the State Department of Public Health's Richmond Laboratory. The Controller shall transfer funds appropriated in this item to the State Department of Public Health, in the amount shown in this provision as and when provided for in the schedule submitted by the State Public Works Board.
5. Of the funds appropriated in this item, $63,405,000 in Schedule (1) is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services to administer the Behavioral Health Continuum Infrastructure Program.
6. Of the funds appropriated in this item, $424,000 in Schedule (1) is available for encumbrance or expenditure until June 30, 2025, for the State Department of Health Care Services to administer the Indian Health Grant Program, appropriated in Item 4260-111-0001.
7. Of the funds appropriated in this item, $24,000,000 in Schedule (1) is available for encumbrance or expenditure until June 30, 2025, for the State Department of Health Care Services to administer the Children and Youth Behavioral Health Initiative.
8. Of the funds appropriated in Schedule (1) of this item, $42,064,000 is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services to implement the Behavioral Health Bridge Housing Program.
9. Of the funds appropriated in Schedule (1) of this item $44,438,000 is available for encumbrance or expenditure until June 30, 2029, to support technical assistance and evaluation contracts for the CalAIM Initiative.
10. Of the funds appropriated in Schedule (1), $20,178,000 is available for the State Department of Health Care Services to support the Community Assistance, Recovery, and Empowerment Act. These funds are contingent on adoption of statutory changes codifying the Community Assistance, Recovery, and Empowerment Act. Of this amount, $14,050,000 is available for encumbrance or expenditure until June 30, 2027, to support contracts to provide technical assistance.
11. Of the funds appropriated in Schedule (1), $3,577,000 is available for the State Department of Health Care Services to support licensing and certification activities pursuant to Chapter 7.3(commencing with Section

11833.01) of Part 2 of Division 10.5 of the Health and Safety Code.

SEC. 135. Item 4260-101-0001 of Section 2.00 of the Budget Act of 2022 is amended to read:

4260-101-0001—For local assistance, State Department of Health Care Services, California Medical Assistance Program, payable from the Health Care Deposit Fund after transfer from the General Fund..... 34,535,034,000

Schedule:

(1) 3960014-Eligibility (County Administration)..... 1,345,282,000

(2) 3960018-Fiscal Intermediary Management..... 134,028,000

(3) 3960022-Benefits (Medical Care and Services)..... 35,017,685,000

(4) Reimbursements to 3960014-Eligibility (County Administration)..... −13,671,000

(5) Reimbursements to 3960022-Benefits (Medical Care and Services).... −1,948,290,000

Provisions:

1. The aggregate principal amount of disproportionate share hospital general obligation debt that may be issued in the current fiscal year pursuant to subparagraph (A) of paragraph (2) of subdivision (f) of Section 14085.5 of the Welfare and Institutions Code shall be $0.
2. Notwithstanding any other law, both the federal and nonfederal shares of any moneys recovered for previously paid health care services, provided pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code, are hereby appropriated and shall be expended as soon as practicable for medical care and services as defined in the Welfare and Institutions Code.
3. Notwithstanding any other law, accounts receivable for recoveries as described in Provision 2 shall have no effect upon the positive balance of the General Fund or the Health Care Deposit Fund. Notwithstanding any other law, moneys recovered as described in this item that are required to be transferred from the Health Care Deposit Fund to the General Fund shall be credited by the Controller to the General Fund without regard to the appropriation from which it was drawn.

4. Without regard to fiscal year, the General Fund shall make one or more loans available not to exceed a cumulative total of $45,000,000 to be transferred as needed to the Health Care Deposit Fund to meet cash needs. All moneys so transferred shall be repaid as soon as sufficient reimbursements have been collected to meet immediate cash needs and in installments as reimbursements accumulate if the loan is outstanding for more than one year.
5. Notwithstanding any other law, the State Department of Health Care Services may give public notice relative to proposing or amending any rule or regulation or administrative directive that could result in increased costs in the Medi-Cal program only after approval by the Department of Finance. Additionally, any rule or regulation adopted by the State Department of Health Care Services and any communication that increases costs in the Medi-Cal program shall be effective only after the date upon which it is approved by the Department of Finance.
6. Change orders to the medical or the dental fiscal intermediary contract for amounts exceeding a total cost of $250,000 shall be approved by the Department of Finance not sooner than 30 days after written notification of the change order is provided to the chairpersons of the fiscal and policy committees in each house of the Legislature and to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time after that notification as the chairperson of the joint committee, or the chairperson's designee, may determine. The semiannual estimates of Medi-Cal expenditures provided to the Legislature in January and May may constitute the notification required by this provision.
7. Recoveries of advances made to counties in prior years pursuant to Section 14153 of the Welfare and Institutions Code are reappropriated to the Health Care Deposit Fund for reimbursement of those counties where allowable costs exceeded the amounts advanced. Recoveries in excess of the amounts required to fully reimburse allowable costs shall be transferred to the General Fund. When a projected deficiency exists in the California Medical Assistance Program, these funds, subject to notification to the Chairperson of the Joint Legislative Budget Committee, are appropriated and shall be expended as soon as practicable for the

state's share of payments for medical care and services, county administration, and fiscal intermediary services.

8. The Department of Finance may transfer funds representing all or any portion of any estimated savings that are a result of improvements in the Medi-Cal claims processing procedures from the Medi-Cal services budget or the support budget of the State Department of Health Care Services (Item 4260-001-0001) to the fiscal intermediary budget item for purposes of making improvements to the Medi-Cal claims system.
9. Notwithstanding any other law, the Department of Finance may authorize the transfer of expenditure authority between schedules within this item and between this item and Items 4260-102-0001, 4260-111-0001, 4260-113-0001, 4260-114-0001, and 4260-117-0001 in order to effectively administer the programs funded in these items. The Department of Finance may revise reimbursement authority in this item in order to effectively administer the programs funded in those items. The Department of Finance shall notify the Legislature within 10 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code. The 10-day notification to the Legislature shall include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred or for which funds are being reduced.
10. If a federal grant that provides 75 percent federal financial participation to allow individuals in nursing homes to voluntarily move into a community setting and still receive the same amount of funding for services is awarded to the State Department of Health Care Services during the current fiscal year, then, notwithstanding any other law, the department may count expenditures from the appropriation made to this item as state matching funds for that grant.
11. Notwithstanding any other law, the Department of Finance may authorize an increase to this appropriation to address costs resulting from adverse court rulings. The Department of Finance shall provide a 30-day notice of any proposed increase to the Legislature. The notification shall include the specifics of any cases with adverse rulings and the overall fiscal impact. Submission of the semiannual Medi-Cal estimate provided to the Legislature in January and May shall

be considered meeting the notification requirement of this provision if the required information is included in the estimate.

12. The Department of Finance may augment the amount appropriated in this item up to $479,557,000 for repayment of over-claimed Title XXI federal funds related to the Non-Optional Targeted Low Income Children Program population of the Medicaid program. Repayment shall occur upon the final determination of the Centers for Medicare and Medicaid Services that associated Title XXI federal funds must be refunded by the state. The Department of Finance shall notify the Legislature within 10 days of authorizing an augmentation pursuant to this provision. The 10-day notification to the Legislature shall describe the reason for the augmentation and the fiscal assumptions used.
13. To the extent practicable and consistent with existing procedures, the State Department of Health Care Services, in its sole discretion, shall seek favorable terms from the federal government regarding the repayment of federal funds for state-only populations in order to minimize the annual impact on the General Fund in any individual fiscal year.
14. Of the funds appropriated in this item, $1,163,750,000 in Schedule (3) is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services to implement the Behavioral Health Continuum Infrastructure Program.
15. (a) Of the amount appropriated in this item, $70,000,000 in Schedule (3) is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services (DHCS) to make equity and practice transformation payments to qualifying Medi-Cal managed care plans, or through Medi-Cal managed care plans to their qualified contracted providers, to advance equity, reduce COVID-19-driven care gaps, invest in upstream care models and partnerships to address health and wellness for ages zero to five, and fund practice transformation aligned with value-based payment models to allow Medi-Cal providers to better serve the state's diverse Medi-Cal enrollee population. Subject to subprovision (b), payments pursuant to this provision are intended to promote patient-centered models of care and align with the goals of the DHCS' Comprehensive Quality Strategy.

(b) The State Department of Health Care Services shall develop the methodology, eligibility criteria, metrics, performance milestones, and any other parameters for receipt of payments authorized in this provision.

(c) This provision shall be implemented only to the extent any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this provision and any associated federal funding by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(e) For purposes of this provision, "Medi-Cal managed care plan" shall have the same meaning as provided in subdivision (j) of Section 14184.101 of the Welfare and Institutions Code.

16. Of the amount appropriated in this item, $230,000,000 in Schedule (1) and $879,000,000 in Schedule (3) are available for encumbrance or expenditure until June 30, 2025, for the Children and Youth Behavioral Health Initiative.

17. (a) Of the funds appropriated in this item, $957,936,000 in Schedule (3) is available to implement the Behavioral Health Bridge Housing Program to award competitive grants to qualified counties and tribal entities to address the immediate housing and treatment needs of people experiencing unsheltered homelessness who have serious behavioral health conditions and shall be available for encumbrance or expenditure until June 30, 2027.

(b) The State Department of Health Care Services shall determine the methodology and distribution of the grant funds appropriated for the Behavioral Health Bridge Housing Program.

(c) An entity shall expend funds to supplement and not supplant existing funds provided for the housing and treatment needs of people experiencing unsheltered homelessness who have serious behavioral health conditions to receive grant funds.

(d) The Behavioral Health Bridge Housing Program shall be implemented only if, and to the extent that, the State Department of Health Care Services determines that federal financial participation under the Medi-Cal program is not jeopardized.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.

(f) For purposes of implementing the Behavioral Health Bridge Housing Program, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

18. (a) Of the funds appropriated in Schedule (3), $100,000,000 is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services to provide grant funding to Los Angeles County to support and expand access to treatment for individuals with behavioral health disorders that are involved in the justice system. Of the $100,000,000 grant funding, $50,000,000 shall support individuals charged with a misdemeanor and found incompetent to stand trial.

(b) Upon order of the Department of Finance, up to $780,000 of the funds made available pursuant to this provision shall be transferred to Schedule (1) of Item 4260-001-0001 for administration of the program described in subprovision (a) and are available for encumbrance or expenditure until June 30, 2027.

(c) (1) Of the grant funding provided pursuant to this provision, at least 75 percent shall be allocated for capital costs to construct, acquire, or rehabilitate real estate assets for use as non-correctional treatment and housing facilities to serve the target population described in subprovision (a). This may include, but is not limited to, residential treatment settings, clinically enhanced interim housing settings, licensed adult and senior care settings, permanent supportive housing, or a capitalized operating subsidy reserve.

(2) Of the grant funding provided pursuant to the provision, up to 25 percent may be allocated for rental subsidies to support placement of the target population described in subprovision (a) within qualified residential settings.

(d) As determined by the State Department of Health Care Services, the County of Los Angeles shall meet all of the following conditions in order to receive grant funding pursuant to this provision: (1) provide qualifying matching funds or real property, as approved by the State Department of Health Care Services, that is equal to at least 10 percent of the grant funding provided; (2) expend grant funding to supplement and not supplant existing funding available for the purposes described in this provision; (3) report relevant data to the State Department of Health Care Services, in a form, manner, and frequency it requires, for the first 5 years of implementation; and (4) for capital costs described in paragraph (1) of subdivision (c), commit to providing health care treatment or housing, or both, for the target population described in subdivision (a) in the financed facility or facilities for a minimum of 30 years.

(e) This provision shall be implemented only if, and to the extent that, the State Department of Health Care Services determines that federal financial participation under the Medi-Cal program is not jeopardized.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of information notices or other

similar instructions, without taking any further regulatory action.

(g) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and shall be exempt from the review or approval of any division of the Department of General Services.

19. (a) Of the funds appropriated in this item, $80,000,000 in Schedule (3) is for the State Department of Health Care Services to support CalHOPE and $1,500,000 in Schedule (1) is for the State Department of Health Care Services to support planning efforts for the behavioral health crisis continuum of care.

(b) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and shall be exempt from the review or approval of any division of the Department of General Services.

20. Notwithstanding any other law, the Department of Finance may adjust amounts in this item, Item 4260-111-0001, or any other related item resulting from the State Department of Health Care Services obtaining federal approval to claim federal financial participation for expenditures associated with Designated State Health Programs as part of the CalAIM Demonstration. Within 30 days of making any adjustment pursuant to this provision, the Department of Finance shall report the adjustment in writing to the Joint Legislative Budget Committee.

21. (a) The nonfederal share amounts received by the State Department of Health Care Services as monetary sanctions collected in the 2022–23 state fiscal year pursuant to subdivision (g) of Section 14197.7 of the Welfare and Institutions Code shall, pursuant to paragraph (1) of subdivision (q) of Section 14197.7 of the Welfare and Institutions Code, be deposited into the General Fund.
    (b) This item shall be augmented by the amount deposited into the General Fund pursuant to subdivision (a), which shall be available for encumbrance or expenditure until June 30, 2024, for the State Department of Health Care Services to award grants to qualifying, non-profit legal aid programs and organizations that serve Medi-Cal managed care enrollees in the County of Los Angeles or other impacted counties, as necessary.
    (c) The State Department of Health Care Services shall determine the eligibility criteria, methodology, and distribution of funds appropriated in this provision.
    (d) The State Department of Health Care Services may enter into exclusive or non-exclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this provision. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and from the State Administrative and State Contracting manuals, and shall be exempt from the review or approval of any division of the Department of General Services.
22. (a) Of the amounts appropriated in Schedule (3), $114,422,000 shall be allocated for the State Department of Health Care Services to forego the recoupment of overpayments from independent pharmacies resulting from implementation of the federally approved actual acquisition cost reimbursement methodology described in Section 14105.45 of the Welfare and Institutions Code for dates of service on or after April 1, 2017, through February 22, 2019, inclusive.

(b) For purposes of this provision, "independent pharmacy" means a pharmacy owned by a person or entity who owns no more than 74 pharmacies in California.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this provision, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(d) This provision shall be implemented only to the extent that the State Department of Health Care Services determines that federal financial participation under the Medi-Cal program is not jeopardized.

23. (a) Of the amounts appropriated in Schedule (3), $20,000,000 is available for encumbrance and expenditure until June 30, 2028, to establish the Los Angeles County Abortion Access Safe Haven Pilot Program for the purpose of expanding and improving access to the full spectrum of sexual and reproductive health care, including abortion, in the County of Los Angeles.

(1) Up to eight percent of the funds may be used by a Program Administrator for the Los Angeles County Abortion Access Safe Haven Pilot Program, as designated by the County of Los Angeles, to cover administrative costs related to completing activities consistent with this provision.

(b) Funds allocated to the Program Administrator, as designated by the County of Los Angeles, for the Los Angeles County Abortion Access Safe Haven Pilot Program shall be used to administer a pilot project to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions. Funds may be used for the purpose of implementing recommendations from the County of Los Angeles, including, but not limited to, any of the following:

(1) Providing medically accurate education and training tools to the community.

(2) Providing training to health care workers and abortion providers.

(3) Building secure infrastructure.

(4) Countering misinformation campaigns and providing medically accurate information to health care providers and patients.
(5) Coordinating care and patient support services.
(6) Advancing and improving access to abortion.

(c) The Program Administrator shall use funds allocated under this provision to maintain a system of financial reporting on all aspects of the fund. The financial reporting shall include information on expenditures and activities using the funds associated with this provision to ensure the use of the funds are consistent with the purposes of this provision.
(1) For purposes of this provision, the Program Administrator shall not require the submission of any identifying personal information about individuals providing, participating in, or receiving any service as part of an application for a grant or reporting of expenditures and activities using grant funds under this provision. Information required by the Program Administrator may only include information in summary, statistical, or other forms that do not identify particular individuals.

(d) The Program Administrator, as designated by the County of Los Angeles, shall determine a funding framework to prioritize funding for pilot programs and projects in consultation with stakeholders, including representatives from the local Department of Public Health, Office of the Los Angeles County CEO, sexual and reproductive health providers that serve the region, and reproductive health, rights, and justice community-based organizations.

(e) The Program Administrator shall provide an annual report to the Legislature summarizing the projects and collaborations funded under this section. The report shall also include data on the balances of funds available under this division for expenditures in that fiscal year and future fiscal years. The first annual report shall be submitted on or before January 1, 2025, and shall cover the period of July 1, 2023, to July 1, 2024, inclusive. Each subsequent annual report shall be submitted on or before January 1, and shall cover the previous fiscal year. The report shall be submitted in

compliance with Section 9795 of the Government Code.

(f) The Legislature finds and declares that California, to protect the safety of those individuals and organization seeking, providing, and supporting access to abortion in the State, has an interest in protecting the privacy of these individuals and organizations that outweighs the public's right of access to grant applications and financial information involving these individuals and organizations.

(1) An application for a grant under this article and financial reporting by grantees are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(g) The State Department of Health Care Services may enter into exclusive or non-exclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this provision. Contracts entered into or amended pursuant to this provision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

24. (a) Of the amounts appropriated in Schedule (3), $10,000,000 is available to backfill the loss of federal Title X family planning funding to maintain and support the delivery of equitable, affordable, high quality, client-centered family planning services to patients with low-incomes across the state.

(b) The State Department of Health Care Services shall receive and provide the funds to Essential Access Health, the designated statewide federal Title X grantee, no later than September 30, 2022.

(c) Funding provided to Essential Access Health may be used for the following purposes:

(1) Meetings between parties at the beginning of a project.

(2) Facilitation of the subcontract agreement and transfer of funds to Essential Access Health

from the State Department of Health Care Services.

(3) Distribution of funds by Essential Access Health to current members of the state's statewide federal Title X network to make up for the unexpected loss of federal funding and prevent any disruption in the delivery of family planning and related services during the 2022–23 state fiscal year.

(4) Drafting and submission of a final report required under subprovision (d).

(d) Essential Access Health shall prepare and submit a report of expenditures, numbers of patient served, and other information that aligns with Title X Family Planning Annual Report requirements and guidelines, to the State Department of Health Care Services no later June 1, 2023.

(e) The State Department of Health Care Services shall submit the report to the Legislature no later than June 30, 2023.

(f) Ninety-two percent of funding shall be distributed to members of the current statewide Title X provider network that includes federally qualified health centers, city and county health departments, Urban Indian Health Centers, universities, hospitals, Planned Parenthood affiliates, and other stand-alone family planning and women's health centers.

(g) Eight percent of funds may be allocated to Essential Access Health to cover administrative costs related to completing activities consistent with this provision.

25. Of the amounts appropriated in Schedule (3), $10,000,000 is available to support grants to St. Paul's Program for All-Inclusive Care for the Elderly (PACE) in San Diego for health information technology, housing, or wellness infrastructure projects.

26. Of the amounts appropriated in Schedule (3), $10,000,000 is available for the Alameda County Health Care Services Agency to fund supportive services for chronically homeless and special needs residents.

27. (a) Of the amounts appropriated in Schedule (3), $120,500,000 is available for encumbrance or expenditure until June 30, 2025, for the State Department of Health Care Services to support wellness and resilience building supports for

children, youth, and parents, support the School-Based Peer Mental Health Demonstration project, develop a video series to provide parents with resources and skills to support their children's mental health, and to develop next generation digital supports for remote mental health assessment and intervention.

(b) Of the amount available in this provision, $75,000,000 is to support wellness and resilience building supports for children, youth, and parents, including support of well-being and mindfulness programs and providing support and training for parents. The support shall be provided in kindergarten and grades 1 through 12, inclusive, school-based or community-based settings that teach wellness and mindfulness practices to teachers and students and support schools and community-based programs to incorporate wellness and mindfulness programs on a regular basis into the school day, before and after school programs, summer school, and community-based settings. These programs shall align with the community schools model by providing integrated student supports to meet academic, physical, social, emotional, and mental health needs, as well as expanded and enriched learning opportunities. For the purpose of administering these grants, the department shall prioritize, to the extent feasible, existing partnerships, which may include those that have been established with resources and support from the Mental Health Student Services Act Partnership Grant Program.

(c) Of the amount available in this provision, $10,000,000 is available to support the School-Based Peer Mental Health Demonstration project, to provide grants to up to eight high schools (grades 9 through 12, inclusive) in urban, suburban, and rural areas of the state to establish peer-to-peer support programs. The State Department of Health Care Services shall enter into a contract with the Children's Partnership to administer this project. The Children's Partnership may utilize up to $2,000,000 of this funding for administration of this project. The Children's Partnership shall define best practices, develop statewide standards for peer-to-peer support programs, and administer a competitive grant application process to award

grants to schools. The Children's Partnership shall develop a request for proposals, select grant recipients, provide technical assistance to grantees, and design and facilitate a demonstration project learning community. Schools with student populations recognized to be at elevated risk for mental health challenges, such as depression, anxiety, and suicide, shall be prioritized for receiving grants. The department shall consult with stakeholders on the implementation of the School-Based Peer Mental Health Demonstration project.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.

(e) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

28. (a) Of amounts appropriated in Schedule (3), $16,423,000 is available for encumbrance or expenditure until June 30, 2025 for the State Department of Health Care Services to support the peer-run warm line administered by the Mental Health Association of San Francisco.

(b) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2

(commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

29. (a) Of the amounts appropriated in Schedule (3), $14,849,000 is available for encumbrance or expenditure until June 30, 2024 for the State Department of Health Care Services to implement a supplemental payment program for nonhospital community clinics, as defined in subdivision (a) of Section 1204 of the Health and Safety Code, that incur significant costs associated with providing abortion services and serve Medi-Cal beneficiaries and meet all the following criteria during the 2022–23 fiscal year:
    (1) Is enrolled as a Medi-Cal provider.
    (2) Does not meet the definition of a federally-qualified health center pursuant to Section 1396(d)(*l*)(2) of Title 42 of the United States Code.
    (3) Provides Medi-Cal covered abortion services, as defined in subdivision (a) of Section 123464 of the Health and Safety Code, to Medi-Cal beneficiaries, including beneficiaries eligible on the basis of presumptive eligibility.
    (4) Any other conditions or criteria established by the State Department of Health Care Services pursuant to subprovision (c).

    (b) No earlier than January 1, 2023, the department shall make available supplemental payments to qualifying nonhospital community clinics in accordance with the methodology established pursuant to subprovision (c), not to exceed the aggregate amount of funds made available for this purpose.

    (c) The department shall develop, establish, and maintain the methodology, eligibility criteria, conditions, and payment amounts for the supplemental payments described this provision, in consultation with eligible nonhospital community clinics.

    (d) The department shall implement this provision only to the extent that federal financial participation under the Medi-Cal program is not jeopardized.

(e) Notwithstanding Chapter 3.5 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this provision, in whole or in part, by means of provider bulletins, letters, or other similar instructions, without taking any further regulatory action.

30. Of the amounts appropriated in Schedule (3), $2,000,000 shall be available to support free and charitable clinics that primarily utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision, or behavioral health services to economically disadvantaged individuals regardless of their ability to pay. The eligible entities shall be 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization and not qualify as Medi-Cal providers. The funds shall be distributed to the California Association of Free and Charitable Clinics. The amount allocated to each free clinic shall be determined through an allocation methodology developed by the California Association of Free and Charitable Clinics.

31. (a) Of the amounts appropriated in Schedule (3), $5,000,000 is available for encumbrance or expenditure until June 30, 2025 for the State Department of Health Care Services to implement the Foster Youth Substance Use Disorder Evidence-Based and Promising Practices Program, a grant program to fund the development and implementation of evidence-based models and promising practices to serve foster youth with substance use disorders, including those who are residing in family-based settings.

(b) Upon order of the Department of Finance, up to $800,000 of the funds made available pursuant to this provision may be transferred to Schedule (1) of Item 4260-001-0001 for administration of the program described in subprovision (a) and are available for encumbrance or expenditure until June 30, 2025, even if transferred.

(c) The State Department of Health Care Services shall administer the grant program consistent with the requirements of this provision and with the input of the stakeholders described in subprovision (e). The State Department of Health Care Services shall determine the methodology and

distribution of funds appropriated in this provision.

(d) In establishing the grant program described in this provision, the State Department of Health Care Services shall do all of the following:
   (1) Develop an application process for eligible applicants, which includes county child welfare agencies, county probation agencies, county behavioral health agencies, foster family agencies, substance use disorder providers, tribal organizations within the state that serve as child welfare services agencies, short term residential therapeutic programs, and wraparound service providers.
   (2) Develop criteria for awarding funding.
   (3) Establish requirements for models and practices funded with a grant described in this provision. The requirements shall include that the models and practices include, at minimum, trauma-informed approaches to serving foster youth, harm-reduction approaches in service delivery, post treatment support planning, and training for clinical service providers to support foster youth with co-occurring substance use and mental health needs.
   (4) Require grantees to collect data relating to the models and practices funded with a grant described in this section.
   (5) Require grantees to submit reports, including reports that address the grantee's implementation activities, the number and characteristics of youth served, and completion rates, and an outcome report.

(e) The State Department of Health Care Services shall convene stakeholders, in partnership with the California Department of Social Services, to advise in the development of the grant program, including, but not limited to, the Chief Probation Officers of California, County Behavioral Health Directors Association of California, County Welfare Directors Association of California, substance use disorder providers, children and youth advocacy organizations, and other stakeholders, as determined by the department. The department shall seek out and identify evidence-based models and promising practices in California and

in other states to provide guidance and support to grantees in the implementation of local programs.

(f) The State Department of Health Care Services, in consultation with the Department of Social Services, shall provide technical assistance to grantees described in this provision to support implementation of evidence-based models and promising practices, including strategies to access funding through specialty mental health services and other Medi-Cal funding, consistent with federal and state laws.

(g) Notwithstanding Chapter 3.5 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this provision by means of information notices or other similar instructions, without taking any further regulatory action.

(h) The State Department of Health Care Services shall submit a report in compliance with Section 9795 of the Government Code including the number of applicant agencies, number of grantees, number of youth served, reported outcomes, and other information obtained pursuant to subprovision (d) upon completion of the Foster Youth Substance Use Disorder Evidence-Based and Promising Practices Program.

(i) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(j) The State Department of Health Care Services shall implement this provision only to extent it determines that federal financial participation under the Medi-Cal program is not jeopardized.

32. (a) Of the funds appropriated in Schedule (1), $57,000,000 is available for the State Department of Health Care Services, contingent on passage

of the Community Assistance, Recovery, and Empowerment Act. The funding shall be distributed by the Controller pursuant to a county schedule provided by the department created in consultation with the California State Association of Counties. The California State Association of Counties shall consult with Urban Counties of California and Rural County Representatives of California. The Controller shall remit funds to a county within 30 days of notification. In order to receive the funding, counties shall report to the State Department of Health Care Services the information necessary to process the payments. The State Department of Health Care Services may issue guidance as necessary regarding the allowable use of the funding.

(b) Of the amount allocated in this provision, $31,000,000 is available to support planning and preparation activities, including, but not limited to, hiring, training, and development of policies and procedures, and to support information technology infrastructure costs, including, but not limited to, changes needed to electronic medical record systems, changes to collect needed reporting data, and case tracking and new billing processes to bill commercial plans, and excluding capital expenses.

(c) Of the amount allocated in this provision, $26,000,000 is available to support Cohort I county planning and preparation to implement the Community Assistance, Recovery, and Empowerment Act.

33. Of the amount appropriated in Schedule (3) of this item, $25,000,000 shall be available for the County of Santa Cruz to support the Pajaro Valley Health Care District acquisition of Watsonville Community Hospital.

34. (a) Of the funds appropriated in Schedule (3), up to $10,000,000 is available for the Hearing Aid Coverage for Children Program for the purpose of providing medically necessary hearing aids and related services to eligible persons as described in subprovision (b).

(b) A person is eligible for the program described in this provision if they meet all of the following criteria:

(1) (A) The person is under 18 years of age; or (B) effective January 1, 2023, the person is under 21 years of age.
(2) The person's household income does not exceed 600 percent of the federal poverty level.
(3) The person is not eligible for the Medi-Cal program or the California Children's Services Program.
(4) The person does not have health insurance coverage for hearing aids.

(c) For purposes of paragraph (4) of subprovision (b), a person is deemed to have no health insurance coverage if any of the following apply:
(1) The person has no health insurance coverage.
(2) The person has health insurance coverage that excludes coverage for hearing aids.
(3) Effective January 1, 2023, the person has health insurance coverage that has a coverage limit of $1,500 or less for hearing aids.

(d) The State Department of Health Care Services shall specify the benefits and services provided to eligible persons under the program described in this provision. This shall include hearing aids, including bone conduction devices, when medically necessary.

(e) The State Department of Health Care Services shall develop processes to ensure, to the extent practicable, health insurance coverage for hearing aids and related services covered pursuant to this provision is used before the Hearing Aid Coverage for Children Program is billed.

(f) The State Department of Health Care Services may contract with public and private entities in order to implement this provision. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 1 (commencing with Section 14600) of Part 5.5 of Division 3 of Title 2 of the Government Code, Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Contracting Manual and the State Administrative Manual, and shall be exempt

from the review or approval of any division of the State Department of General Services.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this provision, in whole or in part, by means of provider bulletin or similar instructions, without taking any further regulatory action.

35. Of the amount in Schedule (3), $70,000,000 shall be available for encumbrance or expenditure until June 30, 2024, for the State Department of Health Care Services to implement a clinic workforce stabilization retention payment program.

SEC. 136. Item 4260-116-0890 of Section 2.00 of the Budget Act of 2022 is amended to read:

4260-116-0890—For local assistance, State Department of Health Care Services, payable from the Federal Trust Fund..... 276,577,000

Schedule:

(1) 3960050-Other Care Services..... 276,577,000

Provisions:

1. Notwithstanding any other law, the Director of Finance may authorize the transfer of expenditure authority between this item and Item 4260-115-0890 in order to effectively administer the programs funded in these items. The Director of Finance shall notify the Legislature within 10 days of authorizing such a transfer. The 10-day notification to the Legislature shall include the reason for transfer and any potential fiscal effects on the program from which funds are being transferred or reduced.
2. For purposes of implementing federal grants included in this item, that address the opioid and stimulant epidemics through prevention, treatment, harm reduction, or recovery services, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Adminis-

Exhibit 3

Pages: RJN-0089 through RJN-0125

**Assembly Committee on Health, Analysis,
Date of Hearing: June 28, 2022**

**Legislative History Report and Analysis for
Senate Bill 1338 (Umberg & Eggman –
2022) Chapter 319, Statutes of 2022**

Date of Hearing: June 28, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 1338(Umberg) – As Amended June 16, 2022
AS PROPOSED TO BE AMENDED

SENATE VOTE: Not relevant

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

SUMMARY: Establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Program and the CARE Act to provide comprehensive treatment, housing and support services to Californians with complex behavioral health care needs. Specifically, **this bill**:

I. Specifies the Following Findings and Declarations

1) That thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

2) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. Too often, this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

   California has made unprecedented investments in behavioral health, housing, and combating homelessness and CARE Court helps those with the greatest needs access these resources and services. CARE Court provides a framework to ensure counties and other local government entities focus their efforts to provide comprehensive treatment, housing and support services to Californians with complex behavioral health care needs so they can stabilize and find a path to wellness and recover.

3) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses (SMI) and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new CARE Court Program.

4) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated SMI with the establishment of a new CARE Supporter role, in addition to legal counsel, for CARE proceedings.

5) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution for some of the most ill and most vulnerable Californians.

II. General Provisions

1) Establishes the CARE Act and states it is the intent of the Legislature that the CARE Act be implemented in a manner that ensures it is effective.

2) Requires the CARE Act to be implemented, with technical assistance and continuous quality improvement as follows:

   a) A first cohort of counties, representing at least half of the population of the State, will begin no later than July 1, 2023, with additional funding provided to support the earlier implementation date; and,
   b) A second cohort of counties, representing the remaining population of the State, will begin no later than July 1, 2024.

3) Defines, for purposes of this bill, certain terms, including:

   a) "CARE agreement" means a voluntary settlement agreement, which includes the same elements as a CARE plan in accessing community-based services and supports;
   b) "CARE plan" means an individualized, appropriate range of community-based services and supports as set forth in the CARE Act, which includes clinically appropriate behavioral health care and stabilization medications, housing and other supportive services as appropriate;
   c) "Counsel" means the attorney representing the respondent, as provided by the CARE Act or chosen by the respondent, in CARE proceedings and matters related to CARE agreements and CARE plans;
   d) "County behavioral health agency" means the local director of mental health services, the local behavioral health director or both as applicable, or their designee;
   e) "Court-ordered evaluation" means an evaluation ordered by a superior court under the CARE Act.
   f) "Graduation plan" means a voluntary agreement entered into by the parties at the end of the CARE program that shall include 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 local government entities and is not enforceable by the court;
   g) "Indian health care provider" means a health care program operated by the Indian Health Services, an Indian tribe, a tribal organization, or urban Indian organization, as specified in the federal Indian Health Care Improvement Act;
   h) "Licensed behavioral health professional" means either of the following:
      i) A licensed mental health professional, as defined; or,
      ii) A person who has been granted a waiver of licensure requirements by the California Department of Health Care Services (DHCS).
   i) "Parties" means the respondent, the county behavioral health agency in the county where CARE Court proceedings under the CARE Act are pending, and other parties that the court may add if they are providing services to the respondent;
   j) "Psychiatric advance directive" means a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis;
   k) "Respondent" means the person who is subject to the petition for CARE Court proceedings;

l) "Stabilization medications" means medications included in the CARE plan that primarily consist of antipsychotic medication to reduce symptoms of hallucinations, delusions, and disorganized thinking. Stabilization medications may be administered as long acting injections if clinically indicated. Stabilization medication cannot be forcibly administered;
m) "Supporter" means an adult, as designated, who assists the respondent to include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE Court process, including a CARE agreement, a CARE plan, and developing a graduation plan. A supporter may not act independently.
n) "Trauma-informed care" means practices that recognize and respond to the signs, symptoms, and risks of trauma to better support the health needs of patients who have experienced Adverse Childhood Experiences (ACEs) and toxic stress.

III. Process:

1) Requires a respondent to qualify for CARE proceedings 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 SMI, as defined and has a diagnosis of schizophrenia spectrum or other psychotic disorder as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, provided that nothing is construed to establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including but not limited to physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. Prohibits a person who has a current diagnosis of substance use disorder (SUD) as defined but who does not meet the required criteria above, from qualifying for CARE proceedings;
   c) The person is not clinically stabilized in on-going 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; and/or,
      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 the CARE proceedings would be the least restrictive alternative necessary to ensure the person's recovery and stability; and,
   f) It is likely that the person will benefit from CARE proceedings.

2) Permits proceedings to commence in any of the following:

   a) The county in which the respondent resides;
   b) The county where the respondent is found. If the respondent does not reside in the county in which proceedings are initiated under the CARE Act and, and the CARE Act is operative in the respondent's county of residence, the proceeding will, with the respondent's consent, be transferred to the county of residence as soon as reasonably feasible. Should the respondent not provide consent to the transfer, the proceedings will continue in the county where the respondent was found; and,
   c) The county where the respondent is facing criminal or civil proceedings.

3) Allows a petition to initiate a CARE proceedings to be brought by:

   a) A person 18 years of age or older with whom the respondent resides or a spouse, parent, adult sibling, adult child, or grandparent of the respondent, or another adult 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 and transportation under the Lanterman-Petris-Short (LPS) Act, 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 of the county in which the respondent is present or reasonably believed to be present (a respondent may be referred from conservatorship proceedings);
   f) The director of a county behavioral health agency, or their designee, of the county in which the respondent resides or is found (a respondent may be referred from assisted outpatient treatment (AOT) proceedings);
   g) The director of the county Adult Protective Services or their designee of the county in which the respondent resides or is found;
   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) A prosecuting attorney (a respondent may be referred from misdemeanor proceedings, as provided); and,
   k) The respondent.

4) Requires the CARE petition to be signed under penalty of perjury and to contain all of the following:

   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 III.1) above; and,
   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 has 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; or,

ii) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to the LPS Act, the most recent of which must be within 60 days from the date of the petition.

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

6) Requires the respondent to:

a) Receive notice of the hearings;
b) Receive a copy of the court-ordered evaluation;
c) Be represented by counsel at all stages of a proceeding regardless of the ability to pay;
d) Be allowed to have a supporter;
e) Be present at the hearing unless the respondent waives the right to be present;
f) Have the right to present evidence;
g) Have the right to all witnesses; and,
h) Have the right to appeal decisions, and to be informed of the right to appeal.

7) Requires all CARE Court hearings to be presumptively closed to the public. Allows the respondent to demand that the hearings be public and 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. Permits a request by another party to make a hearing public to be granted if the judge conducting the hearing finds that the public interest clearly outweighs the respondent's privacy interest. Requires before commencing a hearing, the judge to inform the respondent of their rights.

8) Requires upon receipt of a CARE Court petition, the court to promptly review the petition to determine if it meets the requirements in III. 4) above. Specifies the following about the petition:

a) If the court finds the petition does not meet the requirements in III. 4) above , the court is to dismiss without prejudice, subject to III. 5) above; and,
b) If the court finds that the petition may meet the requirements in III. 4) above, the court is to order a county agency, or their designee, as determined by the judge, to investigate as necessary and file a written report with the court within 21 days that includes:
   i) A determination as to whether the respondent meets, or is likely to meet, the criteria for CARE proceedings; and,
   ii) The outcome of efforts made to voluntarily engage the respondent during the 21-day report period. Requires the court to provide notice to the respondent and petitioner that a report has been ordered.

9) Requires the agency in III. 8 b) above to submit a written report to the court with the findings and conclusions of its investigation, along with any recommendations. Provides that if the agency is making progress to engage the respondent, it may request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

10) Requires the court within five days of the receipt of the report in III. 9) above, to review the report and do one of the following:

    a) If the court determines that respondent meets, or likely meets, the CARE criteria, and engagement is not effective, the court is to do the following:

        i) Set an initial hearing within 14 days;
        ii) Appoint counsel, unless the respondent has their own counsel;
            (1) If the respondent has not retained legal counsel and does not plan to retain legal counsel, whether or not the respondent lacks or appears to lack legal capacity, the court is to, before the time of the initial hearing, appoint a qualified legal services project, as defined, or if no legal services project has agreed to accept such appointments a public defender to represent the respondent for all purposes related to the CARE Act, including appeals; and,
            (2) Counsel appointed in this case will have the authority to represent the individual in any proceeding the CARE Act, and will have the authority to represent the individual, as needed, in matters related to CARE agreements and CARE plans.
        iii) Allows the respondent to select a supporter, unless the respondent chooses not to have one; and,
        iv) Provide notice of the hearing to the petitioner, the respondent, the appointed counsel, the supporter, and the county behavioral health agency in the county where the respondent resides and, if different, the county where the CARE Court proceedings have commenced.

    b) Requires the court, if it determines that the individual meets, or likely meets the CARE criteria, that voluntary engagement is effective, and that the individual has enrolled in behavioral health treatment, to dismiss the matter; or,
    c) Requires the court, if it determines that the individual does not meet, or is likely not to meet the CARE criteria, to dismiss the matter. Requires the court to notify the petitioner and the respondent of the dismissal and the reason for dismissal. Provides that the petitioner may request reconsideration of the dismissal within 10 days.

11) Provides that the court may at the initial hearing, permit the respondent to substitute their own counsel for appointed counsel and substitute their own supporter for the appointed CARE supporter or elect to proceed without a supporter.

12) Specifies that all of the following apply at the initial hearing:

    a) If the petitioner is not present, allows the court to dismiss the matter;
    b) The respondent may waive their appearance and appear through their counsel. If the respondent elects not to waive their appearance and is not present, and appropriate attempts to elicit the attendance of the respondent have failed, allows the court to conduct the hearing in the respondent's absence. If the hearing is conducted without the respondent present, requires the court to set forth the factual basis for doing so and the reasons the proceedings will be successful without the respondent's presence;
    c) Requires a county behavioral health agency representative to be present;
    d) Allows a supporter to be present, subject to the consent of the respondent;
    e) Allows a tribal representative to attend for a respondent who is tribal member, as provided, and subject to the respondent's consent;

f) Requires the court to make a determination whether the petitioner has presented prima facie evidence that the respondent meets the CARE criteria. In making the determination, the court is to consider all evidence properly before it, including the report from the county and any additional evidence presented by the parties;
g) If the court finds there is no reason to believe that the facts stated in the petition are true, requires the court is 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. Requires any new petition to be based on changed circumstances that warrant a new petition;
h) If the court finds there is reason to believe that the facts stated in the petition appear to be true, the court is to order the county behavioral health agency to work with the respondent and the respondent's counsel and supporter to engage in behavioral health treatment. Requires the court to set a case management hearing within 14 days; and,
i) If the respondent is enrolled in a federally recognized Indian tribe, the court is to provide notice of the case management hearing to the tribe subject to the respondent's consent.

13) Requires at the case management hearing for the court to make a determination whether the parties may enter into a CARE agreement and requires a recitation of all terms and conditions on the record.

14) Requires the court, if the parties have agreed to a CARE agreement and the court agrees with the terms, to stay the matter and set a progress hearing in 60 days.

15) Requires the court, if the court finds that the parties have not and are not likely to reach a CARE agreement, to order a clinical evaluation of the respondent, as provided. Requires the evaluation to address the clinical diagnosis and the issue of whether the defendant has capacity to give informed consent regarding psychotropic medication.

16) Requires the county behavioral health agency, through a licensed behavioral health professional, to conduct the evaluation unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation. Requires the court to set a clinical evaluation hearing to review the evaluation within 14 days.

17) Requires the court to review the evaluation and any other evidence from the petitioner, the county behavioral health agency, the respondent, and, if requested by the respondent, the supporter.

18) Permits the petitioner and the respondent to present evidence and call witnesses, including the person who conducted the evaluation.

19) Requires the court to only consider relevant and admissible evidence that fully complies with the rules of evidence.

20) Permits the clinical evaluation hearing to be continued for a maximum of 14 days upon stipulation of the respondent and the county behavioral health agency, unless there is good cause for a longer extension.

21) Requires, if the court finds, by clear and convincing evidence, that the respondent meets the CARE criteria, the court to order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan. Allows, if another

entity will provide services or supports under the CARE plan, that entity to be joined as a party.

22) Requires if the court finds that the evidence does not, by clear and convincing evidence, support that the respondent meets the CARE criteria, the court to dismiss the petition.

23) Allows the respondent and the county behavioral health agency to request appellate review of an order to develop a CARE plan.

24) Requires if the respondent is an American Indian or Alaska Native individual as defined, or is otherwise receiving services from an Indian health care provider or tribal court, the county behavioral health agency is to use best efforts to meaningfully consult with and incorporate the Indian health care provider or tribal court available to the respondent to develop the CARE plan.

25) Requires the date for the hearing to review and consider approval of the proposed CARE plan not be set more than 14 days from the date of the order to develop a CARE plan, unless there is good cause for an extension.

26) Permits the county behavioral health agency or the respondent, or both, to present a proposed CARE plan.

27) 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.

28) 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. Requires that to the extent that the court orders medically necessary stabilization medications, the medication may not be forcibly administered and the respondent's failure to comply with a medication order shall not result in a penalty, including but not limited to contempt or the accountability measures in IV. 1) and IV. 2) below.

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

30) Specifies that the issuance of any orders in III. 27) above begins the "up to one-year CARE program" timeline.

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

32) Requires county behavioral health agency to file with the court, and serve on the respondent and the respondent's counsel and supporter, a report not less than seven 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, any issues the respondent expressed or exhibited in adhering to the CARE plan; and, recommendations for changes to the services and supports to make the CARE plan more successful.

33) Requires that, subject to applicable law, intermittent lapses or setbacks described in the report may not impact access to services, treatment, or housing

34) Requires the status review hearing to occur unless waived by all parties and approved by the court.

35) Allows the county behavioral health agency, the respondent, or the court to request more frequent reviews, as necessary.

36) Requires the court, in the 11th month of the program, 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.

37) Requires that at least seven days prior to the one-year status hearing, the county behavioral health agency to submit to the court, the respondent, the respondent's counsel, and the respondent's supporter, a report on the progress the respondent has made on the CARE plan as provided in III.32) above.

38) Grants the respondent the right to call witnesses and present evidence information at the one-year status hearing as to whether or not the respondent agrees with the report.

39) Specifies that if the respondent has successfully completed the CARE program, the respondent will not be reappointed to the program. Requires the court to review with the parties the voluntary agreement for a graduation plan to support a successful transition out of court jurisdiction and which may include a psychiatric advance directive. Prohibits the graduation plan from placing additional requirements on local government entities and is not enforceable by the court.

40) Permits at the one-year status hearing, the respondent to request reappointment to the CARE proceedings.

    a) If the respondent elects to accept voluntary reappointment to the program, the respondent can request to be re-appointed to the CARE program for up to one additional year; and,
    b) Allows the court to 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 program; ii) all of the required services and supports were provided to the respondent; iii) the respondent would benefit from continuation of the CARE program; and, iv) the respondent currently meets the requirements in III. 1) above.

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

42) Specifies mandatory timeframes, as well as continuances for good cause, throughout the CARE Court proceedings.

43) 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.

44) Allows the Judicial Council to adopt rules to implement the CARE Court provisions.

45) Requires, for all CARE proceedings, the judge to 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. Requires where there is a contested issue of fact or law, 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.

46) Requires all evaluations and reports, documents, and filings submitted to the court pursuant to CARE proceedings to be confidential.

IV. Accountability

1) 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 program. Allows the court to make a referral under the LPS Act, as provided.

2) 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.

3) Allows the court, at any time in the proceeding, if it finds that the county, or other local government entity, is not complying with its orders, to fine the county, or other local government entity, up to $1,000 per day for noncompliance. Allows the court, 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.

4) Establishes the CARE Act Accountability Fund (fund) in the State Treasury to receive penalty payments from each county as collected. Requires that all monies in the fund are reserved and continuously appropriated, without regard to fiscal years. Requires that subject to approval from the Department of Finance, DHCS will determine the use of the funds to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders who experience or are at risk of homelessness, criminal justice involvement, hospitalization or conservatorship.

V. The Supporter and Counsel

1) Requires, subject to appropriation, DHCS to provide optional training and technical resources for volunteer supporters on CARE Act proceedings, community services and supports, Supported Decision Making, and people with behavioral health conditions, trauma-informed care and psychiatric advance directives, with support and input from relevant stakeholders. Allows DHCS to enter into a technical assistance and training agreement.

2) Provides that the supporter is designed to do all of the following:

   a) Offer the respondent flexible and culturally responsive ways to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating and implementation their own informed choices;
   b) Strengthen the respondent's capacity to engage in and exercise autonomous decisionmaking 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.

3) Permits that notwithstanding any other provisions of the CARE Act, the respondent to have a supporter present in any meeting, judicial proceeding, status hearings, or communications related to an evaluation, development of a CARE agreement or CARE plan; establishing a psychiatric advance directive; and, development of a graduation plan.

4) Specifies that a supporter is intended to do all of the following:

   a) Support the will and preferences of the respondent to the best of their ability and to the extent reasonably possible;
   b) Respect the values, beliefs, and preferences of the respondent;
   c) Act honestly, diligently, and in good faith; and,
   d) Avoid, minimize and manage, to the greatest extent possible, conflicts of interest. Disclose conflicts of interest to the court, the respondent and the respondent's counsel. Allows a court to remove a supporter because of any conflict of interest with the respondent, and to remove the supporter if the conflict cannot be managed in such a way to avoid any possible harm to the respondent.

5) Prohibits a supporter, without explicit authorization by the respondent with capacity to make that authorization from making decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury, and to sign documents on behalf of the respondent.

6) Provides that in addition to the obligations specified, a supporter is bound 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. Specifies that the CARE Act does not limit a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion or mistreatment including liability under the Elder Abuse and Dependent Adult Civil Protection Act.

7) Requires subject to appropriation, the Judicial Council to provide funding to qualified legal services projects, as defined to be used to provide legal counsel appointed under III. 10) a) above for representation in CARE proceedings, matters related to CARE agreements and CARE plans, and to qualified support center as defined for training, support and coordination.

VI. Care Plan

1) Requires the CARE plan to only include the following:

   a) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, health care plans and insurers, services provided as specified within portions of the County Aid and Relief to Indigents and services supported by the Mental Health Services Act (MHSA) as specified;
   b) Medically necessary stabilization medication to the extent not described in VI. 1) above;
   c) Housing resources funded through programs as specified including but not limited to the No Place Like Home Program; the California Housing Accelerator; the Homeless Housing Assistance and Prevention Program, the Project Roomkey and Rehousing Program; the Community Care Expansion Program; the Transitional Housing Placement Program; the Behavioral Health Continuum Infrastructure Program; and, the Community Development Block Grant Program; and,
   d) Social services funded through the Supplemental Security Income/State Supplementary Payment Case Assistance program for Immigrants, CalWORKs, California Food Assistance Program, In-Home Supportive Services. and Cal Fresh.

2) Requires individuals who are CARE program participants to be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

3) Requires all CARE plan services and supports ordered by the court to be subject to all applicable federal and state statutes and regulations, contractual provisions and policy guidance governing program eligibility and available funds. Requires that in addition to the resourced funded through programs listed in VI. 1) above, DHCS to identify other adjacent covered Medi-Cal services, including but not limited to, enhanced case management and available community supports, which may be provided, although not ordered by the court, subject to all applicable federal and state statute, regulations contractual provisions, and policy guidance.

4) Requires that for respondents who are Medi-Cal beneficiaries, the county in which the respondent resides is the county of responsibility, as defined.

5) Provides that if a proceeding commences in a county where the respondent is found or is facing criminal or civil proceedings that is different than the county in which the respondent resides, the county in which the respondent is found or is facing criminal or civil proceedings cannot delay proceedings and is the responsible county behavioral health agency for providing or coordinating all components of the CARE agreement and CARE plan.

6) Provides that the county in which respondent resides as defined in VI. 4) above is responsible for the costs of providing all CARE agreement or CARE plan behavioral health services as defined in V.1) a) above.

7) Requires, in the event of a dispute over responsibility for any costs of providing components of the CARE agreement or CARE plan, the impacted counties to resolve the dispute in accordance with the arbitration process established for county mental health plans, including for respondents who are not Medi-Cal beneficiaries.

VII. Technical Assistance and Administration:

1) Requires, subject to appropriation, the California Health and Human Services Agency (CHSSA) or a designated department within CHSSA to:

   a) Engage an independent, research-based entity, as described in VII. 12) below, to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act; and,
   b) Provide coordination, on-going engagement, 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.

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

3) Requires, subject to appropriation, the Judicial Council, in consultation with DHCS, other relevant state entities, and the County Behavioral Health Directors Association, to provide training and technical assistance to judges to support the implementation of the CARE Act, including training regarding the CARE statutes, CARE plan services and supports, working with the supporter, supported decision making, the role of the supporter, trauma -informed care, elimination of bias, best practices, and evidence-based models of care for people with severe behavioral health conditions.

4) Permits for purposes of implementing the CARE Act, the CHSSA and DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

5) Permits CHHSA 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.

6) 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, and other appropriate stakeholders, an annual report. Requires DHCS to post the annual report on its internet website.

7) Requires county behavioral health agencies and any other state or local governmental entity, as identified by DHCS to provide to DHCS data related to the CARE Act participants, services, and supports. Requires DHCS to determine the data measures and specifications, and publish through guidance.

8) Requires each county behavioral health department and any other state and local governmental entity, as identified by DHCS, to provide the required data in a format and frequency as directed by DHCS

9) Requires DHCS to provide information on the populations served and demographic data, stratified by age, sex, race, ethnicity, languages spoken, disability, sexual orientation and gender identity, and county, to the extent statistically relevant data is available.

10) Requires the report to 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 include process measures to examine the scope of impact and monitor the performance of the 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. Requires the report to include outcome measures to assess the effectiveness of the model, such as improvement in housing status, 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 reduction in substance use. Requires the annual report to examine these data through the lens of health equity to identify racial/ethnic and other demographic disparities and inform disparity reduction efforts.

11) Requires that the outcomes be presented to relevant state oversight bodies, including, but not limited to, the California Interagency Council on Homelessness.

12) Requires that an independent, research-based entity be retained by DHCS to develop, in consultation with county behavioral health agencies, county CARE Courts, and other appropriate stakeholders, an independent evaluation of the effectiveness of the CARE Act.

13) Requires the independent evaluation to employ statistical research methodology and include a logic model, hypotheses, comparative and/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. Requires the independent evaluation to highlight racial/ethnic and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts.

14) Requires DHCS to provide a preliminary report to the Legislature three years after the implementation date of the CARE Act and a final report to the Legislature five years after the implementation date of the CARE Act. Requires DHCS to post the preliminary and final reports on its internet website.

15) Requires each county behavioral health department, each county CARE Court, and any other state or local governmental entity, as determined by DHCS, to provide the required data to DHCS, in a format and frequency as directed by DHCS.

VIII. Health Plans and Insurance

1) Requires a health care service plan (health plan) contract that covers hospital, medical, or surgical expenses and an insurance policy, issued, amended, renewed, or delivered on or after July 1, 2023, to cover the cost of developing an evaluation as defined in III. 15) above and the provision of all health care services for an enrollee when required or recommended for

the enrollee under a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under the CARE Act regardless of whether the services are provided by an in-network or out-of-network provider.

2) Prohibits a health care service plan or an insurer from requiring prior authorization for services, other than prescription drugs, required under a CARE agreement or CARE plan approved by a court under the CARE Act.

3) Permits a health plan or an insurer to conduct a postclaim review to determine appropriate payment of a claim. Allows payment for services to be denied only if the health plan or insurer reasonably determines the enrollee was not enrolled at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

4) Permits, notwithstanding VIII. 2) above, a health plan or insurer to require prior authorization for services as permitted by the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI) under VIII. 9) below.

5) Requires a health plan or insurer to provide for reimbursement of services provided to an enrollee under the CARE Act, other than prescription drugs, at the greater of either of the following amounts:

   a) The health plan's or insurer's contracted rate with the provider; or,
   b) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the DHCS.

6) Requires a health plan or insurer to provide for reimbursement of prescription drugs provided to an enrollee under the CARE Act at the contracted rate of the health plan/insurer.

7) Requires a health plan or insurer to provide reimbursement for services provided under the CARE Act in compliance with the requirements for timely payment of claims, as specified.

8) Prohibits from subjecting services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, to copayment, coinsurance, deductible, or any other form of cost sharing. Prohibits an individual or entity from billing the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan regardless of whether such service is delivered by an in-network or out-of-network provider.

9) Requires no later than July 1, 2023, DMHC and CDI to issue guidance to health plans or insurers regarding compliance with the CARE Act. Exempts the guidance from being subject to the Administrative Procedure Act (APA). Provides that such guidance is effective only until DMHC and CDI adopt regulations under the APA.

10) Requires a health plan or insurer to comply with the California Mental Health Parity Act of 2020.

11) Specifies that the health plan/insurer provision does not apply to Medi-Cal managed care contracts between DHCS and a health plan for enrolled Medi-Cal beneficiaries as specified.

12) Specifies that the health plan/insurer provisions become operative on July 1, 2023.

IX. Miscellaneous

1) Permits, if a person who is charged with a misdemeanor or misdemeanors only, or a violation of formal or informal probation for a misdemeanor, where the judge finds reason to believe that the defendant has a mental health disorder, and may, as a result of the mental health disorder, be incompetent to stand trial, and the individual after a hearing is determined to be ineligible for diversion, the court to refer the defendant to the CARE Program.

2) Requires that a hearing to determine eligibility for the CARE Program to be held within 14 days after the date of the referral in IX. 1) above. Requires that if the hearing is delayed beyond 14 days, the court to order the defendant, if confined in a county jail, to be released on their own recognizance pending that hearing. Requires that if the defendant is accepted into CARE Program, the charges pending against the defendant to be dismissed.

3) Expands the systems of care for adults and older adults with SMI that calls for a client to be fully informed and volunteer for all treatment provided, unless danger to self or others or gravely disabled requiring temporary involuntary treatment to also include if the client is under a court order for CARE Court and prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so.

4) Permits when included in a county's MHSA County Plan and annual update, MHSA funds to be used for the provisions of services to clients under the CARE Program.

EXISTING LAW:

1) Establishes the LPS Act to end inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to provide prompt evaluation and treatment of those with mental health disorders or impaired by chronic alcoholism.

2) Defines, as a basis for involuntary commitment under the LPS Act, "grave disability" as a condition in which a person, as a result of a mental disorder, or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter, or is found to be mentally incompetent under the Penal Code. Excludes from that definition persons with intellectual disabilities by reason of that disability alone.

3) Provides that if a person is gravely disabled as a result of mental illness, or a danger to self or others, then a peace officer, staff of a designated treatment facility or crisis team, or other professional person designated by the county, may, upon probable cause, take that person into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement in a designated treatment facility.

4) Allows a person who has been detained for 72 hours to be detained for up to 14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment.

5) Allows a person to be held at the expiration of a 14-day period of intensive treatment for further intensive treatment of up to 14 days if, during the detention period, a person threatened or attempted to take their own life or was detained because they threatened or attempted to their own life and continues to present an imminent threat of taking their own life and other specified condition.

6) Allows a person who has been detained for 14 days of intensive treatment to be detained for up to 30 additional days of intensive treatment if the person remains gravely disabled and is unwilling or unable to voluntarily accept treatment.

7) Requires a certification review hearing to be held within four days of the date on which a person is certified for a 14-day period of intensive treatment or 30 additional days of intensive treatment unless judicial review has been requested or a postponement is requested by a person or their attorney or advocate.

8) Grants every person detained by certification for intensive treatment with a right to a hearing by writ of habeas corpus for their release. Enumerates specified requirements and procedures for judicial review.

9) Allows for antipsychotic medication to be administered to any person subject to specified detentions under the LPS Act if that person does not refuse that medication. Allows antipsychotic medication to be administered when a detained individual indicates refusal of that medication only when the treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient and upon a determination of that person's incapacity to refuse the treatment in a hearing. In the case of emergency, allows for antipsychotic medication to be administered over a detained person's objection prior to a capacity hearing if the medication is required to treat the emergency and is provided in the manner least restrictive to the personal liberty of the patient. Enumerates specified requirements and procedures for capacity hearings pertaining to administering antipsychotic medication.

10) Allows, under the LPS Act, a court to order an imminently dangerous person to be confined under a conservatorship for further inpatient intensive health treatment for an additional 180 days, as provided.

11) Allows the professional person in charge of a facility providing 72-hour, 14-day, or 30-day treatment to recommend an LPS conservatorship to the county conservatorship investigator for a person who is gravely disabled and is unwilling or unable to voluntarily accept treatment; and requires the conservatorship investigator, if they concur with the recommendation, to petition the superior court to establish an LPS conservatorship. Provides that a person for whom an LPS conservatorship is sought has the right to demand a court or jury trial on the issue of whether they are gravely disabled.

12) Requires an officer providing conservatorship investigation to investigate all available alternatives to conservatorship and recommend conservatorship to the court only if no suitable alternatives are available. Requires the officer to render to the court a comprehensive written report containing all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, information concerning the person's property, and information obtained from the person's family members, close friends, social

worker, or principal therapist. Requires the officer, if they recommend against conservatorship, to set forth all alternatives available.

13) Requires a conservator under an LPS conservatorship to place the conservatee in the least restrictive alternative placement, as provided. Gives the LPS conservator the right, if specified in the court order, to require the conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee's being gravely disabled.

14) Requires counties, unless they opt out, to provide AOT, also known as "Laura's Law," for people with serious mental illnesses when a court determines that a person's recent history of hospitalizations or violent behavior, and noncompliance with voluntary treatment, indicates the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment.

15) Establishes a pilot program, until January 1, 2024, for Los Angeles and San Diego Counties, and the City and County of San Francisco, upon authorization by their respective boards of supervisors, to implement a "housing conservatorship" procedure for a person who is incapable of caring for their health and well-being due to a serious mental illness and substance use disorder, as evidenced by eight or more detentions for evaluation and treatment under Section 5150 in the preceding 12 months.

16) Permits, under the Probate Code, any interested person to petition the court for the appointment of a "conservator of the person" for a person who is unable to provide properly for their personal needs for physical health, food, clothing, or shelter, and permits the appointment of a "conservator of the estate" for a person who is unable to manage their financial resources or resist fraud or undue influence. Provides that no conservatorship of the person or of the estate may be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee.

17) Creates a court diversion program for those charged with certain drug offenses.

18) Creates a court diversion program for those with "mental disorders," as defined.

19) Allows a court, if a criminal defendant is found to be mentally incompetent, to, among other things, determine if the defendant is eligible for a diversion program, or, if ineligible, to, among other things, refer the defendant to AOT or to an LPS conservatorship investigation.

20) Defines "Housing First" to mean the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. States that Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

21) Requires all agencies and departments administering state programs, created on or after July 1, 2017, to collaborate with the California Interagency Council on Homelessness to adopt guidelines and regulations to incorporate core components of Housing First.

22) Establishes the Medi-Cal program, which is administered by DHCS, under which qualified low-income individuals receive health care services.

23) Makes children age 18 and under with family incomes up to 266% of the federal poverty level eligible for Medi-Cal.

24) Establishes a schedule of benefits in the Medi-Cal program, which includes mental health and SUD services included in the essential health benefits package adopted by the state for purposes of implementing the federal Patient Protection and Affordable Care (ACA) requirement for benefits that must be included in health plans offered in the private individual and small group market and to the Medicaid expansion population.

25) Requires DHCS to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans (MHPs). Permits MHPs to include individual counties, counties acting jointly, or an organization or nongovernmental entity determined by DHCS to meet MHP standards. Permits a contract to be exclusive and may be awarded on a geographic basis. Requires MHPs to be responsible for providing Specialty Mental Health Services (SMHS) to enrollees.

26) Requires county MHPs to be governed by specified guidelines, which include a requirement that MHPs provide SMHS to eligible Medi-Cal beneficiaries, including both adults and children.

28) Establishes the DMHC to regulate health plans and the CDI to regulate health insurers.

29) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, as specified in state law, which include the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; Mental Health and SUD services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

30) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

31) Requires emergency health care services to be available and accessible to enrollees on a 24 hour a day, seven days a week, basis within the health plan area. Requires emergency health care services to include ambulance services for the area served by the plan to transport the enrollee to the nearest 24 hour emergency facility with physician coverage, designated by the health plan.

32) Requires every health plan contract issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of Mental Health and SUD under the same terms and conditions applied to other medical conditions, as specified.

33) Defines medically necessary treatment of mental health and SUD as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

35) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

36) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by majority vote.

FISCAL EFFECT: Unknown. This bill, as amended, has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL**. 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. The author concludes, this bill seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.

   Governor Newsom, when introducing his CARE Court proposal, stated that 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. He further stated 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. The Governor concluded by stating that we are taking action to break the pattern that leaves people without hope and cycling repeatedly through homelessness and incarceration. CARE Court is a new approach to stabilize people with the hardest-to-treat behavioral health conditions.

2) **BACKGROUND**.

   a) **CARE Court proposal**. In early 2022, Governor Newsom proposed the CARE Court program to help connect a person 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 individuals 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, and connection to social services and a housing plan. According to the CHHSA's website, housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent, or in a vehicle. CHHSA states that CARE Court 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. CHHSA further states that CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity, before they enter the criminal justice system or become so impaired that they end up in a LPS conservatorship due to mental illness. CHSSA states that although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions, and the CARE Court proposal aims to connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness. SB 1338 (Umberg and Eggman) and AB 2830 (Bloom) of this Legislative Session implement the CARE Court proposal.

b) **Housing First:** In 2016, the state's efforts to address homelessness shifted to the use of Housing First core components. SB 1380 (Mitchell) Chapter 847, Statutes of 2016, which created the California Interagency Council on Homelessness to oversee implementation of the Housing First regulations and coordinate the state's response to homelessness, as well as create partnerships among state agencies and departments, local government agencies, nonprofits, and federal agencies to prevent and end homelessness in California. SB 1380 also aligned the Housing First guidelines for any state program that provides housing and supportive services to people experiencing homelessness. Housing First is an evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

As currently in print, this bill includes a housing plan as part of the respondent's CARE plan. This bill provides for the housing plan to describe the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement. It also gives the respondent diverse housing options, including, but not limited to, housing in clinically enhanced interim or bridge housing, licensed adult and senior care settings, and supportive housing. Since this bill goes on to state that "counties may offer appropriate housing placements in the region as early as feasible in the engagement process" it appears this provision "does not allow the court to order housing or to require the county to provide housing," thus an individual could be participating in CARE Court, be required to meet certain treatment plan goals and requirements, and yet remain unhoused. Under the existing Housing First framework, the state is supposed to be working with local governments and Continuums of Care to ensure housing is used as a tool in an individuals' overall path to wellness rather than as a

reward for recovery, even for those with SUD or SMI.

It is unclear how an individual meeting the requirements for participation in CARE Court can truly make progress, in terms of complying with the components of their CARE plan, if they remain unhoused. Additionally, the language of this bill is currently silent on whether an individual who is housed through the CARE Court program may lose their housing if they fail to comply with their CARE plan, stop taking their psychotropic medications, or experience a relapse. These raise questions on how the program complies with existing Housing First principals.

c) **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 SMI. (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. Among those experiencing homelessness, one in four individuals report having a SMI.

The COVID-19 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. The state is projected to continue to face a shortfall of thousands of psychiatric beds for adult inpatient and residential care. 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. Further, 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% fewer psychiatrists and 1% fewer psychologists, therapists, and social workers than are likely to be needed. 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.

d) **A significant portion of California's homeless population is severely mentally ill.** While accurate data on the number of people among California's unhoused population who are mentally ill is available, it is clear that a significant portion of that population has mental health disabilities. According to the 2019 annual point-in-time count, 23% of California's homelessness population is severely mentally ill. A *Los Angeles Times* review of the 2019 point-in-time homelessness count for Los Angeles County found that 51% of homeless were either reported or observed to be affected by mental illness; 46% were affected by substance abuse; and, 67% were affected by either mental illness or substance abuse. A study from the University of California's California Policy Lab, linking Los Angeles County Department of Mental Health records to Street Outreach data, found that 20% of Street Outreach clients had been diagnosed with a SMI within the previous 12 months. That study also found that homeless clients of the Street Outreach program waited, on average, 101 days for interim housing; 112 days for rapid re-housing; and, 188 days for permanent housing.

e) LPS ACT: mandatory treatment options for those with mental illness. California law provides a number of options for forcibly detaining and treating individuals with SMI. The primary option is the 1967 LPS Act, which provides for involuntary commitment for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements or preconditions are met. The goal of the LPS Act is to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities."

i) *LPS involuntary holds and conservatorships.* Under the LPS Act, an individual may be involuntary committed for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements are met. Additionally, the LPS Act provides for LPS conservatorships, resulting in involuntary commitment for the purposes of treatment, if an individual is found to meet the "grave disability" standard in which a person, as a result of a mental disorder or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter.

Typically, a person's first interaction with the LPS Act is through what is commonly referred to as a 5150 hold. This allows an approved facility to involuntarily commit a person for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5150.) The peace officer, or other authorized person, who detains the individual must know of facts that would lead a person of ordinary care and prudence to believe that the individual meets this standard. When making this determination, the peace officer, or other authorized person, may consider the individual's past conduct, character, and reputation, so long as the case is decided on facts and circumstances presented to the detaining person at the time of detention.

Following a 72-hour hold, the individual may be held for an additional 14-days, without court review, if they are found to still be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5250.) When determining whether the individual is eligible for an additional 14-day confinement, the professional staff of the agency or facility providing evaluation services must find that the individual has additionally been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. Additionally, the individual cannot be found at this point to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or third parties who are both willing and able to help. The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing.

If a person is still found to remain gravely disabled and unwilling or unable to accept voluntary treatment following their additional 14 days of intensive treatment, they may be certified for an additional period of not more than 30 days of intensive treatment. (Section 5270) The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing. Additionally, the professional staff of the agency or facility providing the treatment, must analyze the person's condition at

intervals not to exceed 10 days, and determine whether the person continues to meet the criteria for continued confinement. If the person is found to no longer meet the requirements of the 30-day hold, then their certification should be terminated.

Finally, the LPS Act provides for a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. (Section 5350.) The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled individual. The individual for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement, and they have the right to be represented by counsel. An LPS conservatorship lasts for one year, but can be renewed.

ii) *Laura's Law.* As an alternative to an LPS conservatorship, current law provides for court-ordered outpatient treatment through Laura's Law, or the AOT Demonstration Project, enacted in 2002. In participating counties, the court may order a person into an AOT program if the court finds that the person either meets existing involuntary commitment requirements under the LPS Act or the person meets non-involuntary commitment requirements, including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community. Originally, Laura's Law was only operative in those counties in which the county board of supervisors, by resolution, authorized its application and made a finding that no voluntary mental health program serving adults and no children's mental health program would be reduced in order to implement the law. The initial sunset provision provided for within Laura's Law was extended several times until 2020 when legislation was passed requiring that, rather than counties opting into Laura's Law, counties have to, by board of supervisors resolution, opt out of the program. Additionally, the sunset provision was removed, making the program permanent.

Laura's Law is designed to provide counties with tools for early intervention in mental health crises. It allows for family members, relatives, cohabitants, treatment providers, or peace officers to initiate the AOT process with a petition to the county behavioral health director or the director's designee. The health director or designee must then determine how to proceed. If the individual is found to meet the AOT eligibility requirements, a preliminary care plan is developed to meet that person's needs. If this process results in the person voluntarily engaging with treatment, then the patient is deemed to no longer meet the criteria and the petition is no longer available. However, if the client declines their preliminary plan, then a public defender is assigned and the petition process proceeds. A judge either grants or rejects the AOT petition; and if an AOT petition is approved, treatment is ordered and continues for up to 180 days.

iii) *Housing Conservatorship Pilot.* In 2018, the Legislature created a pilot project, known as the "housing conservatorship," for those who have both SMI and SUD (SB 1045 (Wiener & Stern) Chapter 845, Statutes of 2018, and SB 40 (Wiener & Stern) Chapter 467, Statutes of 2019) The counties of Los Angeles, San Diego, and San

Francisco may, through January 1, 2024, elect to establish this new conservatorship, but only after, among other requirements, the board of supervisors determines that money will not be taken from other mental health and conservatorship programs and the board of supervisors ensures that necessary services are available in sufficient quantity, resources, and funding levels to serve the identified population, including access to supportive community housing with wraparound services, public conservators, mental health services, substance use disorder services, and service planning and delivery services.

This new six-month conservatorship, which may be established following a 28-day temporary conservatorship, is designed for those who are incapable of caring for their own health and well-being due to a SMI and SUD, as evidenced not by a contemporary grave disability, but by at least eight 72-hour involuntary holds under Section 5150 in the preceding 12 months. To ensure that this new conservatorship is truly filling a gap and not replacing any existing conservatorship or program, the investigator must consider all alternatives to the proposed conservatorship and only recommend the new conservatorship if no less restrictive alternatives exist and it appears the individual will not qualify for a conservatorship under the Probate Code or the LPS Act. So far, only San Francisco has elected to participate in the pilot and, as of earlier this year, it appears that only two individuals have been conserved under the program, though more individuals could soon be eligible because they are approaching the requisite number of 5150 holds. The pilot requires a thorough evaluation, which should assist the Legislature in determining the need for, and success of, the program.

iv) *Probate Conservatorship.* In California, if an adult is, based on clear and convincing evidence, unable to provide properly for their personal needs for physical health, food, clothing, or shelter, a conservator of the person may be appointed by the court. If an adult who is, based on clear and convincing evidence, substantially unable to manage their own financial resources or resist fraud or undue influence, a conservator of the estate may be appointed by a court to manage the adult's financial matters. The appointment process requires an investigation by a court investigator and approval by the court. The conservator can be a family member, friend, a professional fiduciary, or, more rarely, a county public conservator. A conservatorship involves a court-appointed third party – the conservator – making far-reaching, life-changing decisions on behalf of the conservatee. Historically, a conservatorship lasts until the death of the conservatee or a court order terminating it, based on someone seeking a petition for termination. However, AB 1194 (Low) Chapter 417, Statutes of 2021, requires that these conservatorships be reviewed annually by the probate court and terminated unless the court can legally reestablish them. AB 1194 cannot be implemented until the Legislature specifically allocates funding for it, thus allowing conservatorships to continue indefinitely, despite the recent change in state law.

f) ***California State Auditor (CSA) report on the LPS.*** In July of 2020, the CSA released a report entitled, "Lanterman-Petris-Short Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care." The Joint Legislative Audit Committee called for the audit and the CSA examined the implementation of the LPS Act in Los Angeles County, San Francisco County, and Shasta County. Essentially the audit found that California has not ensured adequate care

of individuals with SMI in its broader mental health system. The audit found that, "perhaps most troublingly, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities." The CSA found that the LPS Act's criteria for involuntary mental health treatment allows counties sufficient authority to provide involuntary treatment to people who need it and no evidence was found to justify expanding the "grave disability" criteria, which could "potentially infringe upon people's liberties." However, while the LPS Act's criteria are sufficient for involuntary holds and conservatorships, significant issues were found with how Californians with SMI are cared for in the LPS system:

i) Individuals on conservatorships have limited treatment options – many could not receive specialized care in state hospital facilities for an average of one year because of a shortage of available treatment beds;
ii) Individual existing involuntary holds have not been enrolled consistently in subsequent care to help them live safely in their communities – in two counties, no more than 9% of these individuals were connected to ongoing services and supports; and,
iii) Less than one-third of the State's counties – only 19 at the time of the audit – had adopted AOT even though it is an effective community-based approach to mental health treatment to help prevent future involuntary holds and conservatorships.

g) Non-mandatory options for treating those with mental illness. Today there are a number of alternatives to the court-ordered involuntary holds or treatment that provide more autonomy, or advance choice, to the individual, while still providing them with necessary treatment and support. These include a durable power of attorney and advance health care directive, as well as supported decisionmaking. More broadly, there are voluntary, community-based supports and services. In addition to other community-based voluntary mental health services and supports, in 2004 California voters adopted Proposition 63, which created the MHSA. The MHSA imposed a one-percent surtax on the wealthiest Californians in order to fund mental health programs and services across the state. Under the MHSA, the DHCS allocates Proposition 63 funds to mental health programs and services through contracts with individual counties.

MHSA programs have three key components: community services and support (CSS); prevention and early intervention (PEI); and innovation. CSS programs, which account for about 80% of allocated funds, provide direct services to individuals with SMI. The guiding concept of CSS programs is to do "whatever it takes" to meet the mental health needs of those who are unserved or underserved. PEI programs, which may account for up to 20% of a county's funding, seek to identify early mental illness (especially in children and young adults) before it becomes severe and disabling. Finally, counties may use up to 5% of their funding for "innovation," or developing, testing, and implementing new approaches that may not yet have demonstrated effectiveness.

While the LPS Act and MHSA have different histories and functions, they share the common goal of helping people obtain treatment for mental illness in the least restrictive and most effective manner possible. The MHSA has the potential to provide alternatives to the choices presented by the LPS system.

h) California's muddled mental health system. While the CSA rightly noted the shortcomings of LPS holds and conservatorships, those shortcomings are not solely attributable to problems within the LPS Act, its definitions, or its implementation. LPS cannot "connect" persons to "ongoing care" if such care does not exist. The LPS Act, was enacted to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." Its primary purpose is not to provide mental health services per se, but to establish commitment criteria that protect the due process rights of persons who are experiencing a dangerous or debilitating mental health crisis. In the absence of voluntary and less restrictive treatment options, the various professionals who make determinations under the LPS Act too often face the choice of releasing a seriously mentally ill person back into the community, or committing them against their will to a locked psychiatric facility.

It was precisely this lack of alternatives in the wider mental health system that prompted California voters in 2004 to adopt the MHSA. A 2016 report by the Little Hoover Commission (Commission) cites several successful and promising local programs developed through the MHSA, but the Commission's overall conclusion was that a "muddled" governance structure makes it difficult to determine if counties use MHSA funds in the most efficient and effective manner, and who should be held accountable when they do not. For example, current law assigns various responsibilities for implementation of the MHSA to three different agencies: DHCS, which absorbed the administrative responsibilities of the now-disbanded Department of Mental Health Services in 2012; the Mental Health Services Oversight and Accountability Commission (MHSOAC), which although created by Proposition 63, has oversight responsibilities for the mental health care system as a whole; and the Mental Health Planning Council, which reviews program performance of the overall mental health system, including MHSA programs. Unfortunately, members of these three agencies informed the Commission that the broad and sometimes overlapping responsibilities mean, in practice, that there is no clear designation of who is responsible for what.

On one key issue, the Commission's report on MHSA found (and the same problem that the State Auditor found in the LPS system) was insufficient data collection. "Despite compelling claims that the MHSA has transformed mental health services in communities across California," the Commission stated, "the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars." Without robust data, policymakers cannot know which programs work with which specific populations. The Commission found that some counties – Los Angeles in particular – have done better than others in tracking outcomes of specific programs. The Commission recommended that the Legislature establish a MHSA data working group within DHCS to build upon the best of the county programs and develop a statewide MHSA database. As guidance, the Commission suggested that the Legislature look to the experience of a working group established in 2014 to collect data on the effectiveness of juvenile justice programs.

If effectively utilized, the MHSA programs may well obviate the need for an LPS hold or conservatorship in the first place, or they might provide less expensive and more effective alternatives to the choice of either releasing or committing persons who are experiencing mental illness. However, LPS decision-makers must first have knowledge of these

programs and their effectiveness with various populations, which would require much more data and analysis, as well as cooperation and collaboration.

i) **Cities and counties have a split position on CARE Courts.** Cities tend to support the legislation and counties and their associated entities, while not opposed, have raised many issues of concern with the legislation. This split is likely due to the fact that many unhoused individuals with mental illness can be found in cities, while the counties will be called upon to provide the supports and services required by the bill (although creation of housing, in large part, is limited by cities).

City support is exemplified by the City of Santee, which recognizes the bill as:

> "An important measure to provide California's civil courts with a new process for earlier action, support, and accountability to protect and care for some of our State's most vulnerable residents. This bill would provide individuals with a clinically appropriate, community-based, court-ordered care plan, including behavioral health care, stabilization medication, and housing support to adults who are suffering from specified mental health disorders (schizophrenia spectrum and psychotic disorders) and who lack medical decision making capacity.
>
> As this legislation could serve as an important tool to help in the City's effort to help address the challenges of homelessness and increase services and safety for those experiencing homelessness, the City Council of the City of Santee passed a unanimous resolution in support of the bill."

County concerns are well illustrated by the letter from the County of Humboldt:

> "…Humboldt County strongly supports a comprehensive, holistic approach to addressing the homeless crisis. However, this bill so far fails to include additional funding for the impact CARE Court would have on our behavioral health, public defender and public guardian offices. Additionally, while we and the cities are working to build our housing stock and behavioral health workforce and infrastructure utilizing recent state investments, we are not yet prepared or funded to implement this new program effectively or operate it ongoing.
>
> New expectations, whether for CARE Court or other programs, require new resources to meet them, especially given decades of underfunding for behavioral health services and zero state investment in the county public guardian offices. Importantly, much of the work envisioned by the CARE Court proposal is not reimbursed by Medi-Cal or private insurance.
>
> Additionally, the proposed sanctions are not appropriate. Our county cannot bear sanctions related to an entirely new program in which we lack the sole authority, housing units and funding to implement. Sanctions would exacerbate the issues our overloaded and underfunded public defender and behavioral health departments are already experiencing, including a severe workforce shortage."

If cities (who may be focused on moving out their unhoused residents) and counties (who will be required to place and serve those individuals) cannot work together to support

CARE Court participants, the program will most likely experience difficulties in succeeding, helping neither counties nor cities, nor, most importantly, the program participants themselves.

j) CARE Court Allocations in Budget. The Governor's May Revision (reflecting the April 7, 2022 version of this bill) includes a total of $64.7 million General Fund in 2022-23 for the support of a new CARE Court process. This amount includes: i) $39.5 million ($37.7 million ongoing) to the judicial branch for court proceedings; ii) $15.2 million (about $1 million ongoing) to the DHCS for training, technical assistance, and data collection; and, iii) $10 million ongoing to the Department of Aging (DOA) for the CARE Court Supporter program (DOA responsibility for the supporter role has been removed from the most recent bill version so it is unknown if these monies will be transferred to DHCS who in this version of the bill is charged with facilitating the supporter role.

3) SUPPORT. Over 45 cities, including the Big City Mayor Coalition write in support of the bill. Specifically, local governments from San Diego, including the City and County of San Diego County (SD), state in support that the creation of CARE Courts 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, SD'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 SMI and SUD issues that have developed over many years resulting in an inability to care for themselves. SD states that 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 this bill provides numerous safeguards to ensure personal civil liberties are respected and protected.

The California Chamber of Commerce (Chamber), along with 27 local chambers of commerce and business associations, also in support state, the CARE Court is a thoughtful, measured response to the tragedy of homeless mentally ill or substance abuse disordered individuals. It attempts to thread the needle of providing necessary care and treatment in an environment appropriate to deliver those services; that is, a supportive setting that is neither outdoors or incarcerated. Importantly, the individuals to be served by this approach lack the capacity to make medical decisions for themselves; the only alternatives are the status quo, which is continued desperate deterioration living outdoors, or in a far more restrictive conservatorship or incarceration. The Chamber states in conclusion that California employers have a clear stake in improving the treatment and outcomes for severely mentally disabled individuals without a fixed residence. First, they are our fellow Californians, in severe need, for whom we have an obligation of care. Second, many employers share neighborhoods with mentally disabled or substance abuse disordered individuals, so have first-hand experience with the failure of our institutions to adequately serve them and address their misery. Finally, as taxpayers and business leaders, employers want to see their private investment return healthy, thriving communities.

4) **OPPOSITION**. A coalition of over 40 advocacy groups, including Disability Rights California, American Civil Liberties Union, and the Depression and Bipolar Support Alliance (Coalition), write in opposition to this bill. The Coalition states that the CARE Court framework this bill seeks to establish is unacceptable for a number of reasons:

   a) It perpetuates institutional racism through a system of coerced treatment and worsens health disparities, directly harming Black, Indigenous and People of Color;
   b) It denies a person's right to choose and have autonomy over personal healthcare decisions;
   c) It does not guarantee housing provided with fidelity to principles that prioritize voluntary services, an approach that is backed by evidence;
   d) Community evidence-based practices and scientific studies show that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment; and,
   e) It will not matter that the terms used are called "Supportive Decision-Making" and "Supporter" because the Supporter's role is to implement an involuntary medical plan ordered by a civil court, and disregards the importance of voluntary decisions in mental health treatment.

   The Coalition continues that 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 Coalition agrees that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with SMI, 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. In concluding, the Coalition states that because CARE Court will harm Californians with disabilities, they strongly oppose this bill and instead, would welcome a proposal developed with input from the people CARE Court seeks to help. The Coalition believes a community-based approach would be far more likely to succeed. Such an approach would expand resources for permanent affordable housing with voluntary supports and increase early access to voluntary, community-based treatment based on principles of trauma-informed care and the complete removal of law enforcement and the courts from the process.

5) **CONCERNS**. Numerous organizations write in with significant concerns regarding this bill, including 13 individual counties. One County Coalition (CC) representing the California State Association of Counties, the Rural County Representatives of California, the Urban Counties of California, the County Behavioral Health Director's Association, the County Welfare Directors Association and the California State Association of Public Administrators, Public Guardians and Public Conservators. CC states that as currently drafted, this bill requires all 58 counties to establish a CARE Court. Counties would play a key and substantial role in implementation as the state's partners in providing critical behavioral health and social services. For these reasons, CC strongly advocates the adoption of the following policy recommendations and local investments to help ensure CARE Courts can be implemented in a practical and achievable manner in all 58 counties:

a) Phased-In Implementation**:** The path to success for counties – more importantly, for those who stand to benefit from CARE Court – must be grounded in an incremental phase-in model, in which counties most prepared to implement are the first adopters. This includes, but is not limited to, the resources and ability of courts to establish the new processes and procedures without contributing to further court backlogs; the staffing and funding capacity for behavioral health and social services to provide the necessary services to existing and new populations; and local solutions for ongoing housing shortages, which presents one of the biggest challenges and most critical elements for program success;

b) Resources: The CARE Court program includes new responsibilities and obligations imposed on counties that require additional resources and ongoing funding, likely in the hundreds of millions of dollars. Adequate and sustainable funding, as well as start-up funding is required across multiple departments, including county behavioral health, public defender, county counsel, public guardians and conservators, and county social services. This is in addition to funding required for court administration, operation, and staffing;

c) Fiscal Protections: The CARE Court proposal must provide protections to counties for any new responsibilities and costs. To ensure our counties have the appropriate long-term resources, we recommend fiscal provisions that preserve current funding and services, while also providing a mechanism for determining and allocating supplementary annual funding for new activities and duties required by this bill;

d) Sanctions: Sanctions should be reserved for deliberate and chronic deficiencies, imposed only after meaningful engagement within the existing regulatory framework along with the appropriate procedural safeguards. In addition, sanctions should not begin until after the program has been fully funded and implemented; and,

e) Housing: Housing is imperative for the successful treatment of those with SMI and foundational to addressing the larger problem of homelessness across California. To ensure that the state's recent housing investments are available to serve the CARE population, counties support recent amendments authorizing the Superior Court to order housing providers that have received specified state funds to accept placement of CARE participants at any available housing option or program as appropriate to meet the respondent's needs.

6) DOUBLE REFERRAL. This bill is double referred. It passed out of the Assembly Judiciary Committee with a 9-1 vote on June 21, 2022.

7) RELATED LEGISLATION.

a) AB 2220 (Muratsuchi) creates the Homeless Courts Pilot Program, which would be administered by the Judicial Council for the purpose of providing comprehensive community-based services to achieve stabilization for, and address the specific legal needs of, individuals who are chronically involved with the criminal justice system. AB 2220 was held in the Assembly Appropriations Committee.

b) AB 2830 (Bloom) is identical to the April 7, 2022, version of this bill. AB 2830 was pulled from hearing in the Assembly Judiciary Committee by the author.

c) SB 1416 (Eggman) expands the definition of "gravely disabled" to include the inability of an individual to provide for their basic personal needs for medical care for the purpose of involuntarily detaining the individual for evaluation and treatment of a mental health

condition, as specified. SB 1416 was not set for hearing in the Assembly Judiciary Committee.

8) **COMMITTEE CONCERNS.** Given the very significant concerns that continue to be raised about the bill by the opposition and those with concerns (many of whom will be required to implement CARE Courts), the authors and the Governor may consider further amending the bill as it moves forward, to address those concerns and other issues, including the following:

   a) Further extend the phased-in implementation period to ensure that counties have adequate time to establish the requisite infrastructure needed to meet the needs of program participants, including all needed housing, supports and services, and sufficient staff to ensure the supports and services are provided timely;
   b) Not order any unhoused individual to participate in the CARE Court unless and until housing, with wrap-around supportive services, can be guaranteed for the duration of the court order and, ideally, even after completion of the program;
   c) Revise the sanctions against counties to ensure that no county is sanctioned unless it has sufficient housing, available services, and other resources to provide the necessary supports and services to program participants. If a fine were necessary, ensure that the fine would not reduce funding for voluntary behavioral health services and supports;
   d) Ensure that funding for voluntary, community-based services is not reduced as a result of CARE Court. Reduction of voluntary services would be counterproductive and would increase the need for more expensive and likely less effective involuntary treatment; and,
   e) Provide indemnification for licensed professionals participating in the CARE Court processes, similar to that which is contained in the LPS Act.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County Families Advocating for The Seriously Mentally Ill
Bay Area Council
Big City Mayors
Building Owners and Managers Association
California Association of Code Enforcement Officers
California Chamber of Commerce
California Downtown Association
California Hospital Association
California Professional Firefighters
California Travel Association (CALTRAVEL)
Central City Association of Los Angeles
City of Alhambra
City of Bakersfield
City of Berkeley
City of Beverly Hills
City of Buena Park
City of Carlsbad
City of Chino Hills
City of Chula Vista
City of Concord

City of Corona
City of Coronado
City of Del Mar
City of El Cajon
City of Encinitas
City of Escondido
City of Fontana
City of Fullerton
City of Garden Grove
City of Half Moon Bay
City of Huntington Beach
City of Imperial Beach
City of Irvine
City of La Mesa
City of Lemon Grove
City of Mission Viejo
City of Montclair
City of National City
City of Oceanside
City of Ontario
City of Paramount
City of Poway
City of Rancho Palos Verdes
City of Redwood City
City of Riverside
City of San Diego
City of San Marcos
City of Santa Monica
City of Santa Rosa
City of Santee
City of Solana Beach
City of Upland
City of Vista
County of Contra Costa
County of Marin
County of San Diego
Family and Consumer Advocates for The Severely Mentally Ill
Family Services Association
Fontana Chamber of Commerce
Fremont Chamber of Commerce
Garden Grove Chamber of Commerce
Golden Gate Restaurant Association (GGRA)
Govern for California
Harbor Association of Industry & Commerce
Hotel Council of San Francisco
Inland Empire Economic Partnership (IEEP)
Laguna Niguel Chamber of Commerce
Lake Elsinore Valley Chamber of Commerce
Los Angeles Area Chamber of Commerce

Los Angeles Business Council
Los Angeles County Business Federation (BIZFED)
National Alliance on Mental Illness (NAMI-CA)
Neighborhood Partnership Housing Services, INC.
Oceanside Chamber of Commerce
Orange County Business Council
Orange County Hispanic Chamber of Commerce
Palos Verdes Peninsula Chamber of Commerce
Psychiatric Physicians Alliance of California (PPAC)
Redondo Beach Chamber of Commerce
Sage Leadership Academy
San Diego County District Attorney's Office
San Diego Regional Chamber of Commerce
San Francisco Chamber of Commerce
San Francisco Travel Association
San Pedro Chamber of Commerce
Santa Clarita Valley Chamber of Commerce
Santa Rosa Metro Chamber of Commerce
Santee Chamber of Commerce
South Bay Association of Chambers of Commerce
Tulare Chamber of Commerce
Valley Industry and Commerce Association
West Ventura County Business Alliance

Opposition

A & L Association
Abolition Study Group of Psychologists for Social Responsibility
American Civil Liberties Union (ACLU), Center for Advocacy & Policy CA
American Civil Liberties Union California Action
American Civil Liberties Union of California
Anti Police-terror Project
Bay Area Legal Aid
California Behavioral Health Planning Council
Cal Voices
California Advocates for Nursing Home Reform
California Assoc. of Mental Health Peer Run Organizations (CAMHPRO)
California Democratic Party Black Caucus Legislative Committee
California Pan-ethnic Health Network
Caravan 4 Justice
Care First California
Corporation for Supportive Housing (CSH)
County of Humboldt
Depression and Bipolar Support Alliance
Dignity and Power Now
Disability Rights Advocates
Disability Rights California
Disability Rights Education & Defense Fund (DREDF)
Disability Rights Legal Center

Drug Policy Alliance
Ella Baker Center for Human Rights
Funders Together to End Homelessness San Diego
Housing California
Housing Is a Human Right - Orange County
Human Rights Watch
Inland Equity Partnership
Justice in Aging
Justice LA
Justice Teams Network
Justice2jobs Coalition
Kelechi Ubozoh Consulting
LA Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Lotus Collective
Love and Justice in The Streets
Loyola Law School
Mental Health Advocacy Services
Mental Health America of California
NAACP San Mateo Branch #1068 Housing Committee
National Association of Social Workers, California Chapter
National Health Law Program
National Homelessness Law Center
Nextgen California
No CARE Court California Coalition
Norcal Resist
Peers Envisioning and Engaging in Recovery Services (PEERS)
People's Budget Orange County
People's Homeless Task Force Orange County
Project Amiga
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld, LLP
Sacramento Homeless Organizing Committee
Sacramento LGBT Community Center
Sacramento Regional Coalition to End Homelessness
San Bernardino Free Them All
San Francisco Pretrial Diversion Project
San Francisco Public Defender's Office
Senior & Disability Action
Senior and Disability Action
Starting Over INC.
Stop the Musick Coalition
Street Watch LA
Stronger Women United
The Bar Association of San Francisco
The Coelho Center for Disability Law Policy and Innovation
Western Center on Law & Poverty

Western Regional Advocacy Project
Women's Wisdom Art
10 individuals

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097

Exhibit 4

Pages: RJN-0126 through RJN-0214

Assembly Committee on Judiciary, Analysis, Date of Hearing: June 21, 2022

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

Date of Hearing: June 21, 2022

ASSEMBLY COMMITTEE ON JUDICIARY
Mark Stone, Chair
SB 1338 (Umberg and Eggman) – As Amended June 16, 2022

SENATE VOTE: 39-0

SUBJECT: THE COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT (CARE) COURT PROGRAM

KEY ISSUES:

1) SHOULD CALIFORNIA ENACT THE COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT (CARE) COURT PROGRAM, WHICH USES A COURT PROCESS TO ORDER THOSE SUFFERING FROM CERTAIN SERIOUS MENTAL ILLNESSES, INCLUDING SCHIZOPHRENIA SPECTRUM, INTO TREATMENT PLANS WITH THE COUNTY?

2) IN ORDER TO BE SUCCESSFUL, SHOULD THE PROGRAM BE FULLY FUNDED, ENSURING THAT PROGRAM PARTICIPANTS RECEIVE NECESSARY HOUSING AND SUPPORTIVE SERVICES, BEFORE IT IS IMPLEMENTED AND BEFORE SANCTIONS FOR FAILURE TO COMPLY WITH COURT ORDERS IMPACT COUNTIES AND PARTICIPANTS?

3) ARE THE DUE PROCESS PROTECTIONS IN CARE COURTS SUFFICIENT TO ENSURE THAT THE CONSTITUTIONAL RIGHTS OF CARE COURT PARTICIPANTS ARE PROTECTED?

4) MIGHT THE RESOURCES THAT WILL GO INTO DEVELOPING AND OPERATING CARE COURTS, PARTICULARLY MONEY FOR COURTS, ATTORNEYS, AND LEGAL SELF-HELP, BE BETTER UTILIZED TO DIRECTLY PROVIDE ADDITIONAL AND CRITICALLY NEEDED HOUSING, SERVICES, AND SUPPORTS TO THE POPULATION?

SYNOPSIS

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. Unhoused individuals not only need housing, but many suffer from other issues that are exacerbated by homelessness, including physical and mental health disorders, and substance abuse disorders. Moreover, these individuals are more likely to be involved with the criminal justice system, many for minor infractions based on being homeless or impoverished. Existing systems and programs to care for and treat the homeless and the mentally ill, including county-based voluntary programs, coerced programs under the Lanterman-Petris-Short Act (LPS Act), and the criminal justice system, have failed to provide sufficient support for those suffering from mental illness, particularly those living on the streets.

This bill, sponsored by Governor Newsom, does not seek to fix the existing system by infusing more resources into it, but instead creates a new program – the CARE Court program. Under the CARE Court program, civil courts could order those suffering from certain mental illnesses into a treatment program 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 ongoing court oversight. Under the bill, a broad range of individuals, including family members, behavioral health professionals, and first responders with knowledge of the person, can petition the civil court to have a person suffering from severe mental illness and a current diagnosis of schizophrenia spectrum or other psychotic disorder ordered into either a voluntary CARE agreement, or a court ordered treatment plan for one year or, if renewed, two years. The Governor states that "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." The bill is supported by, among others, Big City Mayors and many cities; business, travel, and tourism groups; some psychiatrists; and several groups representing family members of those with severe mental illness.

The bill is opposed by a broad array of civil rights and mental illness advocacy organizations. In addition, many county entities and services providers, who will be called upon to implement CARE agreements and plans and provide the needed support and services, have raised significant concerns about the bill. Among the biggest concerns are: (1) there is no funding to support the housing and services required for CARE participants to be successful; (2) additional time is needed to develop the framework and workforce to support the CARE Court program; (3) whatever funding there may be for the courts would be better spent on voluntary and not coerced services; (4) non-coercive treatment approaches work better to help those suffering from mental illness; and (5) the program could discriminate against marginalized groups, particularly Black men. The analysis suggests additional amendments that the Governor and authors may wish to consider to address some of these issues as the bill moves forward.

SUMMARY: Establishes the Community Assistance, Recovery, and Empowerment (CARE) Court program and the CARE Act. Specifically, **this bill**:

1) Establishes the CARE Act. States the intent of the Legislature that the CARE Act be implemented in a manner than ensures it is effective.

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 enumerated services, as provided.

   c) "CARE supporter" is a designated adult who assists the person who is the subject of a CARE petition, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE Act court process, including a CARE agreement, CARE plan, and graduation plan. Provides that a CARE supporter may not act independently.

d) "Graduation plan" is a voluntary agreement entered into by the parties at the end of the CARE program that shall include 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 counties and is not enforceable by the court.

e) "Psychiatric advance directive" is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions, that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis.

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

g) "Respondent" is the person who is subject to the petition for CARE court proceedings.

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

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

b) The person is currently suffering from a severe mental illness, as defined, and has a current diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Does not include a person who has a current diagnosis of substance abuse disorder, but does not otherwise meet the required criteria.

c) The person is not clinically stabilized in on-going 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 the CARE Act services 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 CARE Act services.

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

5) Provides that all CARE Court 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.

6) Allows a petition to initiate a CARE proceedings to be brought by:

   a) An adult with whom the respondent resides or a spouse, parent, adult sibling, adult child, or grandparent of the respondent, or another adult 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 respondent's 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 is present or reasonably believed to be present, or their designee (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) A prosecuting attorney (and a respondent may be referred from misdemeanor proceedings, as provided).

   k) The respondent.

7) Requires the CARE petition, which 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 the Lanterman-Petris-Short Act (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 petitions for CARE Act proceedings that were 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 court proceeding, and requires the court to appoint counsel if the respondent does not have their own attorney.

10) 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.

11) Requires that all evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings are confidential.

12) Upon receipt of a CARE Court petition the court shall promptly review the petition to see if it meets the requirements in 7).

a) If the court finds the petition does not meet the requirements in 7), the court shall dismiss without prejudice, subject to 8).

b) If the court finds the petition may meet the requirements in 7), the court shall order a county agency, or their designee, as determined by the judge, to investigate as necessary and file a written report with the court within 21 days that includes: (i) a determination as to whether the respondent meets, or is likely to meet, the criteria for CARE proceedings; and (ii) the outcome of efforts made to voluntarily engage the respondent during the 21-day report period. Requires the court to provide notice to the respondent and petitioner that a report has been ordered.

13) Requires the agency in 12b) to submit a written report to the court with the findings and conclusions of its investigation, along with any recommendations. If the 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.

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

   a) 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; (iii) appoint a CARE supporter, unless the respondent chooses their own CARE supporter or chooses not to have a CARE supporter; and (iv) provide notice of the hearing to the petitioner, the respondent, the appointed counsel, the CARE supporter, and the county behavioral health agency in the county where the respondent resides.

   b) Requires the court, if it determines that the individual meets, or likely meets the criteria, voluntary engagement is effective, and the individual has enrolled in behavioral health treatment, to dismiss the matter.

   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. The court must notify the petitioner and the respondent of the dismissal and the reason for dismissal. The petitioner may request reconsideration.

15) 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, and appropriate attempts to elicit the attendance of the respondent have failed, allows the court to conduct the hearing in the respondent's absence. If the hearing is conducted without the respondent present, requires the court to set forth the factual basis for doing so and the reasons the proceedings will be successful without the respondent's presence.

   c) Requires a county behavioral health agency representative and a supporter (subject to the respondent's consent) to be present, 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.

16) At the case management hearing:

   a) If the parties have agreed to a CARE agreement, and the court agrees with the terms, requires the court to stay the matter and set a progress hearing for 60 days.

b) If the court finds that the parties have not and are not likely to reach a CARE agreement, requires the court to order a clinical evaluation of the respondent, as provided. Requires the evaluation to address the clinical diagnosis and the issue of whether the defendant has capacity to give informed consent regarding psychotropic medication. Requires the county behavioral health agency, through a licensed behavioral health professional, to conduct the evaluation unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation.

17) At the clinical evaluation review hearing:

a) Requires the court to consider the evidence, 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 that the evidence does not, by clear and convincing evidence, support that the respondent meets the CARE criteria, requires the court to dismiss the petition.

c) If the court finds, by clear and convincing 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 CARE supporter to jointly develop a CARE plan. If another entity will provide services or supports under the CARE plan, allows that entity to be joined as a party.

18) Allows the respondent and the county behavioral health agency to request appellate review of an order to develop a CARE plan.

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

a) 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.

b) 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, the medication shall not be forcibly administered and the respondent's failure to comply with a medication order shall not result in a penalty, including but not limited to contempt or the accountability measures in 27) and 28).

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

20) The issuance of any orders in 19) begins the up to one-year CARE program timeline.

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

a) Requires county behavioral health to file with the court, and serve on the respondent and the respondent's counsel and supporter, a report not less than seven 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) Requires that the status review hearing occur unless waived by all parties and approved by the court.

c) Allows county behavioral health, the respondent, or the court to request more frequent reviews as necessary.

22) Requires the court, in the 11 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 county behavioral health before the status conference, as provided.

b) If the respondent has successfully completed the CARE program, the respondent may not be reappointed to the program, but 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.

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.

d) Allows the court to 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 program; (ii) all of the required services and supports were provided to the respondent; (ii) the respondent would benefit from continuation of the CARE program; and (iv) the respondent currently meets the requirements in 3).

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

27) 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 program. Allows the court to make a referral under the LPS Act, as provided.

28) 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.

29) Allows the court, at any time in the proceeding if it finds that the county, or other local government entity, is not complying with its orders, to fine the county, or other local government entity, up to $1,000 per day for noncompliance. Allows the court, 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. Requires that any fines be deposited in a special fund and used for the purpose of supporting county activities serving individuals with serious mental illness.

30) Allows either the respondent or the county behavioral health agency to appeal an adverse court decision.

31) Requires the Department of Aging, to administer a CARE supporter program, which includes specified training. Requires that the CARE supporter program be designed to do the following:

    a) Provide 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 any of the following:

    a) Evaluation;

    b) Creation of the CARE plan;

    c) Establishing a psychiatric advance directive; and

    d) Development of a graduation plan.

33) Sets forth the duties and limitations of the supporter, which include:

    a) Support the will and preferences of the respondent, as provided;

    b) Respect the values, beliefs, and preferences of the respondent;

    c) Act honestly, diligently, and in good faith;

d) Avoid, to the greatest extent possible, conflicts of interest, as provided; and

e) Unless explicitly authorized by a respondent with capacity, not:

i) Make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury; and

ii) Sign documents on behalf of the respondent.

34) 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, and provides that the supporter's presence at any meeting, proceeding, or communication does not waive confidentiality or any privilege.

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.

37) Provides that all CARE plan services and supports ordered by the court are subject to all applicable federal and state statutes, regulations, contractual provisions and policy guidance governing program eligibility, and available funding.

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

39) Requires the Department of Health Care Service (DHCS), subject to an appropriation, to provide 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, and data collection.

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

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

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

43) Allows the Health and Human Services Agency, DHCS, and the Department of-Aging 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.

44) Requires DHCS, in consultation with county behavioral health agencies, CARE supporters, disability rights groups, individuals with lived experience, and other appropriate stakeholders, to prepare an annual CARE Act report. Requires the counties to provide data required by DHCS. Requires DHCS to provide information on the populations served and demographic data, stratified by age, sex, race, ethnicity, languages spoken, disability, and county, to the extent statistically relevant data is available. 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.

45) Requires DHCS, in consultation with others, to develop an independent evaluation of the effectiveness of the CARE Act. 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.

46) 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.

47) 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.

EXISTING LAW:

1) Defines “Housing First” to mean the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. States that Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services. (Welfare & Institutions Code Section 8255. Unless stated otherwise, all further statutory references are to the Welfare & Institutions Code.)

2) Requires all agencies and departments administering state programs, created on or after July 1, 2017, to collaborate with the California Interagency Council on Homelessness to adopt guidelines and regulations to incorporate core components of Housing First. (Section 8256.)

3) Establishes the LPS Act to end inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to provide prompt evaluation and treatment of those with mental health disorders or impaired by chronic alcoholism. (Section 5000 *et seq*.)

4) Defines, as a basis for involuntary commitment under the LPS Act, "grave disability" as a condition in which a person, as a result of a mental disorder, or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter, or is found to be mentally incompetent under the Penal Code. Excludes from that definition persons with intellectual disabilities by reason of that disability alone. (Section 5008 (h).)

5) Provides that if a person is gravely disabled as a result of mental illness, or a danger to self or others, then a peace officer, staff of a designated treatment facility or crisis team, or other professional person designated by the county, may, upon probable cause, take that person into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement in a designated treatment facility. (Section 5150.)

6) Allows a person who has been detained for 72 hours to be detained for up to 14 days of intensive treatment if the person continues to pose a danger to self or others, or to be gravely disabled, and the person has been unwilling or unable to accept voluntary treatment. (Section 5250.)

7) Allows a person to be held at the expiration of a 14-day period of intensive treatment for further intensive treatment of up to 14 days if, during the detention period, a person threatened or attempted to take their own life or was detained because they threatened or attempted to their own life and continues to present an imminent threat of taking their own life and other specified conditions. (Section 5260.)

8) Allows a person who has been detained for 14 days of intensive treatment to be detained for up to 30 additional days of intensive treatment if the person remains gravely disabled and is unwilling or unable to voluntarily accept treatment. (Section 5270.15.)

9) Requires a certification review hearing to be held within four days of the date on which a person is certified for a 14-day period of intensive treatment or 30 additional days of intensive treatment unless judicial review has been requested or a postponement is requested by a person or their attorney or advocate. (Section 5256.)

10) Provides every person detained by certification for intensive treatment with a right to a hearing by writ of habeas corpus for their release. Enumerates specified requirements and procedures for judicial review. (Sections 5275, 5276.)

11) Allows for antipsychotic medication to be administered to any person subject to specified detentions under the LPS Act if that person does not refuse that medication. Allows antipsychotic medication to be administered when a detained individual indicates refusal of that medication only when the treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient and upon a determination of that person's incapacity to refuse the treatment in a hearing. In the case of emergency, allows for antipsychotic medication to be administered over a detained person's objection prior to a capacity hearing if the medication is required to treat the emergency and is provided in the manner least restrictive to the personal liberty of the patient. Enumerates specified requirements and procedures for capacity hearings pertaining to administering antipsychotic medication. (Sections 5332, 5334, 5336.)

12) Allows, under the LPS Act, a court to order an imminently dangerous person to be confined under a conservatorship for further inpatient intensive health treatment for an additional 180 days, as provided. (Section 5366.1.)

13) Allows the professional person in charge of a facility providing 72-hour, 14-day, or 30-day treatment to recommend an LPS conservatorship to the county conservatorship investigator for a person who is gravely disabled and is unwilling or unable to voluntarily accept treatment; and requires the conservatorship investigator, if they concur with the recommendation, to petition the superior court to establish an LPS conservatorship. Provides that a person for whom an LPS conservatorship is sought has the right to demand a court or jury trial on the issue of whether they are gravely disabled. (Section 5350 *et seq.*)

14) Requires an officer providing conservatorship investigation to investigate all available alternatives to conservatorship and recommend conservatorship to the court only if no suitable alternatives are available. Requires the officer to render to the court a comprehensive written report containing all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, information concerning the person's property, and information obtained from the person's family members, close friends, social worker, or principal therapist. Requires the officer, if they recommend against conservatorship, to set forth all alternatives available. (Section 5354 (a).)

15) Requires that a conservator under an LPS conservatorship place the conservatee in the least restrictive alternative placement, as provided. Gives the LPS conservator the right, if specified in the court order, to require the conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee's being gravely disabled. (Sections 5358, 5258.2.)

16) Requires counties, unless they opt out, to provide Assisted Outpatient Treatment (AOT), also known as "Laura's Law," for people with serious mental illnesses when a court determines that a person's recent history of hospitalizations or violent behavior, and noncompliance with voluntary treatment, indicates the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment. (Section 5345 *et seq.*)

17) Establishes a pilot program, until January 1, 2024, for Los Angeles and San Diego Counties, and the City and County of San Francisco, upon authorization by their respective boards of supervisors, to implement a "housing conservatorship" procedure for a person who is incapable of caring for their health and well-being due to a serious mental illness and substance use disorder, as evidenced by eight or more detentions for evaluation and treatment under Section 5150 in the preceding 12 months. (Section 5450 *et seq.*)

18) Provides that all hearings under the LPS Act are presumptively closed to the public if the hearings involve the disclosure of confidential information, including certification review hearings and jury trials. (Section 5118 (c).)

19) Permits, under the Probate Code, any interested person to petition the court for the appointment of a "conservator of the person" for a person who is unable to provide properly for their personal needs for physical health, food, clothing, or shelter, and permits the appointment of a "conservator of the estate" for a person who is unable to manage their financial resources or resist fraud or undue influence. Provides that no conservatorship of the person or of the estate may be granted by the court unless the court makes an express finding

that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee. (Probate Code Sections 1800.3, 1801.)

20) Creates a court diversion program for those charged with certain drug offenses. (Penal Code Section 1000 *et seq.*)

21) Creates a court diversion program for those with "mental disorders," as defined. (Penal Code Section 1001.35 *et seq.*)

22) Allows a court, if a criminal defendant is found to be mentally incompetent, to, among other things, determine if the defendant is eligible for a diversion program, or, if ineligible, to, among other things, refer the defendant to AOT or to an LPS conservatorship investigation. (Penal Code section 1370.01.)

FISCAL EFFECT: As currently in print this bill is keyed fiscal.

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 bill's authors add:

> 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.

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 percent of the nation's homeless population – over 160,000 – of which 70.4 percent 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.) More than half of the unsheltered in the United States are in California. (*Ibid.*) More veterans are homeless in California than anywhere else in the United States, representing 31 percent of the nation's total. (*Ibid.)* Likewise, California is home to 15 percent of the nation's homeless children. (*Ibid.)* By comparison, California has just 11.9 percent of the nation's population, according to the most recent census data. (U.S. Census Bureau, *Resident Population for the 50 States, the District of Columbia, and Puerto Rio: 2020 Census, available at* https://www2.census.gov/programs-surveys/decennial/2020/data/apportionment/apportionment-2020-table02.pdf.) In addition, California experienced the largest increase in homelessness in the nation from 2018 to 2019 (6.8 percent increase) and the second largest from 2007 to 2020 (45.8% increase). (*Ibid.*)

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

State Auditor finds that the current approach to helping reduce homelessness is uncoordinated and lacks effectiveness. The California State Auditor reviewed California's approach to addressing homelessness and determined that its disjointed approach has likely, in part, led to California's largest in the nation homeless population. (State Auditor, *Homelessness in California: The State's Uncoordinated Approach to Addressing Homelessness has Hampered the Effectiveness of its Efforts* (Feb. 2021), p. 1.) Instead of a single state entity responsible for overseeing California's efforts to address homelessness, "at least nine state agencies administer and oversee 41 different programs that provide funding for purposes related to homelessness." (*Ibid.*) The State Auditor found that the Homeless Coordinating and Financing Council (Homeless Council) created in 2017 to, among other things, coordinate funding, establish partnerships to develop strategies to end homelessness, and create a statewide data system, has not lived up to its promise of coordinating the state's response to homelessness, and major gaps in services remain. The State Auditor recommends:

> Given the magnitude of the homelessness crisis in California and the amount of funding the state and federal governments are committing to combat this crisis, the State needs to ensure that its system for addressing problems at both the [Continuum of Care] and the state level is coherent, consistent, and effective. Centralizing performance data collection from service providers and tracking federal and state funds dedicated to combating homelessness is a critical step toward that goal. By investing added responsibility and authority in the [H]omeless [C]ouncil to coordinate the State's response to homelessness, the Legislature can ensure that decision makers have the ability to clearly assess the State's efforts, successes, and challenges and to make informed decisions in the fight to reduce homelessness. (*Id.* at 4.)

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.

A significant portion of California's homeless population is severely mentally ill. While data on the number of people among California's unhoused population who are mentally ill is not entirely clear, it is clear that a significant portion of that population has mental health disabilities. According to the 2019 annual point-in-time count, 23 percent of California's homelessness population is severely mentally ill. (Legislative Analyst's Office, *California's Homelessness Challenges in Context, supra*, citing the U.S. Department of Housing and Urban Development's 2019 point-in-time homelessness count.) A Los Angeles Times review of the 2019 point-in-time homelessness count for Los Angeles County found that 51 percent of homeless were either reported or observed to be affected by mental illness; 46 percent were affected by substance abuse; and 67 percent were affected by either mental illness or substance abuse. (Doug Smith and Benjamin Oreskes, *Are many homeless people in L.A. mentally ill? New findings back public perception,* Los Angeles Times (Oct. 7, 2019).) A study from the University of California's California Policy Lab, linking Los Angeles County Department of Mental Health records to Street Outreach data, found that 20 percent of Street Outreach clients had been diagnosed with a serious mental illness within the previous 12 months. (Nathan Hess, *et al., Unsheltered in Los Angeles: Insights from Street Outreach Service Data* (Feb. 24, 2021) California Policy Lab.) That study also found that homeless clients of the Street Outreach program waited, on average, 101 days for interim housing; 112 days for rapid re-housing; and 188 days for permanent housing. (*Ibid.*)

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 U.S. 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. Generally speaking, courts demand that statutes are written and implemented in a way that requires government to achieve its legitimate interest in the least restrictive manner possible. But at some point, a statute that goes beyond the boundaries of *O'Connor* – if it allowed the detention of persons who do not *currently* suffer from a grave disability, do not *currently* constitute a threat to themselves or others, or disregarded the availability of others to provide basic necessities of life, for example – could be found by a court to be unconstitutional.

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.

However, under a significant exception to the *Olmstead* requirement to provide integrated services, a state or local jurisdiction can seek to show that providing integrated community services would be too costly or beyond their capacity in light of "the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." (*Id.* at 604.) State and local jurisdictions must provide community-based services to individuals with disabilities (which include mental disabilities) provided the services are appropriate, the individuals do not oppose the services, and community-based services can be reasonably accommodated. (*Id.* at 607.)

California's mandatory treatment options for those with mental illness. California law provides a number of options for forcibly detaining and treating individuals with severe mental illness. The chief legal option is the 1967 LPS Act, which provides for involuntary commitment for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements or preconditions are met. The goal of the LPS Act is to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities." (Section 5001.)

LPS involuntary holds and conservatorships. Under the LPS Act, an individual may be involuntary committed for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements are met. Additionally, the LPS Act provides for LPS conservatorships, resulting in involuntary commitment for the purposes of treatment, if an individual is found to meet the "grave disability" standard in which a person, as a result of a mental disorder or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter. (Section 5008.)

Typically, a person's first interaction with the LPS Act is through what is commonly referred to as a 5150 hold. This allows an approved facility to involuntarily commit a person for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5150.) The peace officer, or other authorized person, who detains the individual must know of facts that would lead a person of ordinary care and prudence to believe that the individual meets this standard. (*People v. Triplett* (1983) 144 Cal.App.3rd 283, 287-88.) When making this determination, the peace officer, or other authorized person, may consider the individual's past conduct, character, and reputation, so long as the case is decided on facts and circumstances presented to the detaining person at the time of detention. (*Heater v. Southwood Psychiatric Center* (1996) 42 Cal.App.4th 1068, 1080.)

Following a 72-hour hold, the individual may be held for an additional 14-days, without court review, if they are found to still be, as a result of a mental health disorder, a threat to themselves or others, or gravely disabled. (Section 5250.) When determining whether the individual is eligible for an additional 14-day confinement, the professional staff of the agency or facility providing evaluation services must find that the individual has additionally been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. Additionally, the individual cannot be found at this point to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or third parties who are both willing and able to help. The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing.

If a person is still found to remain gravely disabled and unwilling or unable to accept voluntary treatment following their additional 14 days of intensive treatment, they may be certified for an additional period of not more than 30 days of intensive treatment. (Section 5270.15.) The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing. Additionally, the professional staff of the agency or facility providing the treatment, must analyze the person's condition at intervals not to exceed 10 days, and determine whether the person continues to meet the criteria for continued confinement. If the person is found to no longer meet the requirements of the 30-day hold, then their certification should be terminated.

Finally, the LPS Act provides for a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. (Section 5350.) The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled individual. The individual for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement, and they have the right to be represented by counsel. An LPS conservatorship lasts for one year, but can be renewed.

Laura's Law. As an alternative to an LPS conservatorship, current law provides for court-ordered *outpatient* treatment through Laura's Law, or the Assisted Outpatient Mental Health Treatment Program (AOT) Demonstration Project, enacted in 2002. (AB 1421 (Thompson) Chap. 1017, Stats. 2002; Section 5345 *et seq*.) In participating counties, the court may order a person into an AOT program if the court finds that the person either meets existing involuntary commitment requirements under the LPS Act or the person meets non-involuntary commitment requirements, including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community. Originally, Laura's Law was only operative in those counties in which the county board of supervisors, by resolution, authorized its application and made a finding that no voluntary mental health program serving adults and no children's mental health program would be reduced in order to implement the law. The initial sunset provision provided for within Laura's Law was extended several times until 2020 when legislation was passed requiring that, rather than counties opting into Laura's Law, counties have to, by board of supervisors resolution, opt out of the program. Additionally, the sunset provision was removed, making the program permanent.

Laura's Law is designed to provide counties with tools for early intervention in mental health crises. It allows for family members, relatives, cohabitants, treatment providers, or peace officers to initiate the AOT process with a petition to the county behavioral health director or the director's designee. The health director or designee must then determine how to proceed. If the individual is found to meet the AOT eligibility requirements, a preliminary care plan is developed to meet that person's needs. If this process results in the person voluntarily engaging with treatment, then the patient is deemed to no longer meet the criteria and the petition is no longer available. However, if the client declines their preliminary plan, then a public defender is assigned and the petition process proceeds. A judge either grants or rejects the AOT petition; and if an AOT petition is approved, treatment is ordered and continues for up to 180 days.

Housing Conservatorship Pilot. In 2018, the Legislature created a pilot project, known as the "housing conservatorship," for those who have both serious mental illness and substance use disorder. (SB 1045 (Wiener & Stern) Chap. 845, Stats. 2018; revised by SB 40 (Wiener & Stern)

Chap, 467, Stats. 2019; Section 5450 *et seq.*) The counties of Los Angeles, San Diego, and San Francisco may, through January 1, 2024, elect to establish this new conservatorship, but only after, among other requirements, the board of supervisors determines that money will not be taken from other mental health and conservatorship programs and the board of supervisors ensures that necessary services are available in sufficient quantity, resources, and funding levels to serve the identified population, including access to supportive community housing with wraparound services, public conservators, mental health services, substance use disorder services, and service planning and delivery services.

This new six-month conservatorship, which may be established following a 28-day temporary conservatorship, is designed for those who are incapable of caring for their own health and well-being due to a serious mental illness and substance use disorder, as evidenced not by a contemporary grave disability, but by at least eight 72-hour involuntary holds under Section 5150 in the preceding 12 months. San Francisco requested creation of this new conservatorship to address a target population who, following a period of sobriety obtained during a 72-hour hold, have their psychiatric symptoms abate to the point that they are no longer considered gravely disabled and thus do not qualify for a longer involuntary hold under the LPS Act, yet repeatedly are brought in for 72-hour holds. To ensure that this new conservatorship is truly filling a gap and not replacing any existing conservatorship or program, the investigator must consider all alternatives to the proposed conservatorship and only recommend the new conservatorship if no less restrictive alternatives exist and it appears the individual will not qualify for a conservatorship under the Probate Code or the LPS Act. So far, only San Francisco has elected to participate in the pilot and, as of earlier this year, it appears that only two individuals have been conserved under the program, though more individuals could soon be eligible because they are approaching the requisite number of 5150 holds. The pilot requires a thorough evaluation, which should assist the Legislature in determining the need for, and success of, the program.

Probate Conservatorship. In California, if an adult is, based on clear and convincing evidence, unable to provide properly for their personal needs for physical health, food, clothing, or shelter, a conservator *of the person* may be appointed by the court. (Probate Code Section 1801.) If an adult who is, based on clear and convincing evidence, substantially unable to manage their own financial resources or resist fraud or undue influence, a conservator *of the estate* may be appointed by a court to manage the adult's financial matters. (*Id.*) The appointment process requires an investigation by a court investigator and approval by the court. The conservator can be a family member, friend, a professional fiduciary, or, more rarely, a county public conservator. A conservatorship involves a court-appointed third party – the conservator – making far-reaching, life-changing decisions on behalf of the conservatee. Historically, a conservatorship lasts until the death of the conservatee or a court order terminating it, based on someone seeking a petition for termination. (Probate Code Section 1860.) However, AB 1194 (Low, Chap. 417, Stats. 2021), requires that these conservatorships be reviewed annually by the probate court and terminated unless the court can legally reestablish them. Unfortunately, AB 1194 cannot be implemented until the Legislature specifically allocates funding for it, thus allowing conservatorships to continue indefinitely, despite the recent change in state law.

California's non-mandatory options for treating those with mental illness. Today there are a number of alternatives to the court-ordered involuntary holds or treatment that provide more autonomy, or advance choice, to the individual, while still providing them with necessary treatment and support. These include a durable power of attorney and advance health care

directive, as well as supported decisionmaking. More broadly, there are voluntary, community-based supports and services. In addition to other community-based voluntary mental health services and supports, in 2004 California voters adopted Proposition 63, which created the Mental Health Services Act (MHSA). The MHSA imposed a one-percent surtax on the wealthiest Californians in order to fund mental health programs and services across the state. Under the MHSA, the Department of Health Care Services (DHCS) allocates Proposition 63 funds to mental health programs and services through contracts with individual counties.

MHSA programs have three key components: community services and support (CSS); prevention and early intervention (PEI); and innovation. CSS programs, which account for about 80 percent of allocated funds, provide direct services to individuals with severe mental illness. The guiding concept of CSS programs is to do "whatever it takes" to meet the mental health needs of those who are unserved or underserved. PEI programs, which may account for up to 20 percent of a county's funding, seek to identify early mental illness (especially in children and young adults) before it becomes severe and disabling. Finally, counties may use up to five percent of their funding for "innovation," or developing, testing, and implementing new approaches that may not yet have demonstrated effectiveness. (Little Hoover Com., *Promises Still to Keep: A Decade of the Mental Health Services Act* (Jan. 2015) at 8.)

While the LPS Act and MHSA have different histories and functions, they share the common goal of helping people obtain treatment for mental illness in the least restrictive and most effective manner possible. The MHSA has the potential to provide alternatives to the sometimes stark choices presented by the LPS system.

Concerns raised about the LPS system may beg the question: is the remedy to fix the LPS system, or create a new system that may suffer from the same or similar problems? In July of 2020, the California State Auditor released a report entitled, "Lanterman-Petris-Short Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care." (California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra*.) The Joint Legislative Audit Committee called for the audit and the State Auditor examined the implementation of the LPS Act in Los Angeles County, San Francisco County, and Shasta County. Essentially the audit found that California has not ensured adequate care of individuals with serious mental illnesses in its broader mental health system. The audit found that, "perhaps most troublingly, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities." (Elaine Howell to Governor of California, President pro Tempore of the Senate, and Speaker of the Assembly, July 28, 2020, in California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care*, Report 2019-119, July 2020.) The Auditor found that the LPS Act's criteria for involuntary mental health treatment *allows counties sufficient authority to provide involuntary treatment* to people who need it and no evidence was found to justify expanding the "grave disability" criteria, which could "potentially infringe upon people's liberties." (California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra*, at 1 [emphasis added].) However, while the LPS Act's criteria are sufficient for involuntary holds and conservatorships, significant issues were found with how Californians with serious mental illnesses are cared for in the LPS system.

- Individuals on conservatorships have limited treatment options – many could not receive specialized care in state hospital facilities for an average of one year because of a shortage of available treatment beds;
- Individual existing involuntary holds have not been enrolled consistently in subsequent care to help them live safely in their communities – in two counties, no more than nine percent of these individuals were connected to ongoing services and supports; and
- Less than one-third of the State's counties – only 19 at the time of the audit – had adopted AOT even though it is an effective community-based approach to mental health treatment to help prevent future involuntary holds and conservatorships.

LPS is only part of an already muddled mental health system. While the State Auditor rightly noted the shortcomings of LPS holds and conservatorships, those shortcomings are not solely attributable to problems within the LPS Act, its definitions, or its implementation. LPS cannot "connect" persons to "ongoing care" if such care does not exist. The LPS Act, after all, was enacted to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." (Welfare & Institutions Code Section 5001.) Its primary purpose is not to provide mental health services per se, but to establish commitment criteria that protect the due process rights of persons who are experiencing a dangerous or debilitating mental health crisis. In the absence of voluntary and less restrictive treatment options, the various professionals who make determinations under the LPS Act too often face the choice of releasing a seriously mentally ill person back into the community, or committing them against their will to a locked psychiatric facility. This Hobson's choice does not reflect flaws in the LPS system as much as it exposes the lack of alternatives.

It was precisely this lack of alternatives in the wider mental health system that prompted California voters in 2004 to adopt the MHSA, discussed above. A 2016 report by the Little Hoover Commission (Little Hoover Com., *Promises Still to Keep: A Second Look at the Mental Health Services Act,* Paper #233, September 2016) cites several successful and promising local programs developed through the MHSA, but the Commission's overall conclusion was that a "muddled" governance structure makes it difficult to determine if counties use MHSA funds in the most efficient and effective manner, and who should be held accountable when they do not. For example, current law assigns various responsibilities for implementation of the MHSA to three different agencies: DHCS, which absorbed the administrative responsibilities of the now-disbanded Department of Mental Health Services in 2012; the Mental Health Services Oversight and Accountability Commission (MHSOAC), which although created by Proposition 63, has oversight responsibilities for the mental health care system as a whole; and the Mental Health Planning Council, which reviews program performance of the overall mental health system, including MHSA programs. Unfortunately, members of these three agencies informed the Little Hoover Commission that the broad and sometimes overlapping responsibilities mean, in practice, that there is no clear designation of who is responsible for what. (*Id.* at 10.)

On one key issue, the Little Hoover Commission's report on MHSA found (and the same problem that the State Auditor found in the LPS system) was insufficient data collection. "Despite compelling claims that the MHSA has transformed mental health services in communities across California," the Commission stated, "the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars." Without robust data, policymakers cannot know which programs work with which specific populations. The Commission found that some counties – Los Angeles in particular – have done better than others in tracking outcomes of specific programs. The

Commission recommended that the Legislature establish a MHSA data working group within DHCS to build upon the best of the county programs and develop a statewide MHSA database. As guidance, the Commission suggested that the Legislature look to the experience of a working group established in 2014 to collect data on the effectiveness of juvenile justice programs. (*Id.* at 16-18.)

If effectively utilized, the MHSA programs may well obviate the need for an LPS hold or conservatorship in the first place, or they might provide less expensive and more effective alternatives to the choice of either releasing or committing persons who are experiencing mental illness. However, LPS decision-makers must first have knowledge of these programs and their effectiveness with various populations, which would require much more data and analysis, as well as cooperation and collaboration.

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 Court Program. While the details of how the CARE Courts 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 CARE Court if, among other things:

- The person is currently suffering from a severe mental illness and has a current diagnosis of schizophrenia spectrum or other psychotic disorder.
- The person is not clinically stabilized in on-going treatment.
- At least one of the following is true:
    - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
    - 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.
- Participation in the CARE Act services would be the least restrictive alternative necessary to ensure the person's recovery and stability.
- It is likely that the person will benefit from CARE Act services.

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 a supporter for the duration of the process. They choose their own counsel and supporter, or the court will appoint and attorney and supporter for them. If the petitioner sets forth a prima facie case (sufficient initial evidence) that the respondent qualifies for CARE Court, 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 the CARE plan and to get the supports and services provided by the plan. However, if an agreement cannot be reached, and an evaluation proves that the respondent meets the CARE Courts 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 could be extended for and additional year if certain criteria were met.

While housing with supportive or wrap-around services would clearly be required for any unhoused respondent to be successful in the CARE plan, the bill does not require that housing is provided, but instead prioritizes the participant for certain housing. As discussed below, it is hoped that that the CARE Court program will be sufficiently well funded and will have sufficient resources to provide housing, with wrap-around services, to those in the program who lack stable housing. Otherwise it is hard to imagine that the CARE plan will be able to successfully support those it is designed to help.

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 the hearing that the respondent needs additional interventions beyond the supports and services provided by the CARE plan. Further, if a court finds that a county is not complying with a court order, it may fine the county up to $1,000 for each day of noncompliance; and if the county is consistently noncompliant, the court may, at the county's cost, appoint a receiver to secure the county's compliance. These penalties are subject to 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 Courts program appropriately requires an evaluation of the program so that the Legislature can learn how CARE Courts are 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.

This bill adds yet another program to the already long list of programs to help those with mental health disorders, without providing any apparent support to California's voluntary, community-based mental health system. Given the Auditor's concerns of an already muddled mental health system in California, could CARE Courts simply be another uncoordinated approach that seeks to help those suffering from mental illness, but that does not, by itself, secure any more treatment beds, housing, or critically needed services to help those suffering from

mental illness, particularly those who are also unhoused? Opponents argue that the considerable funding needed for CARE Courts could be better invested in providing desperately needed housing, services, and supports to the would-be participants. Human Rights Watch states:

> CARE Court shifts the blame for homelessness onto individuals and their vulnerabilities, rather than recognizing and addressing the root causes of homelessness such as poverty, affordable housing shortages, barriers to access to voluntary mental health care, and racial discrimination. CARE Courts are designed to force unhoused people with mental health conditions into coerced treatment that will not comprehensively and compassionately address their needs.
>
> Californians lack adequate access to supportive mental health care and treatment. However, this program does not increase that access. Instead, it depends on money already earmarked for behavioral health initiatives and layers harmful court involvement onto an already inadequate system. Similarly, the "Care plans" mandated by the CARE Courts do not address the shortage of housing.
>
> Investing in involuntary treatment ties up resources that could otherwise be invested in voluntary treatment and the services necessary to make that treatment effective. California should provide well-resourced holistic community-based voluntary options and remove barriers to evidence-based treatment to support people with mental health conditions who might be facing other forms of social exclusion. Such options should be coupled with investment in other social supports and especially housing, not tied to court-supervision. (Footnotes omitted.)

A group of over 40 organizations advocating on behalf of those who would be subject to CARE Courts adds:

> California should use the resources earmarked for CARE Court to invest in systems that will eliminate racial disparities in the healthcare, housing and other contributing systems to address houselessness. The first step would be to create and fund truly voluntary services, starting with housing, outside of the pressure of a court process. A fully funded system would permit a person to choose their services without fear of adverse legal consequences if they are found to be "non-compliant" with treatment.

The opponents' concerns can be briefly summarized as the following: before we create another involuntary system, we should fully fund and support a voluntary, community-based system of care. They add that, "no studies exist to prove that a court order for outpatient treatment *in and of itself* has any independent effect on client outcomes," but that there is strong evidence of the effectiveness of Assertive Community Treatment (ACT), a [voluntary] multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management." (Footnotes omitted.)

Regarding the need for adequate funding for housing and mental health services, an attorney with the Mental Health Unit at the San Francisco Public Defender's Office writes that what is needed "is more care, not more courts":

> The governor's CARE Court proposal will neither solve homelessness nor treat individuals with mental health needs. It is a referral system to nowhere. The proposal doesn't include any provisions or funding for housing or treatment. In fact, the state would burden already-

> limited local resources by imposing fines on counties unable to carry out court orders for involuntary treatment. . . .
>
> Rather than setting up a new bureaucracy to impose short-term solutions to entrenched problems that require long-term engagement, the state should aggressively invest in measures that would improve outcomes for some of the most vulnerable Californians . . . . (Kara Chien, *Without funding, the governor's CARE Court plan is just an empty gesture,* CalMatters (June 1, 2022).)

However, Family & Consumer Advocates for California's Severely Mentally Ill, a group of family members with loved ones with severe mental illness (SMI) disagrees, stating:

> It is also, in our view, inaccurate to label SB 1338 as "coercive" given the number of settlement hearings where the SMI individual has both a lawyer and supporter to help him/her decide on a treatment plan before the matter ever goes to a judge. Millions of Americans are subject to court orders (notably, most divorce decrees) and don't see themselves as "coerced' if they agreed to the decision. Several studies have shown that clients of Laura's Law/AOT (which most of these self-labelled civil "rights" activists also misguidedly oppose) generally like their AOT programs, presumably because they are involved in decisionmaking and at some level, recognize that they need help. People who do not understand this population should not project their own abilities and preferences onto others who do not share their gifts.

Should CARE Courts be delayed until there is adequate funding for the housing and services required to care for this population; or it be implemented only in counties with sufficient resources to adequately support CARE Court participants? At this point, it appears that the CARE Courts program will include additional funding for the courts and for self-help within the courts; for the Department of Health Care Services for training, technical assistance and an evaluation; and for the Department of Aging for recruitment and training of supporters. There is, however, no additional, funding, at this time, for housing, services, and supports for those who are required to participate in CARE plans. There is also no new funding for public defenders, or other attorneys who will represent the CARE Court participants, or for the increased behavioral health staff and county counsel personnel necessary to make the program work and represent the county's interests in court.

There is unanimous agreement that what is needed to treat this population is housing and various services and supports, including behavioral health and substance use treatments. The authors and supporters point out that counties have been given billions of dollars for housing and supportive services in the last few years, including $1.5 billion in housing funded by the Behavioral Health Bridge Housing program this year. However, without any new, targeted funding, those critically needed supports, services, and, especially, housing, may not be available; or if they were provided in some limited fashion, they could deplete funds available for voluntary, community-based care. As a result, a coalition of county groups, including the California State Association of Counties and the County Behavioral Health Directors Association recommends not only providing dedicated funds, but also allowing for sufficient time to ensure that resources are in place before the CARE Courts program is implemented:

> The path to success for counties – more importantly, for those who stand to benefit from CARE Court – must be grounded in an incremental phase-in model, in which counties most

> prepared to implement are the first adopters. This includes, but is not limited to, the resources and ability of courts to establish the new processes and procedures without contributing to further court backlogs; the staffing and funding capacity for behavioral health and social services to provide the necessary services to existing and new populations; and local solutions for ongoing housing shortages, which presents one of the biggest challenges and most critical elements for program success.

On the need for resources, the county coalition adds:

> The CARE Court program includes new responsibilities and obligations imposed on counties that require additional resources and ongoing funding, likely in the hundreds of millions of dollars. Adequate and sustainable funding, as well as start-up funding is required across multiple departments, including county behavioral health, public defender, county counsel, public guardians and conservators, and county social services. This is in addition to funding required for court administration, operation, and staffing. . . .
>
> The CARE Court proposal must provide protections to counties for any new responsibilities and costs. To ensure our counties have the appropriate long-term resources, we recommend fiscal provisions that preserve current funding and services, while also providing a mechanism for determining and allocating supplementary annual funding for new activities and duties required by SB 1338.

A coalition of service providers who likely will be called upon to deliver the supportive services required for CARE Court participants, while urging that the program be delayed until adequately funded, staffed, and ready to accept participants, note that "if critical resources such as workforce for treatment settings and housing do not exist, an individual is bound to fail. As such, we request reconsideration of a pilot program of several select counties for the next three years beginning January 1 2024, with a sunset, and a robust evaluation conducted by a university or another independent entity. This will allow the state to test the effectiveness of this new court model and correct unforeseen challenges with the program prior to statewide rollout."

Cities and counties have a split position on CARE Courts, which may raise questions about their ability to work together cooperatively to ensure needed housing and services are provided to CARE Court participants. As a general rule, cities support the legislation and counties and their associated entities, while not opposed, have raised many issues of concern with the legislation. (The exception is San Diego, where both the cities and county submitted a joint letter of support.) The split is likely due to the fact that many unhoused individuals with mental illness can be found in cities, while the counties will be called upon to provide the supports and services required by the bill (although creation of housing, in large part, is limited by cities).

City support is exemplified by this letter from the City of Santee, which recognizes the bill as:

> [A]n important measure to provide California's civil courts with a new process for earlier action, support, and accountability to protect and care for some of our State's most vulnerable residents.
>
> SB 1338 would provide individuals with a clinically appropriate, community-based, court-ordered care plan, including behavioral health care, stabilization medication, and housing

> support to adults who are suffering from specified mental health disorders (schizophrenia spectrum and psychotic disorders) and who lack medical decision making capacity.
>
> As this legislation could serve as an important tool to help in the City's effort to help address the challenges of homelessness and increase services and safety for those experiencing homelessness, the City Council of the City of Santee passed a unanimous resolution in support of SB 1338

While county concerns are illustrated by the letter from the County of Humboldt:

> As you know, Humboldt County strongly supports a comprehensive, holistic approach to addressing the homeless crisis. However, this bill so far fails to include additional funding for the impact CARE Court would have on our behavioral health, public defender and public guardian offices. Additionally, while we and the cities are working to build our housing stock and behavioral health workforce and infrastructure utilizing recent state investments, we are not yet prepared or funded to implement this new program effectively or operate it ongoing.
>
> New expectations, whether for CARE Court or other programs, require new resources to meet them, especially given decades of underfunding for behavioral health services and zero state investment in the county public guardian offices. Importantly, much of the work envisioned by the CARE Court proposal is not reimbursed by Medi-Cal or private insurance.
>
> Additionally, the proposed sanctions are not appropriate. Our county cannot bear sanctions related to an entirely new program in which we lack the sole authority, housing units and funding to implement. Sanctions would exacerbate the issues our overloaded and underfunded public defender and behavioral health departments are already experiencing, including a severe workforce shortage.

Unfortunately, if cities (who may be focused on moving out their unhoused residents) and counties (who will be required to place and serve those individuals) cannot work together to support CARE Court participants, the program is unlikely to succeed, helping neither counties nor cities, nor, most importantly, the program participants themselves.

These concerns are exemplified in a recent article in the Los Angeles Times about a lawsuit between an advocacy organization and the City of Los Angeles regarding the provision of housing for the homeless, exposing a rift between city and county officials: "Housing is largely the city's purview, while services are the county's, [John Maceri, chief executive of the People Concern, a nonprofit focused on homelessness] said, adding, 'If we cannot bring those two things together in a meaningful strategic way, we're never going to have the kind of impact we need.'" (Benjamin Oreskes and Doug Smith, *L.A. says it can't take care of its sickest and most vulnerable. The county isn't buying it* (April 21, 2022) Los Angeles Times.) Similarly, CARE Courts will only succeed if cities and counties work together.

Will this new involuntary program of coerced care discriminate against people of color, particular Black Californians, and other marginalized groups? The group of over 40 opponents write of its concern that CARE Court will "perpetuate institutional racism and worsen health disparities":

> Due to a long and ongoing history of racial discrimination in housing, banking, employment, policing, land use, and healthcare systems, Black people experience houselessness at a vastly

> disproportionate level compared to the overall population of the state. . . . On June 1, 2022, the Task Force [to Study and Develop Reparation Proposals for African Americans] issued its initial findings, ... [which] details the pervasive effects of racial discrimination in these systems resulting in serious harm to the health and welfare of Black Californians.
>
> These racial disparities are reflected in California's acute houselessness problem, which places a particularly heavy burden on Black Californians. In Los Angeles County alone, Black people make up 8% of the population, but 34% of people experiencing houselessness. Statewide statistics are even more dire: 6.5% of Californians identify as Black or African-American, but they account for nearly 40% of the state's unhoused population.
>
> Moreover, the Reparations Report recounts the history of racial discrimination enacted against Black people in the health care system over centuries, including the weaponizing of a mental health diagnosis to force sterilization and treatment. Research demonstrates that Black, Indigenous, and People of Color (BIPOC) and immigrant racial minorities are more likely to be diagnosed, and misdiagnosed, with psychotic disorders than white Americans because of clinicians' prejudice and misinterpretation of patient behaviors. In California, rates of those living with mental health disabilities requiring intense support vary considerably by racial and ethnic groups, with American Indian and Alaska Native and Black Californians experiencing the highest rates of diagnosis for serious mental health disabilities. For unhoused LGBTQIA+ people of color, the intersecting identities can result in even more significant mental health struggles and intensified discrimination. (Footnotes omitted.)

Peers Envisioning and Engaging in Recovery Services (PEERS) adds:

> California has a shameful history of discrimination against Black and Brown people in housing, employment, access to healthcare, policing, and the criminal justice system. Black and Brown individuals experience substantially higher rates of homelessness than their overall share of the population. CARE Court does nothing to change this reality. Instead, **it proposes a system of state sponsored control through court ordered treatment and medication, without offering any form of permanent supportive housing or community-based social supports**.

Does the bill, as amended, sufficiently protect the constitutional rights of CARE Court respondents and participants? As discussed above, there are significant constitutional constraints on the detention and forced treatment of those who are mentally ill, and while this bill does not involve detention per se, it does require individuals with certain severe mental illnesses to comply with court orders, including court-ordered medication. As initially drafted, the bill had some constitutional infirmities. Human Rights Watch noted:

> The legislation does not set meaningful standards to guide judicial discretion and does not delineate procedures for those decisions. It establishes a contradictory and unworkable procedure that allows certain people diagnosed with schizophrenia or other psychotic disorders to be ordered into treatment if, among other criteria, a judge believes that they have impaired insight or judgment that risks their health and safety, or that they are at risk of relapse or deterioration into grave disability or potential harm. These criteria are extremely subjective and speculative and subject to bias. On a mere showing of "prima facie" evidence that the petition is true, the person is then required to enter into negotiations with the county behavioral health agency to come up with a purportedly voluntary treatment plan. However,

> failure to agree to that plan results in an evaluation by that same behavioral health agency, which is used to impose a mandatory, court-ordered course of treatment. Once ordered, if a person does not complete the CARE program, they may be "involuntarily reappointed" to the program for an additional year. This process is entirely involuntary and coercive. The role of the behavioral health agency poses a great potential for conflicts of interest, as they will presumably be funded to carry out the Care Plans that result from their negotiations and their evaluations.
>
> The CARE Court plan threatens to create a separate legal track for people perceived to have mental health conditions, without adequate process, negatively implicating basic rights. (Footnotes omitted.)

However, the most recent version of the bill has expanded the protections and rights of respondents and participants in CARE Court. In particular, it tightens up the required criteria for respondents, shortens the time that non-contemporaneous assessments can be considered by the court, limits consequences for noncompliance with a medication order, and limits the impact that a participant's failure to complete the CARE plan program could have in a subsequent proceeding under the LPS Act. All of these changes increase protections for respondents and participants; but, if challenged in court, it remains to be seen whether these changes would be sufficient to pass constitutional muster.

How effective will CARE Courts be in compelling unwilling participants to participate in the program? The bill provides multiple opportunities for courts and petitioners to compel unwilling individuals to participate in CARE Courts, including by allowing a petition to be filed even if the proposed participant refused to be examined by a licensed behavioral health professional, or did not appear at the initial hearing. But that begs the question of whether someone who refused to participate in the court process would likely be successful in the program; or would this scenario simply result in the waste of precious resources, trying to compel them to do what they chose not to do. A coalition of service providers who will likely be called upon to deliver the supportive services required for CARE Court participants argue that the bill should focus more on voluntary treatment, rather than coercive treatment, (as discussed above) and ask the following questions:

> What will happen if a homeless outreach worker or a police officer refers an individual to be evaluated and placed into CARE Court, but the individual refuses? To what location are the notices served when the individual is unhoused? Will the person be arrested or detained by law enforcement? Further, how does the person actually get to the court? Are they transported? Where will the person be detained until they are evaluated? We believe that jails are not the appropriate place for individuals with behavioral health conditions and psychiatric hospitals are already at capacity. What protections will exist for situations where an inappropriate referral is made?

Other issues raised by opponents and concerned parties. In an effort at brevity, the following is a non-exhaustive list of additional concerns that have been raised by either opponents of the bill, those with concerns, or both:

- *Significantly revise financial penalties on counties:* The county coalition writes: "Sanctions should be reserved for deliberate and chronic deficiencies, imposed only after meaningful engagement within the existing regulatory framework along with the appropriate procedural safeguards. Counties support modeling the process adopted in

Assembly Bill 101 (Statutes of 2019) for jurisdictions that fail to comply with their obligations under state housing laws, which includes a pathway for both fines and receivership as proposed in SB 1338. In addition, sanctions should not begin until after the program has been fully funded and implemented."

- *Additional funding necessary for other parts of the mental health system:* SEIU California notes that this bill may increase the workload for public conservators because of possible increased LPS conservatorships, so additional funding will be required for them.

- *Framework and funding needed before implementation:* SEIU California writes: "Successful implementation of this program will be predicated on both sufficient funding and establishing a framework that protects participants and workers throughout the CARE Court system. Absent these elements, California runs the risk of doing more harm to the targeted population of CARE Courts, which is among the most vulnerable in our state."

- *Concern about interaction with criminal courts and criminal diversion:* The Chief Probation Officers of California write with concerns about the CARE Courts' method of service delivery for those involved with the criminal justice system: "There is no question that the treatment and housing services proposed to be provided via CARE Court are critically needed. However, the current language establishing a civil court framework may create difficulties in the coordination and delivery of services, particularly for justice involved individuals."

- *Bill could be a misuse of Mental Health Services Act funding.* In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which raised taxes on millionaires to fund a broad continuum of behavioral needs from prevention, to early intervention, and to services. Cal Voices, one of the bill's opponents, believes that the bill unconstitutionally amends Proposition 63: "When voters approved the MHSA, they were told that funds generated from the tax could only be used for specified new county programs and the expansion of existing, proven voluntary community mental health services. The funds could not be diverted by the State and local stakeholders had an ongoing role in determining the use of the funds, which was based on their current needs and capacity. Therefore, we believe, using MHSA funds for the CARE Court program would be invalid as inconsistent with the MHSA because SB 1338 unconstitutionally amends the MHSA without voter approval."

Additional amendments that the authors and sponsor should strongly consider. Given the very significant concerns about the bill raised by the opposition and those with concerns (many of latter of whom will be required to implement CARE Courts), as this bill moves forward, the authors and the Governor should strongly consider amending the bill to address those concerns and other issues, including the following:

- Piloting the CARE Court program in a limited number of counties to ensure all implementation issues are resolved before the program begins statewide.

- Not beginning CARE Courts in any the county that does not have the infrastructure set up to meet the needs of program participants, including all needed housing, supports and services, and sufficient staff to ensure the supports and services are provided timely.

- Not ordering any unhoused individual to participate in the CARE Court unless and until housing, with wrap-around supportive services, can be guaranteed for the duration of the court order and, ideally, even after completion of the program.

- Requiring the initial behavioral health affidavit required with the petition to include a recent behavioral health assessment of the respondent.

- Requiring that the respondent attend the initial hearing on the petition, or the petition would be dismissed, while leaving sufficient time to allow the county to encourage the respondent's participation. If the respondent fails to show up, it is difficult to imagine that a court order requiring them to participate will have much of an impact.

- Revising the sanctions against counties to ensure that no county is sanctioned unless it has sufficient housing, available services, and other resources to provide the necessary supports and services to program participants. If a fine were necessary, ensure that the fine would not reduce funding for voluntary behavioral health services and supports.

- Not reducing funding for voluntary, community-based services in order to support CARE Court. Reduction of voluntary services would be counterproductive and would increase need for more expensive and likely less effective involuntary treatment.

- Having the Judicial Council, rather than DHCS, provide required training to appointed counsel.

- Ensuring that the data for the CARE Courts evaluation includes, at a minimum:

    - The services ordered, the services provided, and the services ordered but not provided;
    - The housing placements of all participants during and following termination of the CARE plan;
    - The continued treatment that was provided following termination of the CARE plan;
    - Substance use disorder treatment rates;
    - Detentions and other LPS Act involvement during and following termination of the CARE plan;
    - Criminal justice involvement during and following termination of the CARE plan;
    - Deaths during and following termination of the CARE plan, along with causes of death; and
    - A subjective survey of the participants served, as well as the service providers.

Technical clean-up. Given the significant amendments taken on June 16, 2022, and the speed with which those amendments were completed, it is not surprising that there were several drafting errors that need to be corrected. The authors have agreed to make those technical changes in the Assembly Health Committee.

***ARGUMENTS IN SUPPORT**:* In support of the 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.

Adds the California Chamber of Commerce, along with 21 local chambers of commerce:

> The CARE Court is a thoughtful, measured response to the tragedy of homeless mentally ill or substance abuse disordered individuals. It attempts to thread the needle of providing necessary care and treatment in an environment appropriate to deliver those services; that is, a supportive setting that is neither outdoors or incarcerated. Importantly, the individuals to be served by this approach lack the capacity to make medical decisions for themselves; the only alternatives are the status quo, which is continued desperate deterioration living outdoors, or in a far more restrictive conservatorship or incarceration.
>
> California employers have a clear stake in improving the treatment and outcomes for severely mentally disabled individuals without a fixed residence. First, they are our fellow Californians, in severe need, for whom we have an obligation of care. Second, many employers share neighborhoods with mentally disabled or substance abuse disordered individuals, so have first-hand experience with the failure of our institutions to adequately serve them and address their misery. Finally, as taxpayers and business leaders, employers want to see their private investment return healthy, thriving communities.

***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.)

Pending Related Legislation: AB 2380 (Bloom) was identical to the April 7, 2022 version of this bill. It was pulled from hearing in this Committee by the author.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County Families Advocating for the Seriously Mentally Ill
Bay Area Council
Big City Mayors
Building Owners and Managers Association
California Association of Code Enforcement Officers
California Chamber of Commerce
California Downtown Association
California Hospital Association/California Association of Hospitals and Health Systems (if amended)

California Professional Firefighters
California Travel Association
Central City Association of Los Angeles
City of Alhambra
City of Bakersfield
City of Berkeley
City of Beverly Hills
City of Big Bear Lake
City of Buena Park
City of Carlsbad
City of Chino Hills
City of Chula Vista
City of Concord
City of Corona
City of Coronado
City of Del Mar
City of El Cajon
City of Encinitas
City of Escondido
City of Fontana
City of Fullerton
City of Garden Grove
City of Huntington Beach
City of Imperial Beach
City of Irvine
City of La Mesa
City of Lemon Grove
City of Mission Viejo
City of Montclair
City of National City
City of Oceanside
City of Ontario
City of Paramount
City of Poway
City of Redlands
City of Redwood City
City of San Diego
City of San Marcos
City of Santa Monica
City of Santee
City of Solana Beach
City of Upland
City of Vista
County of Orange (if amended)
Family & Consumer Advocates for California's Severely Mentally Ill
Family Services Association
Fontana Chamber of Commerce
Fremont Chamber of Commerce
Garden Grove of Chamber Commerce

Golden Gate Restaurant Association
Govern for California
Harbor Association of Industry and Commerce
Hotel Council of San Francisco
Island Empire Economic Partnership
Laguna Niguel Chamber of Commerce
Lake Elsinore Valley Chamber of Commerce
Los Angeles Area Chamber of Commerce
Los Angeles Business Council
Los Angeles County Business Federation, BizFed
National Alliance on Mental Illness – California (NAMI-CA)
Neighborhood Partnership Housing Services, Inc.
Oceanside Chamber of Commerce
Orange County Hispanic Chamber of Commerce
Palos Verdes Peninsula Chamber of Commerce
Psychiatric Physicians Alliance of California
Redondo Beach Chamber of Commerce
Sage Leadership Academy
San Diego Board of Supervisors
San Diego County District Attorney's Office
San Diego Regional Chamber of Commerce
San Francisco Chamber of Commerce
San Francisco Travel Association
San Pedro Chamber of Commerce
Santa Clarita Valley Chamber of Commerce
Santa Rosa Metro Chamber of Commerce
Santee Chamber of Commerce
South Bay Association of Chambers of Commerce
Steinberg Institute (in concept)
Tulare Chamber of Commerce
Valley Industry and Commerce Association
West Ventura County Business Alliance
One individual

Opposition

American Civil Liberties Union California Action
Anti Police-Terror Project
Bar Association of San Francisco
Bay Area Legal Aid
Bazelon Center
Cal Voices
California Behavioral Health Planning Council
California Advocates for Nursing Home Reform
California Association of Mental Health Peer-Run Organizations
California Democratic Party Black Caucus Legislative Committee
Caravan4Justice
Care First California
The Coelho Center for Disability Law, Policy & Innovation

Corporation for Supportive Housing
Depression and Bipolar Support Alliance – California
Decarerate Sacramento
Dignity and Power Now
Disability Rights Advocates
Disability Rights California
Disability Rights Education & Defense Fund
Disability Rights Legal Center
Drug Policy Alliance
Ella Baker Center for Human Rights
Ezekiel's Project
Funders Together to End Homelessness
Housing California
Housing Is a Human Right - Orange County
Housing Not Handcuffs Campaign
Human Rights Watch
Humboldt County Board of Supervisors
Inland Equity Partnership
Justice in Aging
Justice LA
Justice Teams Network
Justice2Jobs Coalition
La Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Lotus Collective
Love and Justice in The Streets
Mental Health Advocacy Services
Mental Health America of California
Mental Health First
National Association of Social Workers - California
National Health Law Program
National Homelessness Law Center
New Life Ministries of Tulare County
No CARE Court Coalition
Peers Envisioning and Engaging in Recovery Services (PEERS)
People's Homeless Task Force – Orange County
People's Budget - Orange County
Project Amiga
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld, LLP
Sacramento Homeless Organizing Committee
Sacramento LGBT Community Center
Sacramento Regional Coalition to End Homelessness
San Bernardino Free Them All
San Francisco Pretrial Diversion Project
San Francisco Public Defender's Office
San Mateo Branch of the NAACP Housing Committee

Senior & Disability Action
SmithWaters Group
Starting Over, Inc.
Street Watch LA
Transforming Justice Orange County
Unapologetically Black Unicorn
Western Center on Law & Poverty
Western Regional Advocacy Project
White People 4 Black Lives
Women's Wisdom Art
Eight individuals

Concerns

California Alliance of Child and Family Services
California Association of Alcohol and Drug Addiction Program Executives
California Association of Health Plans
California Association of Public Administrators, Public Guardians, and Public Conservators
California Association of Social Rehabilitation Agencies
California Council of Community Behavioral Health Agencies
California Psychological Association
California State Association of Counties
California State Council of Service Employees International Union (SEIU California)
Chief Probation Officers of California
Contra Costa Board of Supervisors
County Behavioral Health Directors Association of California
County of Butte
County of Lassen
County of Nevada Board of Supervisors
County of Santa Clara
County Welfare Directors of California
Del Norte County Board of Supervisors
Fresno County Board of Supervisors
Kern County Board of Supervisors
Monterey County
Rural County Representatives of California
Sacramento County Board of Supervisors
San Bernardino County Board of Supervisors
San Luis Obispo County Board of Supervisors
Santa Barbara County Board of Supervisors
Tulare County Board of Supervisors
Urban Counties of California

Analysis Prepared by: Leora Gershenzon / JUD. / (916) 319-2334

IN THE SUPREME COURT OF CALIFORNIA

Conservatorship of the Person and Estate of ERIC B.

PUBLIC GUARDIAN OF CONTRA COSTA COUNTY, as Conservator, etc.,
Petitioner and Respondent,
v.
ERIC B.,
Objector and Appellant.

S261812

First Appellate District, Division Five
A157280

Contra Costa County Superior Court
P18-01826

April 28, 2022

Justice Corrigan authored the opinion of the Court, in which Chief Justice Cantil-Sakauye and Justices Liu, Kruger, Groban, Jenkins, and Moore* concurred.

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* Associate Justice of the Court of Appeal, Fourth Appellate District, Division Three, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

Justice Kruger filed a concurring opinion, in which Justices Liu and Groban concurred.

Conservatorship of ERIC B.

S261812

Opinion of the Court by Corrigan, J.

The Lanterman-Petris-Short (LPS) Act authorizes one-year conservatorships for those gravely disabled by a mental disorder or chronic alcoholism. (Welf. & Inst. Code, § 5350.) Conservatorship proceedings are civil in nature, so the constitutional protections afforded criminal defendants do not directly apply. However, the Legislature has extended many of the same rights *by statute* to the commitment of persons found not guilty of crimes by reason of insanity (NGI's). (Pen. Code, § 1026.5, subd. (b)(7).) Among those is the right not to give compelled testimony at trial. (See *Hudec v. Superior Court* (2015) 60 Cal.4th 815, 826 (*Hudec*).) The question here is whether those facing conservatorship due to an inability to care for themselves should enjoy the same protection. We conclude that, for purposes of the right against compelled testimony, the groups are sufficiently similar that equal protection principles require the government to justify its disparate treatment of these proposed conservatees. However, because it is undisputed any error here was harmless, we need not decide what level of scrutiny is appropriate or whether the disparate treatment of conservatees can be constitutionally justified. We affirm the judgment.

I. BACKGROUND

The Contra Costa County Public Guardian (Public Guardian) petitioned for an LPS conservatorship on the ground

that appellant Eric B. was gravely disabled. Appellant requested a jury trial on the petition and objected to giving compelled testimony, based on the holding in *Hudec*, *supra*, 60 Cal.4th 815. The court overruled the objection.

Psychiatrist Michael Levin, M.D., testified that appellant has chronic schizophrenia. Treatment included three medications, one of which required weekly white blood cell monitoring. Appellant's minimal insight about his illness made it difficult for him to cooperate with treatment. When not housed in a treatment facility, he had failed to take his medication, which aggravated his symptoms. Levin considered appellant gravely disabled and doubted he could provide for his basic needs without a conservatorship.

Therapist James Grey became appellant's case manager at the Concord Adult Mental Health Clinic in 2016, after paranoid behaviors put appellant's subsidized housing at risk. Appellant had tried to change door locks and damaged his apartment searching for monitoring devices. Although Grey arranged transportation for clinic appointments, appellant was usually unwilling to go. According to Grey, appellant displayed the paranoia, guardedness, and agitation typical of schizophrenia, and his cooperation with treatment was "very inconsistent." Appellant had full bottles of medication that were months old and other psychiatric prescriptions went unfilled. The county had been serving as appellant's money manager, providing him an allowance, but he often failed to cash these checks. Appellant was treated as a psychiatric inpatient when a temporary conservatorship was ordered but was later released against Grey's advice. Within a week, he was admitted to an emergency psychiatric facility and was eventually transferred to his current placement. Appellant remained guarded and

paranoid, with an extremely flat affect and disorganized thoughts. He sometimes believed his mother was not actually his mother and that others posed a threat to him. He had significant difficulty complying with treatment and medications and was generally unable to meet his needs for food and clothing without support.

Called to the stand by the Public Guardian, appellant testified that he lived in a board and care facility and was previously in an intensive treatment unit. After multiple questions about where he had lived, appellant remarked, "I didn't know[,] T-Con had to deal with being here and being there. It has nothing to do with each other." He knew that Grey believed he should be moved from a temporary to a full conservatorship. Asked what he wanted to happen, appellant gave a rambling and partially incoherent response, asserting he might not need a conservatorship because, though he had a mental health disorder, he did not always need medications for it.[1] He said he was told he had attention deficit disorder as a child. "I just had a learning disability. They didn't say anything about anxiety disorders or any manic problem or anything else like that." He could name two of his medications but did not

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[1] He stated: "Oh, I even kind of have really spoken not too clearly about this. But I'm more towards the neutrality and leaving enough area of a cushion that I could have — so I could leave the temporary conservatorship because maybe it's that I don't need it. And I know I have a mental health — mental health. [¶] . . . [¶] I know what it is. I live with it. I take medications for it. When I know I don't need medications, I don't need medications. [¶] But if you will there's always a little strike pad here that we can always roughly just braze and find out my history find out my — and my future means too. I'm trying to save this for myself."

understand why he was taking them. He believed, "[T]here's just a basic medication standard issue in a given area. And they hand you medication." Apparently referring to his inpatient admission, he said: "I was admitted out of unbreeching contract. There's something just going on." Asked to clarify this statement, he responded, "This is penetrating. That's what I mean. We'll pass on this." He acknowledged that he was "sort of still dependent" on his current program. He had no plans for where he would live or how he would support himself if released from the conservatorship. He thought he might get a job but acknowledged he had not worked since 2011. He said he would take his medications but when asked how he would pay for food responded, "Pay for food? Rely on the conservatorship."

The jury found appellant gravely disabled. The court appointed the Public Guardian as conservator, ordered that appellant continue in his current placement, and restricted his ability to possess firearms and refuse treatment. On appeal, appellant challenged the order compelling his testimony. He argued that because the right to silence is statutorily provided in NGI extension proceedings, equal protection required that the same right should apply in the LPS context. The Court of Appeal held that LPS conservatees are similarly situated with NGI's for this purpose but ruled the error in compelling his testimony was harmless. Because the Court of Appeal expressly disagreed with the contrary holding in *Conservatorship of Bryan S.* (2019) 42 Cal.App.5th 190 (*Bryan S.*), we granted review to resolve the conflict.[2]

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[2] The Public Guardian represents that the conservatorship at issue here terminated on June 16, 2020, rendering the appeal

II. DISCUSSION

A. *Overview of Relevant Civil Commitment Schemes*

"California has no fewer than nine involuntary commitment procedures that may apply to persons who have various mental problems, and who pose a threat to their own welfare or to the safety of others. Some of these laws . . . operate in a manner largely independent of the criminal justice system. (See [Welf. & Inst. Code,] §§ 4825 [developmentally disabled persons . . .], 5000 et seq. [mentally ill persons under the LPS Act].) Others apply depending on whether a criminal prosecution has occurred." (*People v. Barrett* (2012) 54 Cal.4th 1081, 1093 (*Barrett*).) We discuss only the most pertinent commitment schemes here.

1. *Extended Commitments Connected to a Criminal Case*

NGI Commitments "A person found not guilty of a felony by reason of insanity may be committed to a state hospital for a period no longer than the maximum prison sentence for" the offense. (*Hudec*, *supra*, 60 Cal.4th at p. 818; Pen. Code, § 1026.5, subd. (a).) Thereafter, the district attorney may petition to extend the NGI commitment by two years if the person "represents a substantial danger of physical harm to others" because of "a mental disease, defect, or disorder." (Pen. Code, § 1026.5, subd. (b)(1).) The respondent has a statutory

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moot. The problem frequently arises in this area of law given the short duration of conservatorships. (See *Conservatorship of John L.* (2010) 48 Cal.4th 131, 142 fn. 2.) Because the case raises important issues capable of repetition but likely to evade review, we exercise our discretion to decide this otherwise moot appeal. (See *Conservatorship of K.P.* (2021) 11 Cal.5th 695, 705, fn. 3.)

right to representation by counsel and a jury trial. (*Id*., subd. (b)(3)–(4).) As discussed further below (see *post*, at pp. 13–15), statutes also require that NGI extension hearings comply with certain federal and state constitutional guarantees applicable in criminal proceedings. (Pen. Code, § 1026.5, subd. (b)(7).) The commitment can be renewed for two-year periods without limitation, subject to the same procedural requirements. (*Id*., subd. (b)(10).) Although provided for by the Penal Code, NGI extension trials are considered "essentially civil in nature, rather than criminal, because they are directed at confinement for treatment rather than punishment." (*Hudec*, at p. 819.) NGI's are typically confined in state hospital facilities. (See Pen. Code, § 1026, subd. (a).)

Other Criminally Based Commitments The Penal Code also provides for the involuntary civil commitment of violent offenders with mental health disorders (see Pen. Code, § 2960 et seq.) (OMHD's)[3] and those convicted of sexually violent offenses (see Welf. & Inst. Code, § 6600 et seq.) (SVP's). In these instances, the person has been convicted of serious crimes and incarcerated. The civil commitment proceedings may be brought once the term of incarceration has ended. (Pen. Code, §§ 2970, subd. (b), 2972, subd. (c); Welf. & Inst. Code, §§ 6601–6603.) In both cases, the statutes provide for renewable terms

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[3] Such prisoners were previously described as mentally disordered offenders, or MDO's. (See, e.g., *People v. Blackburn* (2015) 61 Cal.4th 1113, 1116 (*Blackburn*).) The Legislature recently changed this terminology to "offender with a mental health disorder." (Pen. Code, § 2962, subd. (d)(3); Stats. 2019, ch. 9, § 7.) In accordance with this change, we now refer to extension proceedings under Penal Code section 2962 as OMHD commitments.

of commitment, as well as the rights to counsel, jury trial, proof beyond a reasonable doubt, and a unanimous verdict. (Pen. Code, § 2972, subds. (a)(1)–(2), (e); Welf. & Inst. Code, §§ 6603, subd. (a), 6604.)[4] As does appellant, we focus our analysis primarily on the comparison between LPS Act commitments and those under the NGI scheme.

2. *LPS Act Commitments*

The Legislature has also enacted a civil commitment scheme for involuntary mental health treatment *without* an underlying criminal offense. The LPS Act authorizes short-term involuntary detentions (see Welf. & Inst. Code, §§ 5150, 5250) and one-year conservatorships for those who are gravely disabled due to a mental health disorder or chronic alcoholism (see *id.*, § 5350).

When a treatment professional determines a person is gravely disabled and unwilling or unable to accept treatment voluntarily, the county's public guardian may petition to establish a conservatorship. (Welf. & Inst. Code, § 5352; see *Conservatorship of K.P.*, *supra*, 11 Cal.5th at pp. 708−709.) If the matter proceeds to trial and the person is found gravely disabled, the court appoints a conservator (Welf. & Inst. Code, § 5350), imposes "disabilities" as needed (*id.*, § 5357), and determines an appropriate treatment placement (*id.*, § 5358).

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[4] The original SVP statutes provided for renewable two-year commitments. (See *People v. McKee* (2010) 47 Cal.4th 1172, 1185 (*McKee*).) Now, however, SVP's are committed for an indeterminate period (Welf. & Inst. Code, § 6604) but may petition for discharge if they are no longer "a danger to the health and safety of others and . . . not likely to engage in sexually violent criminal behavior" (*id.*, § 6605, subd. (a)(2); see *id.*, §§ 6608–6609).

(See *Conservatorship of K.P.*, at pp. 709–710.) A conservatorship terminates after one year but may be extended for additional one-year terms upon petition. (Welf. & Inst. Code, § 5361.)

The LPS Act provides for two types of conservatorships. The first and most common is for those who are unable to meet their own needs for food, clothing, or shelter due to a mental health disorder. (Welf. & Inst. Code, § 5008, subd. (h)(1)(A).) This type, which we refer to as a traditional conservatorship, is the kind at issue here. Those subject to a traditional conservatorship have a right to be treated in "the least restrictive alternative placement" (*id.*, § 5358, subd. (a)(1)(A)), with first priority given to their home or that of a relative (see *id.*, subd. (c)(1)). However, a significant number of these conservatees are placed in locked facilities, including state hospitals. For example, as of February 2019, about 63 percent of LPS conservatees in the City and County of San Francisco were placed in locked facilities. (City and County of S.F., Budget and Legis. Analyst's Office, Policy Analysis Report: Review of Lanterman-Petris-Short (LPS) Conservatorships in San Francisco (Nov. 12, 2019) p. A-11 (San Francisco Analyst's Report).) As of November 2019, LPS conservatees made up approximately 11 percent of the population in state hospital facilities, with the remainder composed of individuals whose commitments arose from the criminal justice system. (Cal. State Auditor, Rep. No. 2019-119 (July 2020) Lanterman-Petris-Short Act: California Has Not Ensured That Individuals With

Serious Mental Illnesses Receive Adequate Ongoing Care, p. 25 (State Auditor's Report).)[5]

A second type of LPS conservatorship, not at issue here, may be imposed when a person has been ruled incompetent to stand trial for a criminal accusation (see Pen. Code, § 1370) yet still "represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder" (Welf. & Inst. Code, § 5008, (h)(1)(B)(iv)). This kind of commitment is commonly referred to as a " 'Murphy conservatorship,' " after the legislator who sponsored the amendment adding this ground to the LPS Act. (*Jackson v. Superior Court* (2017) 4 Cal.5th 96, 102; *People v. Karriker* (2007) 149 Cal.App.4th 763, 775.) Criminal defendants ruled incompetent for trial are initially committed under Penal Code section 1370. If they do not regain competence within the statutory period, or if there is no substantial likelihood competence will be regained, the court will order the public guardian to initiate LPS proceedings. (Pen. Code, § 1370, subd. (c)(2); see *Jackson*, at p. 102.) A Murphy conservatorship may be imposed only if the person has been charged with a violent felony, a formal finding of probable cause supports the charge, a mental health disorder prevents the person from understanding the proceedings, and the person poses a substantial danger of physical harm to others. (Welf. & Inst. Code, § 5008, subd. (h)(1)(B).)[6]

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[5] We granted judicial notice of the San Francisco Analyst's Report and State Auditor's Report at the request of amici curiae Disability Rights California, et al.

[6] Many of the statistics cited throughout this opinion do not differentiate between traditional and Murphy conservatees. However, it appears that Murphy conservatees make up a very

LPS conservatees have the right to a jury trial to determine whether they are gravely disabled, as that condition is statutorily defined. (*Conservatorship of K.P.*, *supra*, 11 Cal.5th at p. 709; see Welf. & Inst. Code, § 5350, subd. (d)(1).) They enjoy the right to counsel and a unanimous verdict based on proof beyond a reasonable doubt. We extended these trial rights to the LPS context in *Conservatorship of Roulet* (1979) 23 Cal.3d 219, 235 (*Roulet*), reasoning that "commitment to a mental hospital, despite its civil label, threatens a person's liberty and dignity on as massive a scale as that traditionally associated with criminal prosecutions." (*Id.* at p. 223; see also *Addington v. Texas* (1979) 441 U.S. 418, 425.) "At the same time, a civil commitment proceeding is not a criminal proceeding, even though it is often collateral to a criminal trial." (*Blackburn*, *supra*, 61 Cal.4th at p. 1119.) Thus, although some constitutional protections have been extended from the criminal context based on due process concerns, "we have also found various constitutional protections inapplicable." (*Id.* at p. 1120.) For example, *Conservatorship of Susan T.* (1994) 8 Cal.4th 1005, 1015 (*Susan T.*) held that the exclusionary rule does not apply in conservatorship proceedings because the purpose of an LPS commitment is treatment, not punishment. For similar reasons, we concluded conservatees have no constitutional right to the appellate review procedures of *Anders v. California* (1967) 386 U.S. 738 and *People v. Wende* (1979) 25 Cal.3d 436. (*Conservatorship of Ben C.* (2007) 40 Cal.4th 529, 538–540, 543 (*Ben C.*).)

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small proportion of the total number. (See, e.g., San Francisco Analyst's Report, *supra*, at p. A-11.)

B. *No Constitutional Right Against Compelled Testimony in Civil Commitment Proceedings*

As a matter of constitutional protection, criminal defendants cannot be compelled to testify against themselves. (U.S. Const., 5th Amend.; Cal. Const., art. I, § 15.)[7] Furthermore, witnesses in both criminal and civil proceedings have the right to refuse to answer any question that might tend to incriminate them. (Evid. Code, § 940.)[8]

The constitutional right against compelled testimony has not been extended to civil commitment proceedings, however. Citing the "predominantly civil character of the proceedings," this court in *Cramer v. Tyars* (1979) 23 Cal.3d 131, 137 (*Cramer*) did not extend the right to individuals who faced confinement under former statutes governing the commitment of developmentally disabled persons. (See Welf. & Inst. Code, former § 6500 et seq.) We declined to analogize the proceedings to criminal prosecutions because the statutory scheme served only the purposes of "custodial care, diagnosis, treatment, and protection," and the resulting commitment could not be deemed

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[7] The Fifth Amendment privilege against self-incrimination is, of course, broader than the right not to testify against oneself in a criminal proceeding. (See, e.g., *Miranda v. Arizona* (1966) 384 U.S. 436, 467.) Here, however, we are concerned only with the right against giving compelled testimony at a commitment trial. We need not and do not decide whether any other aspect of the privilege applies outside the context of a criminal prosecution.

[8] Other privileges are set out in the Evidence Code and relate to a variety of circumstances. (See, e.g., Evid. Code, §§ 954 [attorney-client privilege], 980 [marital communications], 1014 [psychotherapist-patient privilege], 1033–1034 [clergy and penitent privileges].) None of these Evidence Code privileges is implicated in this appeal.

punishment. (*Cramer*, at p. 137.) We further reasoned that the individual's testimony would provide the best evidence of whether commitment was necessary: "Reason and common sense suggest that it is appropriate under such circumstances that a jury be permitted fully to observe the person sought to be committed, and to hear him speak and respond in order that it may make an informed judgment as to the level of his mental and intellectual functioning. The receipt of such evidence may be analogized to the disclosure of physical as opposed to testimonial evidence and may in fact be the most reliable proof and probative indicator of the person's present mental condition." (*Id.* at p. 139.) Later decisions extended *Cramer*'s holding to conservatorship trials (*Conservatorship of Baber* (1984) 153 Cal.App.3d 542, 550 (*Baber*)) and LPS proceedings for the confinement of imminently dangerous persons[9] (*Conservatorship of Bones* (1987) 189 Cal.App.3d 1010, 1015−1016).

Further, the constitutional right against compelled testimony does not apply in commitment proceedings that arise in connection with criminal charges. In *Allen v. Illinois* (1986) 478 U.S. 364, 373–374, the high court held that the federal privilege against self-incrimination did not apply in proceedings under Illinois's Sexually Dangerous Persons Act because the commitments were essentially civil in nature. California courts extended *Allen*'s holding in the SVP (*People v. Leonard* (2000) 78 Cal.App.4th 776, 792−793) and OMHD commitment

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[9] In addition to short-term holds for intensive treatment and one-year conservatorships, the LPS Act provides for commitments up to 180 days for individuals who present a substantial risk of physical harm to others as a result of a mental health disorder. (Welf. & Inst. Code, § 5300.)

contexts. (*People v. Clark* (2000) 82 Cal.App.4th 1072, 1081–1082; *People v. Merfeld* (1997) 57 Cal.App.4th 1440, 1446). These courts reasoned that the proceedings were designed only to determine the subjects' status, including the potential for danger and need of mental health treatment, and that their testimony offered reliable evidence on these issues. (See *Clark*, at p. 1082; *Leonard*, at pp. 792−793.)

In recognition of this precedent, appellant does not claim he is entitled to refuse to testify as a matter of constitutional right. (See *Hudec*, *supra*, 60 Cal.4th at p. 819.) Instead, he argues equal protection principles require that he be extended the same *statutory* right not to testify that applies for NGI extended commitment proceedings. "[W]hen certain due process protections for those civilly committed are guaranteed by statute, even if not constitutionally required, the denial of those protections to one group must be reasonably justified in order to pass muster under the equal protection clause." (*McKee*, *supra*, 47 Cal.4th at p. 1207.) Before turning to appellant's equal protection claim, we discuss the origins and applications of this statutory right.

C. *Statutory Right Against Compelled Testimony in Commitment Proceedings Connected to a Criminal Case*

The statutory right against compelled testimony in an NGI extension proceeding is found in Penal Code section 1026.5, subdivision (b)(7). The history of its enactment is informative.

Before 1978, criminal defendants who successfully asserted an insanity defense were most often committed to a state hospital or other facility *indefinitely* and could be released only if they proved their sanity had been restored. (Pen. Code, former §§ 1026, 1026a; see *In re Moye* (1978) 22 Cal.3d 457, 461

(*Moye*).)[10] The NGI commitment scheme was substantially altered thereafter in response to a series of decisions from this court.

In companion cases dealing with the since-repealed Mentally Disordered Sex Offender (MDSO) law (Welf. & Inst. Code, former § 6300 et seq.), *People v. Burnick* (1975) 14 Cal.3d 310, 318 held that due process required the offender's status to be proven beyond a reasonable doubt. *People v. Feagley* (1975) 14 Cal.3d 338, 349–352, 375–376 recognized the right to a unanimous jury verdict and disapproved indefinite commitments. In 1977, the Legislature amended the former MDSO statutes to codify these holdings. (See *Moye*, *supra*, 22 Cal.3d at p. 464.) The revised statutes provided for renewable annual commitments once the maximum allowable incarceration term had expired. (Welf. & Inst. Code, former §§ 6316.1, 6316.2, subds. (a), (h).) The statutes also provided for counsel, discovery, and a jury trial. (Welf. & Inst. Code, former § 6316.2, subds. (d), (e); see *Hudec*, *supra*, 60 Cal.4th at p. 821.) One provision gave MDSO's the constitutional rights applicable in criminal trials. (Welf. & Inst. Code, former § 6316.2, subd. (e).) The following year, *Moye* concluded equal protection principles required that initial NGI commitments likewise be limited to the maximum term applicable to the underlying criminal offense. (*Moye*, at p. 467.)

As with the MDSO decisions, the Legislature codified the *Moye* holding. (See Sen. Com. on Judiciary, Analysis of Sen. Bill No. 1022 (1979–1980 Reg. Sess.) as amended Apr. 30, 1979, p. 2;

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[10] Indefinite commitments for outpatient treatment could also be ordered under certain circumstances. (See Pen. Code, former § 1026.1; *Moye*, *supra*, 22 Cal.3d at p. 461.)

Hudec, *supra*, 60 Cal.4th at p. 821.) Penal Code, section 1026.5, enacted in 1979, limits initial NGI commitments to the longest available term of imprisonment for the underlying offense. The commitment may be extended by renewable two-year terms if a "mental disease, defect, or disorder" renders the person a substantial risk of physical harm to others. (Pen. Code, § 1026.5, subd. (b)(1); see *id*., subd. (b)(8), (10).) Mirroring the former MDSO statutes, Penal Code section 1026.5 provides for counsel, discovery, and jury trial rights. (*Id*., subd. (b)(3), (4).) Significantly, the statute also declares: "The person shall be entitled to the rights guaranteed under the federal and State Constitutions for criminal proceedings. All proceedings shall be in accordance with applicable constitutional guarantees." (*Id*., subd. (b)(7).) In quasi-civil commitment trials, the statute effectively confers many of the rights available by constitutional mandate in criminal proceedings.[11]

Hudec, *supra*, 60 Cal.4th 815 considered the scope of this statutory language. Appellant Hudec acknowledged that the trial to extend his NGI commitment was civil in nature, and thus he had no *constitutional* right to refuse to testify. (*Id*. at p. 819.) Nevertheless, he argued Penal Code section 1026.5, subdivision (b)(7) granted him this *statutory* right. (*Hudec*, at pp. 819–820.) We agreed. (*Id*. at p. 826.) Although not every constitutional right from the criminal context can be sensibly

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[11] The distinction primarily impacts the applicable standard of review. Constitutional errors require reversal if there is a reasonable possibility they affected the verdict (*Chapman v. California* (1967) 386 U.S. 18, 23–24), whereas state law errors require reversal only if it is reasonably probable a different result would have been reached absent the error (*People v. Watson* (1956) 46 Cal.2d 818, 837).

imported into civil proceedings, *Hudec* concluded no inconsistency or absurdity would result from recognizing a right against compelled testimony in NGI commitment extension trials. (*Id*. at p. 829.) Because the commitment extension would typically be supported by other evidence (see, e.g., *People v. Haynie* (2004) 116 Cal.App.4th 1224, 1227), NGI commitments could be extended even if the respondent declined to testify. (*Hudec*, at p. 829.) *Hudec* acknowledged that recognizing this right would sometimes exclude relevant evidence and that the ability to hear and observe the person's testimony can assist the fact finder's assessment of mental state. (See *id*. at pp. 829–830.) However, "[g]ranting that trial accuracy considerations arguably support compelling a committee's testimony," the court concluded, "other considerations," such as fairness, "militat[ed] against such compulsion." (*Id*. at p. 830.)[12]

After *Hudec*, a number of Court of Appeal decisions considered whether equal protection required extending the statutory right against compelled testimony to offenders facing postconviction treatment under other commitment schemes. These courts uniformly extended the right in SVP and OMHD contexts. (See *People v. Flint* (2018) 22 Cal.App.5th 983, 989 (*Flint*) [SVP]; *People v. Alsafar* (2017) 8 Cal.App.5th 880,

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[12] *Hudec* discussed varying approaches taken in the Courts of Appeal grappling with just how broadly Penal Code section 1026.5, subdivision (b)(7) should be interpreted to sweep. It rejected cases employing an overly narrow interpretation but acknowledged that an application leading to absurd consequences could not have been what the Legislature intended. (See *Hudec*, *supra*, 60 Cal.4th at pp. 826–830.) *Hudec* did not attempt to plumb the depths of the question, limiting its analysis to the right against compelled testimony. We do the same.

882−883 [OMHD]; *People v. Field* (2016) 1 Cal.App.5th 174, 193−194 [SVP]; *People v. Dunley* (2016) 247 Cal.App.4th 1438, 1450 [OMHD]; *People v. Landau* (2016) 246 Cal.App.4th 850, 865 [SVP]; *People v. Curlee* (2015) 237 Cal.App.4th 709, 720 (*Curlee*) [SVP].) While recognizing differences between the statutory schemes, these courts concluded the differences were not dispositive. (See, e.g., *Dunley*, at pp. 1449−1450.) Individuals in all three groups had committed criminal acts; all had been diagnosed with mental health disorders that made them potentially dangerous to others; and all were subject to commitment in a state facility for involuntary treatment. (See *Curlee*, at p. 720.) Further, the purpose of commitment in all three statutory schemes was the same: "To protect the public from those who have committed criminal acts and have mental disorders and to provide mental health treatment for the disorders. (See Pen. Code, § 1026.5, subd. (b); *McKee*[], *supra*, 47 Cal.4th at pp. 1203, 1207; *Moye*, *supra*, 22 Cal.3d at p. 466.)" (*Curlee*, at p. 720.)

D. *Extending the Statutory Right Against Compelled Testimony to LPS Commitment Proceedings*

The LPS Act does not include a statutory right against compelled testimony, nor does it contain the broad mention of rights set out in Penal Code section 1026.5, subdivision (b)(7). Nevertheless, appellant argues equal protection demands that the same right to refuse testimony applies.

"Because of the fundamental interests at stake, equal protection principles are often invoked in civil commitment cases to ensure that the statutory scheme applicable to a particular class of persons has not treated them unfairly in comparison with other groups with similar characteristics." (*Barrett*, *supra*, 54 Cal.4th at p. 1107.) An equal protection

analysis has two steps. "'"The first prerequisite . . . is a showing that the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner." [Citations.] This initial inquiry is not whether persons are similarly situated for *all* purposes, but "whether they are similarly situated *for purposes of the law challenged*."'" (*McKee*, *supra*, 47 Cal.4th at p. 1202, some italics added.) If the groups are similarly situated, the next question is whether the disparate treatment can be justified by a constitutionally sufficient state interest. (See *id*. at pp. 1207–1209; *Moye*, *supra*, 22 Cal.3d at pp. 465–466.)

1. *The Similarly Situated Prong*

Three lower court decisions have addressed whether traditional LPS conservatees are similarly situated with individuals facing an extended NGI commitment. *Bryan S.*, *supra*, 42 Cal.App.5th at pages 196–197 concluded they are not, because a conservatorship may be imposed without any connection to a crime or any showing of danger to others, and conservatees may be placed in nonhospital settings.[13] The Court of Appeal decisions here, *Conservatorship of E.B.* (2020) 45 Cal.App.5th 986 (*E.B.*), and in *Conservatorship of J.Y.* (2020) 49 Cal.App.5th 220 disagreed with *Bryan S.* They concluded traditional LPS conservatees are similarly situated with those facing an NGI commitment extension because both are subject

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[13] Although conservatorship proceedings were initiated after Bryan S. was found incompetent to stand trial, it appears that a traditional conservatorship was ultimately imposed because the trial court ruled "that Bryan was gravely disabled as a result of a mental disorder *and was currently unable to provide for food, clothing, or shelter*." (*Bryan S.*, *supra*, 42 Cal.App.5th at p. 194, italics added.)

to involuntary confinement that could be extended indefinitely, and both are committed for the dual purposes of mental health treatment and public protection. (See *J.Y.*, at pp. 229–231; *E.B.*, at pp. 993–994.) We agree with these latter cases that the groups are similarly situated for purposes of the right not to give compelled testimony.[14]

An equal protection analysis typically focuses on the practical consequences of a challenged law to the groups in question. In *McKee*, for example, we concluded SVP's and OMHD's were similarly situated with regard to certain procedural rights because, despite their differences in other respects, both had "the same interest at stake — the loss of liberty through involuntary civil commitment." (*McKee*, *supra*, 47 Cal.4th at p. 1204.) Here, too, the most striking and decisive similarity between the groups is the potential loss of liberty both face in the proceedings at issue. Like NGI's, LPS conservatees are subject to physical confinement and the loss of many personal rights. (See *Ben C.*, *supra*, 40 Cal.4th at p. 540; *Roulet*, *supra*, 23 Cal.3d at p. 223.) Although traditional conservatees are entitled to be placed in the least restrictive suitable setting (Welf. & Inst. Code, § 5358, subds. (a), (c)), the LPS statutes authorize confinement in a residential facility or hospital when appropriate (see Welf. & Inst. Code, § 5358, subd. (a)(2)). Here, the Public Guardian's petition for conservatorship requested authority to seek this most restrictive placement for appellant. As noted, institutional placements for LPS conservatees are

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[14] We consider only the first rationale articulated by *E.B.* and *J.Y.*, recognizing that the traditional conservatorships under consideration here are ordinarily imposed for the protection of the conservatee, not the public.

fairly common; so much so that in July 2020 the state auditor criticized the long wait times LPS conservatees had to endure before state hospital admission. (State Auditor's Report, *supra*, at pp. 22–26.) Although LPS conservatees occupied around 11 percent of state hospital beds in 2019, the auditor reported that 200 more were waiting for admission and, as a result, receiving lower levels of care than they needed. (*Id*. at p. 25.)

The Public Guardian concedes that LPS conservatees are frequently confined in locked facilities but argues the prevalence of such commitments is "not surprising" given that conservatorships are only ordered for individuals who are unable to care for themselves. The parties do not dispute that there may be good reasons for such confinements, or that they may be necessary to provide the care and treatment a conservatee requires. Both traditional LPS conservatorships and those relating to criminal proceedings share the goal of treatment, not punishment. Nonetheless, it cannot be denied that "civil commitment for any purpose constitutes a significant deprivation of liberty . . . ." (*Addington v. Texas*, *supra*, 441 U.S. at p. 425; see *Blackburn*, *supra*, 61 Cal.4th at p. 1119.) "In addition to physical restraint, '[t]he gravely disabled person for whom a conservatorship has been established faces the loss of many other liberties . . . .' " (*Ben C.*, *supra*, 40 Cal.4th at p. 540.) Apart from their possible confinement, conservatees may lose the rights to drive, vote, enter contracts, and make decisions about their treatment. (See Welf. & Inst. Code, § 5357.) In light of the potential for such a significant loss of liberty, conservatorship cases are governed by many of the same procedural protections that apply in criminal trials. (See Welf. & Inst. Code, § 5350, subd. (d)(1); *Ben C.*, at p. 541; but see *Ben C.*, at p. 538 [recognizing "that the analogy between criminal

proceedings and proceedings under the LPS Act is imperfect at best" and that "not all of the safeguards required in the former are appropriate to the latter"]; *Susan T.*, *supra*, 8 Cal.4th at p. 1015 [holding the exclusionary rule does not apply in conservatorship proceedings].)

Moreover, a year-long conservatorship may be extended through the filing of successive petitions. (Welf. & Inst. Code, § 5361.) As a result, the LPS statutes can "assure in many cases an unbroken and indefinite period of state-sanctioned confinement." (*Roulet*, *supra*, 23 Cal.3d at p. 224.) In San Francisco, for example, almost 38 percent of LPS conservatorships, excluding Murphy conservatorships, had been extended for 10 years or more as of December 2018. (San Francisco Analyst's Report, *supra*, at p. A-9.) An additional 23 percent had been extended from five to 10 years. (*Ibid.*) Thus, in practice, traditional LPS conservatorships can impose substantially the same restraint on liberty as involuntary commitments connected to criminal proceedings.

To be sure, traditional LPS conservatees differ in certain respects from civilly committed NGI's. The latter are adjudged to have committed a criminal actus reus but are found not guilty because their insanity negates the required mens rea. (See *Moye*, *supra*, 22 Cal.3d at p. 466.) While those confined as an SVP or OMHD have been convicted of crimes, most conservatorships are not based on criminal allegations. LPS conservatorships are ordinarily imposed solely because a mental illness prevents the conservatee from providing for basic survival needs. (See Welf. & Inst. Code, §§ 5008, subd. (h)(1)(A), 5350.) For these individuals, "'[t]he commitment is not initiated in response, or necessarily related, to any criminal acts . . . .'" (*Susan T.*, *supra*, 8 Cal.4th at p. 1015.) Murphy

conservatorships bear a much closer resemblance to NGI commitments in this regard. Murphy conservatees have been charged with serious felonies involving actual or threatened physical harm (Welf. & Inst. Code, § 5008, subd. (h)(1)(B)(i)–(ii)), and, unlike the traditional LPS conservatees at issue in this case, their dangerousness to others is assessed in determining whether a conservatorship is necessary (see *id.*, subd. (h)(1)(B)(iv)). Murphy conservatorships are comparatively rare, however, accounting for only around 2 percent of all LPS conservatorships in San Francisco, for example. (See San Francisco Analyst's Report, *supra*, at p. A-11.)

It is "incontrovertible" that conservatees "do not share identical characteristics" with civilly committed NGI's. (*McKee*, *supra*, 47 Cal.4th at p. 1203.) But these differences are not dispositive of whether the groups are similarly situated with respect to the testimonial privilege. (See *ibid.*) In this part of an equal protection analysis, the question "'"is not whether persons are similarly situated for *all* purposes, but 'whether they are similarly situated *for purposes of the law challenged*.'"'" (*People v. Valencia* (2017) 3 Cal.5th 347, 376, italics added.) "In other words, we ask at the threshold whether two classes that are different in some respects are sufficiently similar with respect to the laws in question to require the government to justify its differential treatment of these classes under those laws." (*McKee*, at p. 1202.)[15] In some cases, we

[15] Because an equal protection analysis considers whether groups are similarly situated with respect to a particular law, cases cited by the Public Guardian holding that conservatees or NGI's are not similarly situated with other civilly committed

have concluded traditional LPS conservatees were not sufficiently similar to other groups in regard to a challenged law. For example, in *Cooley v. Superior Court* (2002) 29 Cal.4th 228, 253–254, we concluded individuals facing an SVP probable cause hearing were not similarly situated with those seeking habeas review of a short-term detention under the LPS Act because the purposes served by the standard of proof at the LPS hearing had no rational application in the SVP context. Here, however, we reach a different conclusion.

In rejecting the same equal protection challenge raised here, the *Bryan S.* court considered the purpose served by the testimonial privilege. It reached back to *Cramer*, *supra*, 23 Cal.3d 131, where we held the *constitutional* privilege does not apply in civil commitment proceedings. *Cramer* explained that "the historic purpose of the privilege against being called as a witness has been to assure that the *criminal* justice system remains accusatorial, not inquisitorial. [Citations.] The extension of the privilege to an area outside the criminal justice system . . . would contravene both the language and purpose of the privilege." (*Id.* at pp. 137–138; see *Bryan S.*, *supra*, 42 Cal.App.5th at p. 197.) After *Cramer* was decided, however, the Legislature chose to extend the privilege beyond the criminal justice system by enacting Penal Code section 1026.5, subdivision (b)(7). We observed in *Hudec* that "*Cramer*'s constitutional reasoning ha[d] no bearing on the interpretation of" Penal Code section 1026.5, subdivision (b)(7). (*Hudec*, *supra*, 60 Cal.4th at p. 830.) It is likewise inapt to the equal protection challenge here. The issue is not whether traditional LPS

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groups for purposes *other* than the testimonial privilege shed little light on the issue here.

conservatees are similar to criminal defendants, but whether they are similar to *NGI's*. Like these conservatees, NGI's no longer stand accused of crimes. And, like conservatorships, NGI extension proceedings are civil in nature and examine only whether the statutory grounds for commitment have been met. (See *Hudec*, at p. 819.)

The more precise similarity question, then, is what purpose does the testimonial privilege serve in civil commitment proceedings? *Hudec* offers one answer. *Hudec* acknowledged that testimony from those facing commitment may be particularly helpful in determining their mental condition but noted that "other considerations" might weigh against compelling their testimony, "notably 'our sense of fair play which dictates "a fair state-individual balance by requiring the government . . . in its contest with the individual to shoulder the entire load." ' (*Murphy v. Waterfront Comm'n.* (1964) 378 U.S. 52, 55.)" (*Hudec*, *supra*, 60 Cal.4th at p. 830.) "The right to not be compelled to testify against oneself is clearly and relevantly implicated when a person is called by the state to testify in a proceeding to [commit or] recommit him or her even if what is said on the witness stand is not per se incriminating." (*People v. Haynie*, *supra*, 116 Cal.App.4th at p. 1230.) The privilege's role in enforcing fair play, and ensuring the government meets its burden, is not unique to the criminal context. Like NGI's, traditional LPS conservatees also face the prospect of extended involuntary confinement and the loss of other liberties.

In reaching a different conclusion, the trial court here cited the importance of allowing the trier of fact to observe the "physical and mental characteristics" of the proposed conservatee. Compelled testimony from the conservatee may well assist the fact finder and contribute to more accurate

verdicts in conservatorship trials. (See *Cramer*, *supra*, 23 Cal.3d at p. 139; *Baber*, *supra*, 153 Cal.App.3d at p. 550.)[16] It might also be argued that the predicates for traditional LPS and NGI commitments are significantly different. Most of those for whom an LPS conservatorship is sought will not have been subject to a criminal adjudication or any showing that they pose a danger to others. As a result, they will not have undergone the kinds of extended restraints on liberty and resultant therapeutic and rehabilitative efforts extended to NGI, SVP, and OMHD individuals. While we acknowledge these differences and note that they may bear on whether the disparate treatment of traditional LPS conservatees and NGI's is constitutionally justified, they are not sufficient to undermine the two groups' similarity for purposes of the testimonial privilege.

Accordingly, despite their differences, we conclude NGI's and traditional LPS conservatees "are sufficiently similar to bring into play equal protection principles that require a court to determine ' "whether distinctions between the two groups justify the unequal treatment." ' (*People v. Hofsheier* (2006) 37 Cal.4th 1185, 1200.)" (*In re Marriage Cases* (2008) 43 Cal.4th 757, 832, fn. 54.) *Conservatorship of Bryan S.*, *supra*, 42 Cal.App.5th 190 is disapproved to the extent it conflicts with the views expressed herein.

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[16] Of course, even if it is ultimately determined that equal protection requires extending the statutory right against compelled testimony to LPS conservatorship trials, a question we do not reach here, recognition of that right would not preclude testimony from other competent witnesses or the admission of relevant documents bearing on grave disability.

2. *Justification for Disparate Treatment*

The next step of an equal protection analysis asks whether the disparate treatment of two similarly situated groups is justified by a constitutionally sufficient state interest. (See *McKee*, *supra*, 47 Cal.4th at pp. 1207–1208.) Varying levels of judicial scrutiny apply depending on the type of claim. "[M]ost legislation is tested only to determine if the challenged classification bears a rational relationship to a legitimate state purpose." (*People v. Hofsheier*, *supra*, 37 Cal.4th at p. 1200.) However, differences "in statutes that involve suspect classifications or touch upon fundamental interests are subject to strict scrutiny, and can be sustained only if they are necessary to achieve a compelling state interest." (*Ibid.*)

Decisions from the Courts of Appeal have reached differing conclusions about the level of scrutiny appropriate for assessing claims of disparate treatment in civil commitments. (Compare *Flint*, *supra*, 22 Cal.App.5th at pp. 992–993 [strict scrutiny] with *People v. Nolasco* (2021) 67 Cal.App.5th 209, 225 [rational basis].) Because the courts below did not reach this prong of the equal protection analysis, arguments have not been well developed here concerning the proper degree of scrutiny or whether the government can demonstrate a sufficient justification for granting the testimonial privilege to NGI's but not traditional LPS conservatees.

Ordinarily, we would remand to the trial court for a hearing at which the Public Guardian would have an opportunity to show why the differential treatment is constitutionally justified. (See *McKee*, *supra*, 47 Cal.4th at pp. 1207–1209; see also *Curlee*, *supra*, 237 Cal.App.4th at p. 722.) However, the Court of Appeal determined the error in

this case was harmless under either the state (*People v. Watson*, *supra*, 46 Cal.2d at p. 836) or federal (*Chapman v. California*, *supra*, 386 U.S. at p. 24) standard for harmless error. The court observed that, apart from appellant's testimony, "two other witnesses who were familiar with appellant . . . painted a vivid picture of someone who was unable to care for himself left to his own devices due to his mental illness." (*E.B.*, *supra*, 45 Cal.App.5th at p. 999.) Appellant does not challenge that conclusion. Accordingly, although we have concluded traditional LPS conservatees are similarly situated with NGI's for purposes of the right against compelled testimony, a remand is not appropriate here. Whether the government can justify its differential treatment of traditional conservatees with regard to this right must await decision in another case.

III. DISPOSITION

We affirm the judgment of the Court of Appeal.

CORRIGAN, J.

We Concur:

CANTIL-SAKAUYE, C. J.
LIU, J.
KRUGER, J.
GROBAN, J.
JENKINS, J.
MOORE, J.[*]

[*] Associate Justice of the Court of Appeal, Fourth Appellate District, Division Three, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

Conservatorship of ERIC B.

S261812

Concurring Opinion by Justice Kruger

This case involves a federal equal protection challenge to the statutory procedures for establishing conservatorships for persons with grave disabilities. Eric B., a potential conservatee, argues the statute is unconstitutional because it contains no right to refuse to testify akin to the statutory right enjoyed by NGI's (that is, persons found not guilty of a crime by reason of insanity) in commitment extension proceedings. (Compare Welf. & Inst. Code, § 5350, subd. (d)(1), (2) with Pen. Code, § 1026.5, subd. (b)(7).) But the question now before this court is not the ultimate question whether this difference in treatment is constitutional. Rather, the sole question before us concerns a threshold inquiry: Whether potential conservatees are sufficiently similarly situated to NGI's, for purposes of the challenged law, to warrant further inquiry into whether the differential treatment violates equal protection. The court answers yes. (Maj. opn., *ante*, at pp. 1, 25.) I agree with this limited holding and have signed the court's opinion.

I write separately, however, to suggest that this threshold inquiry doesn't serve much purpose. Worse, it risks harm. The simple fact that a law differently benefits or burdens two identifiable groups is — or at least ought to be — sufficient reason for us to examine whether the difference in treatment is consistent with equal protection. To the extent our cases have taken a different approach, it is probably time to reevaluate.

I.

In answering the question before us, the court's opinion describes a two-step approach for analyzing equal protection challenges. " ' " 'The first prerequisite . . . is a showing that the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner.' [Citations.] This initial inquiry is not whether persons are similarly situated for *all* purposes, but 'whether they are similarly situated *for purposes of the law challenged*.' " ' ([*People v.*]*McKee*[(2010)] 47 Cal.4th [1172,] 1202, some italics added.) If the groups are similarly situated, the next question is whether the disparate treatment can be justified by a constitutionally sufficient state interest. (See *id.* at pp. 1207–1209; [*In re*]*Moye*[(1978)] 22 Cal.3d [457,] 465–466.)" (Maj. opn., *ante*, at p. 18.) In other words: (1) Are the parties sufficiently similarly situated to call for further inquiry? If no, the analysis is done. But (2) if yes, can the challenged disparity be justified? At the second step, we employ the familiar tiered system of scrutiny to determine the amount of justification required. We apply the most lenient standard — so-called rational basis review — to most forms of differential treatment; we apply more searching scrutiny to, and thus require greater justification for, differential treatment that either infringes on a fundamental right or is based on a suspect or quasi-suspect classification, such as race or sex. (*People v. Chatman* (2018) 4 Cal.5th 277, 288–289.)

This is the approach set out in many — though not all — of our recent equal protection cases. Both parties assume it applies here, as did the Court of Appeal in this case, and as have many other California courts addressing similar questions. Whether the approach makes sense is a different matter.

A.

This two-step approach is not how equal protection analysis was always done in California. This court did often observe that equal protection requires like treatment for those "similarly situated with respect to the legitimate purpose of the law." (*Purdy & Fitzpatrick v. State of California* (1969) 71 Cal.2d 566, 578.) But we did not initially use this general observation about the concept of equal protection as a springboard for engaging in a threshold inquiry into whether two groups are similarly situated. We instead described the relevant constitutional inquiry solely in terms of whether the challenged difference in treatment was justified under the applicable standard of scrutiny. (*Id.* at pp. 578–579; see, e.g., *In re Antazo* (1970) 3 Cal.3d 100, 110–111.)

The two-step approach appears to have emerged from two cases decided in the late 1970's, both concerning challenges to statutes governing the treatment of juveniles. In the first case, *In re Roger S.* (1977) 19 Cal.3d 921 (*Roger S.*), a minor objected to involuntary admission to a state mental hospital on the application of a parent. He argued that he was denied equal protection because his admission was not conditioned on a finding that he was gravely disabled or a danger to himself or others, as it would have been for an adult or a minor ward of the court. This court rejected the argument. " '[T]he Constitution,' " we observed, " 'does not require things which are different in fact or opinion to be treated in law as though they were the same.' " (*Id.* at p. 934, quoting *Tigner v. Texas* (1940) 310 U.S. 141, 147.) Given the differences between the liberty interests of children and adults, we concluded that minors "are not 'similarly situated' with adults for purposes of equal protection analysis." (*Roger S.*, at p. 934.) We also found minors like Roger S.

dissimilar from court wards, explaining that courts have options for the psychiatric treatment of nondangerous minors that parents may not. The difference in the standards for the involuntary confinement of the two groups, we held, "does not in our view deny equal protection to either class." (*Id.* at p. 935, citing, inter alia, *Reed v. Reed* (1971) 404 U.S. 71, 75–76.)

In the second case, *In re Eric J.* (1979) 25 Cal.3d 522 (*Eric J.*), this court considered a juvenile's equal protection challenge to laws extending more favorable sentencing treatment to an adult convicted of a crime warranting imprisonment than to juveniles subject to confinement for committing the same crime. Rejecting the claim, the court cited *Roger S.*, *supra*, 19 Cal.3d at page 934 for the proposition that the "first prerequisite to a meritorious claim under the equal protection clause is a showing that the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner." (*Eric J.*, at p. 530; see also *id.* at p. 530, fn. 1 [quoting, as *Roger S.* had, *Tigner v. Texas*, *supra*, 310 U.S. at p. 147 for the proposition that " '[t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same' "].) We went on to conclude that "because minors and adults are not 'similarly situated' with respect to their interest in liberty," and because the two groups "are not confined for the same purposes," the difference in treatment did not violate equal protection. (*Eric J.*, at p. 533.)

The two-step framework the court applies today traces back to this particular gloss on the United States Supreme Court's admonition that equal protection "does not require things which are different in fact or opinion to be treated in law as though they were the same." (*Tigner v. Texas*, *supra*, 310 U.S. at p. 147.) Of course, it is not clear that either *Roger S.* or

Eric J. in fact applied anything like the two-step framework; both cases undertook what was essentially a one-step, holistic inquiry into whether the challenged differential treatment violated equal protection. *Roger S.* looked for support to *Reed v. Reed*, *supra*, 404 U.S. 71, a high court decision that had evaluated an equal protection challenge to a sex-based classification by asking whether the classification was justified in view of the state's interests (*Roger S.*, *supra*, 19 Cal.3d at p. 935); *Eric J.*, in turn, looked to *Roger S.*

And notwithstanding the language in *Eric J.* suggesting the existence of a preliminary "similarly situated" step as a "first prerequisite" to further inquiry (*Eric J.*, *supra*, 25 Cal.3d at p. 530, italics omitted), the cases were not initially understood as establishing a two-step framework. In a case decided not long after *Eric J.*, this court considered an equal protection challenge to a decision limiting a school district election to a certain group of district residents, while excluding a second group. "The first step in evaluating this contention," we explained, "is to determine the applicable level of judicial review," rational basis or heightened scrutiny. (*Fullerton Joint Union High School Dist. v. State Bd. of Education* (1982) 32 Cal.3d 779, 798 (*Fullerton*).) We dismissed the notion that *Eric J.* required a different order of operations: "Some decisions speak of an initial constitutional inquiry to determine whether the groups affected are similarly situated with respect to the purpose of the legislation or other state action. (See, e.g., *In re Eric J.*[, *supra*,] 25 Cal.3d [at p.] 531 [159 Cal.Rptr. 317, 601 P.2d 549].) To ask whether two groups are similarly situated in this context, however, is the same as asking whether the distinction between them can be justified under the appropriate test of equal protection. Obvious dissimilarities between groups will not

justify a classification which fails strict scrutiny (if that test is applicable) or lacks a rational relationship to the legislative purpose." (*Fullerton*, at p. 798, fn. 19; accord, *People v. Allen* (1986) 42 Cal.3d 1222, 1295 (lead opn.).)

As time went on, however, the language of *Eric J.* took precedence over its limiting treatment in *Fullerton*. Courts repeatedly invoked *Eric J.*'s "first prerequisite" language and rejected equal protection claims on the basis that the two groups treated differently were insufficiently similar to one another. (See *People v. Williams* (1988) 45 Cal.3d 1268, 1330 ["persons convicted under the death penalty law are manifestly not similarly situated to persons convicted under the Determinate Sentencing Act and accordingly cannot assert a meritorious claim to the 'benefits' of the act under the equal protection clause"], citing *Eric J.*, *supra*, 25 Cal.3d at p. 530; *People v. Andrews* (1989) 49 Cal.3d 200, 223 [citing *Eric J.* for the proposition that "the first prerequisite to [an equal protection] claim is a showing that 'the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner' " and rejecting equal protection claim]; *Coleman v. Department of Personnel Administration* (1991) 52 Cal.3d 1102, 1125 [same]; *People v. Massie* (1998) 19 Cal.4th 550, 571 [same]; *Manduley v. Superior Court* (2002) 27 Cal.4th 537, 568–571 [citing *Eric J.* and rejecting claim on ground the defendant had not shown unequal treatment of similarly situated groups]; *People v. Wutzke* (2002) 28 Cal.4th 923, 943–944 [same]; *Cooley v. Superior Court* (2002) 29 Cal.4th 228, 253–254 [same].)

The language of *Eric J.* was repeated from case to case. Eventually, shorn of context, the language morphed and hardened to become the first step of the formal two-step inquiry the court's opinion recites today. (See, e.g., *People v. Hofsheier*

(2006) 37 Cal.4th 1185, 1199–1200 [detailed analysis of the similarly situated requirement as a threshold matter independent of subsequent inquiry into justification]; *People v. McKee*, *supra*, 47 Cal.4th at p. 1202 [treating the similarly situated inquiry as a necessary "threshold" question]; *id.* at pp. 1202–1209 [deciding only that question and remanding for further proceedings on the separate question of justification].) Indeed, the court stopped citing *Eric J.* itself, simply asserting as a settled matter that the "initial inquiry in any equal protection analysis is whether persons are '*similarly situated* for purposes of the law challenged.' " (*In re Lemanuel C.* (2007) 41 Cal.4th 33, 47.) And in some cases, the court has concluded they are not — a conclusion that has simply ended the equal protection analysis, without review of the challenged governmental action under any level of scrutiny. (See, e.g., *People v. Lewis* (2004) 33 Cal.4th 214, 231; *Conservatorship of Ben C.* (2007) 40 Cal.4th 529, 543; *People v. Salazar* (2016) 63 Cal.4th 214, 227; *People v. Valencia* (2017) 3 Cal.5th 347, 376.)

B.

Although the threshold similarly situated test nominally has its roots in United States Supreme Court case law, the high court itself has neither required nor applied any similar gatekeeping test. Rather, in cases involving challenges to discrimination between identifiable groups, the court proceeds directly to the justification step: It identifies the appropriate level of scrutiny for a particular challenged distinction and then examines whether the actual or potential justification for that differentiation is sufficient, without separately analyzing whether the groups receiving differential treatment are otherwise similarly situated. (See, e.g., *Grutter v. Bollinger* (2003) 539 U.S. 306, 326–343 [determining appropriate level of

scrutiny (strict) and moving directly to a consideration of the adequacy of the proffered justification]; *United States v. Virginia* (1996) 518 U.S. 515, 531–534 [same, applying intermediate scrutiny]; *Cleburne v. Cleburne Living Center, Inc.* (1985) 473 U.S. 432, 439–450 [same, applying rational basis scrutiny].)

The high court's cases do make clear that a similarly situated inquiry has a useful role to play in other kinds of cases — particularly cases involving so-called " 'class of one' " equal protection claims, "where the plaintiff alleges that she has been intentionally treated differently from others similarly situated and that there is no rational basis for the difference in treatment." (*Village of Willowbrook v. Olech* (2000) 528 U.S. 562, 564.) In such cases, where a plaintiff does not allege that she has been treated differently because of "membership in a class or group" (*ibid.*), a similarly situated inquiry helps identify whether the plaintiff has suffered differential treatment that warrants scrutiny under the equal protection clause. (See also *Engquist v. Oregon Dept. of Agriculture* (2008) 553 U.S. 591, 601–602 [discussing "class-of-one" claims under *Olech*].) But in a case like the one before us, as in many others, the law clearly treats Eric B. differently from others because of the group — that is, potential conservatees — to which he belongs. The critical question is whether that group-based difference in treatment comports with equal protection principles. In comparable cases, the high court has proceeded directly to this critical question, without first attempting to gauge the degree of similarity between the groups, as California courts have done.

We are, of course, not bound to follow where the United States Supreme Court leads in matters of state constitutional law. So if the two-step framework articulated in our cases had

developed as an explication of unique state constitutional principles, there would be no need to concern ourselves with whether it comports with United States Supreme Court guidance. But in elaborating a two-step approach, we've never invoked any special features of the state Constitution's equal protection provision. (Cal. Const., art. I, § 7, subd. (a).) To the contrary, when urged to use that provision to articulate a unique set of state law specific principles, we've declined. (*Manduley v. Superior Court*, *supra*, 27 Cal.4th at p. 572 [rejecting petitioners' invitation to rely on state constitutional principles and "deem[ing]" the "analysis of petitioners' equal protection claim under the Fourteenth Amendment to the United States Constitution also applicable to their equal protection claim made pursuant to provisions in the California Constitution"]; see, e.g., *Johnson v. Department of Justice* (2015) 60 Cal.4th 871, 881 [accepting "the high court's analysis of federal . . . equal protection principles [as] persuasive for purposes of the state Constitution"].)

It is true that while the United States Supreme Court has not used the same two-step approach to analyze federal equal protection issues, it also has never formally repudiated any such approach.[1] But if we choose to chart a different path, we at least

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[1] A handful of other jurisdictions have also sometimes applied some version of a threshold similarly situated inquiry. (See, e.g., *Morrison v. Garraghty* (4th Cir. 2001) 239 F.3d 648, 654; *Rodriguez v. Lamer* (11th Cir. 1995) 60 F.3d 745, 749; *T.M. v. State* (Fla.Ct.App. 1997) 689 So.2d 443, 444–445; *Miami County Bd. v. Kanza Rail-Trails* (2011) 292 Kan. 285, 315–316 [255 P.3d 1186, 1207]; *DuPont v. Commissioner of Correction* (2007) 448 Mass. 389, 399–400, 403, fn. 24 [861 N.E.2d 744, 752–753, 754–755, fn. 24]; *Vison Net, Inc. v. Dept. of Revenue*

ought to be clear that that's what we're doing. Instead, our cases appear to assume the United States Supreme Court has pointed us in the direction of the two-step framework. It has not.

C.

Even in this court, this two-step approach is not always how the equal protection analysis is done — which is to say, we are not always rigid or consistent in our application of the two-step framework. In a number of cases, we have analyzed equal protection questions much as *Fullerton* had once instructed and as the United States Supreme Court does regularly: We have begun by asking not whether two groups are similarly situated but what level of scrutiny should apply. (See, e.g., *Hernandez v. City of Hanford* (2007) 41 Cal.4th 279, 298 ["we begin with the question of the appropriate equal protection standard applicable in this case"]; *Kasler v. Lockyer* (2000) 23 Cal.4th 472, 480 ["we must address plaintiffs' equal protection challenge on the merits, and the threshold question we confront is which standard of review applies"].) This line of cases has tackled equal protection questions without requiring the plaintiff to show, at the first step, that other groups are similarly situated.

(2019) 397 Mont. 118, 124–125 [447 P.3d 1034, 1038]; cf. *Jackson v. Raffensperger* (2020) 308 Ga. 736, 741 [843 S.E.2d 576, 581] [applying threshold similarly situated inquiry as matter of state constitutional law].) That inquiry has not escaped criticism elsewhere. (See, e.g., *State v. Kelsey* (2015) 51 Kan.App.2d 819, 830 [356 P.3d 414, 421] (conc. opn. of Atcheson, J.) [noting that in Kansas — much as in California — a "potentially dispositive threshold test has crept fog-like into our cases on little cat feet. It hasn't a basis in generally accepted equal protection jurisprudence, and akin to a morning fog, it obscures the landscape to no particularly useful ends and conceivably dangerous ones"].)

(See, e.g., *People v. Turnage* (2012) 55 Cal.4th 62, 74–75; *California Grocers Assn. v. City of Los Angeles* (2011) 52 Cal.4th 177, 208–211; *Warden v. State Bar* (1999) 21 Cal.4th 628, 640–651.)

If we have sometimes done without the two-step approach, the question arises whether we might always do without, or whether instead the approach offers some useful assistance to courts evaluating equal protection challenges like this one. But on a brief review of the cases decided under this approach, its utility seems doubtful.

The basic reason is the one *Fullerton* identified decades ago: At least as our cases have described the approach, it is not clear how the threshold similarly situated inquiry differs in any material way from the ultimate question in a group-based discrimination case, except that it offers substantially less guidance about how to answer. That two groups are similarly situated, or are not similarly situated, with respect to the purposes of a law is a conclusion one can only reach after considering the law's aims and how the differential treatment relates to those aims. Even then, the issue remains: *How* similarly situated, precisely, relative to *which* aims? These are questions courts already explore at the justification step, using the tiers of scrutiny to guide their answers. It is unclear what purpose is served by asking the same questions, in a substantially more general way, as part of a separate threshold step of the analysis.

Our cases have not, of course, treated the two prongs of the analysis as merely duplicative or interchangeable. But we have also failed to explain in any meaningful way how the two prongs should differ from one another. This has led to some

oddities. Take *Johnson v. Department of Justice*, *supra*, 60 Cal.4th 871, which overruled an earlier decision finding an equal protection violation in the statutory requirement that those convicted of oral copulation with a minor, but not those convicted of intercourse with the same, register as sex offenders. (See *People v. Hofsheier*, *supra*, 37 Cal.4th 1185.) *Hofsheier* found the groups similarly situated and then concluded no rational basis existed for treating them unequally. *Johnson* purported to accept the similarly situated half of *Hofsheier*'s analysis, but then concluded that a rational basis existed for differential treatment because of relevant differences between the groups. (*Johnson*, at pp. 882, 884–887.) In other words, the groups were not similarly situated with respect to the purposes of the law after all. A reader might be forgiven for experiencing a sense of whiplash. (See also, e.g., *In re C.B.* (2018) 6 Cal.5th 118, 134 [in the span of a few paragraphs, assuming that two groups *were* similarly situated with respect to the purposes of a voter initiative and then explaining how "voters rationally could differentiate" between them because of an interest in cost savings].)

Employing a framework that contains a potentially duplicative step carries more risks than just the possibility of wasted effort or seeming inconsistencies in the analysis. By adding a step not directly focused on the ultimate question of justification, we run the risk of mistakenly cutting off potentially meritorious equal protection claims. Interposing an unnecessary gatekeeping inquiry always raises the possibility that the gate will sometimes slam shut, when the gate shouldn't have been there in the first place.

At the very least, the two-step framework creates unnecessary confusion. Because it is a requirement of our own

creation, the threshold similarly situated inquiry comes with no clear high court guidelines as to its proper application. Nor have we offered much guidance ourselves. This case illustrates the kinds of unresolved questions that courts still confront, decades after the inquiry first emerged in the case law. To decide whether two groups are similarly situated with respect to the purpose of a given law, one must define what that purpose is. But how does one do so when the law's purpose involves a balance of considerations (as laws generally do)? Here, the court's opinion says one possible purpose for conferring a privilege against testifying on NGI committees is a sense of fair play that outweighs the interest in accurate determinations. (Maj. opn., *ante*, at p. 24, citing *Hudec v. Superior Court* (2015) 60 Cal.4th 815, 830.) The court then assesses whether Lanterman-Petris-Short committees are similarly situated for purposes of the fair-play interest (maj. opn., *ante*, at p. 24), without considering whether they are also similarly situated with respect to the countervailing interest in accurate determinations. Should the inquiry consider one, or the other, or both? It seems impossible to say without knowing what the similarly situated test is meant to achieve. The case law yields no clear answers.

The way the court's opinion tackles the inquiry is by no means wrong; the point is only that the inquiry itself injects unnecessary uncertainty into the law. That uncertainty might be worth clearing up if the similarly situated test added sufficient value. I doubt that it does.

II.

All that said, this is not the case in which to reexamine our equal protection framework. The parties have not raised any question about that framework here; instead, in reliance on our current case law, they have focused entirely on the proper application of the similarly situated step some cases have told them is necessary. The Court of Appeal decision likewise focused only on that step, and then, without resolving whether any different treatment would have been justified, found any potential constitutional error harmless under the circumstances of the case. And — as we already knew when we granted review — this case is moot, so it does not make sense to press the issue further. Finally, I agree that the choice of framework would not be outcome-determinative in any event: Given our conclusion that potential conservatees and NGI's are sufficiently similarly situated to warrant further scrutiny, if this case were to proceed, the government would be required to come forward with a sufficient justification, just as it would if we were to proceed directly to the justification inquiry.

For all these reasons, in today's case it makes little difference that we have occupied ourselves with a threshold inquiry into whether two groups are similarly situated. So long as we continue to employ this framework, that is presumably how it should be; the threshold similarly situated test should not cut off inquiry into the core question, whether an admitted difference in treatment of two groups is justified under the law. But going forward, it is unclear why we should hold on to a legal test that serves so little purpose. In an appropriate future case,

we ought to consider whether it is time to let the similarly situated test go.

KRUGER, J.

We Concur:

LIU, J.
GROBAN, J.

See next page for addresses and telephone numbers for counsel who argued in Supreme Court.

Name of Opinion Conservatorship of Eric B.

Procedural Posture (see XX below)
Original Appeal
Original Proceeding
Review Granted (published) XX 45 Cal.App.5th 986
Review Granted (unpublished)
Rehearing Granted

Opinion No. S261812
Date Filed: April 28, 2022

Court: Superior
County: Contra Costa
Judge: Susanne M. Fenstermacher

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CARE COURT
Governor Newsom's Proposal to Get People with Mental Health & Substance Use Disorders the Support they Need

- Community Assistance, Recovery and Empowerment (CARE) Court is a new proposal to get people with mental health and substance use disorders the support and care they need.
- CARE Court is aimed at helping the thousands of Californians who are suffering from untreated schizophrenia spectrum or psychotic disorders that too often lead to homelessness, incarceration, institutionalization, or premature death.
- California is taking a new approach to act early and get people the support they need and address underlying needs - and we're doing it without taking away people's rights.
- CARE Court includes accountability for everyone – on the individual and on local governments – with court orders for services.

SPONSORING NEW CARE COURT LEGISLATION

- In March the Governor unveiled the CARE Court framework, and engaged the public and stakeholders in community roundtables across the state and listening sessions with diverse stakeholders.
- Legislation was introduced by Senator Umberg, Orange County and Senator Eggman, San Joaquin County (SB 1338). Legislative hearings which started in April, will continue to engage the public including people living with mental illness, families, local government, community behavioral health care providers, first responders, judges, and more - and further develop CARE Court.
- To meet the urgent needs for care and housing we see in our communities, families, and streets, CARE Court must be enacted by July 1, and local partners can begin implementation in the following months.

FOCUSING UNPRECEDENTED FUNDING ON RESULTS

- Behavioral health is now funded at a record **$11.6 billion each year** - up 70% from $6.7 billion eight years ago. Funding comes from five major sources, including Prop 63 Mental Health Services Act, Medi-Cal and non-Medical Behavioral Health, and Realignment in 1991 and 2011. See CalHHS Funding Backgrounder for more details.
- Housing and homelessness investments totaled a historic **$12 billion** in last year's budget. An additional **$2 billion** is proposed this year - with $1.5 billion focused on Behavioral Health Bridge Housing that will be prioritized to serve people in CARE Court.
- The Governor's May Revision to the Budget will include costs for the new Care Court process, including judges and appointed counsel.

HOW CARE COURT WORKS

Updated April 25, 2022

CARE Court connects a person struggling with untreated mental illness – and often also substance use challenges – with a court-ordered Care Plan for up to 24 months. Each plan is managed by a care team in the community and can include clinically prescribed, individualized interventions with several supportive services, medication, and a housing plan. The client-centered approach also includes a public defender and supporter to help make self-directed care decisions in addition to their full clinical team, as well as opportunities for early engagement and settlement agreements for treatment plans.

CARE Court is designed on the evidence that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. It's a long-term strategy to positively impact the individual in care and the community around them. The plan advances an upstream diversion from more restrictive conservatorships or incarceration.

The CARE Court response can be initiated by family, county and community-based social services, behavioral health providers, or first responders. Individuals exiting a short-term involuntary hospital hold or a misdemeanor arrest may be especially good candidates for CARE Court. The Care Plan can be ordered for up to 12 months with periodic review hearings and subsequent renewal for up to another 12 months.

CARE Court is based on accountability for all. Participants who do not successfully complete Care Plans may, under current law, be hospitalized or referred to conservatorship - with a new presumption that no suitable alternatives to community care are available. All counties across the state will participate in CARE Court under the proposal. If local governments do not meet their specified duties under court-ordered Care Plans, the court will have the ability to order sanctions and, in extreme cases, appoint a receiver to ensure services are provided.

Updated April 25, 2022

Exhibit 5

Pages: RJN-0215 through RJN-0217

California Psychological Association, Written Testimony dated June 23, 2022, submitted to Assembly Health Committee

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

CALIFORNIA PSYCHOLOGICAL ASSOCIATION
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916-286-7979 (p) • 916-286-7971 (f)
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June 23, 2022

The Honorable Jim Wood, DDS
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814
(Transmitted via online portal)

RE: SB 1338 (Umberg & Eggman) – CONCERNS

Dear Assemblymember Wood:

On behalf of the California Psychological Association (CPA), a non-profit association of licensed psychologists and others affiliated with the delivery of psychological services across California, I write to you with continued CONCERNS about SB 1338, as amended June 16th. This bill establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Program as initially proposed by Governor Gavin Newsom, which would authorize specified people to petition a civil court to create a CARE plan and implement behavioral health services for those living with schizophrenia or other psychotic disorders.

We appreciate the work to amend the legislation and improve the program; however, there remains two serious concerns for any psychologist who would wish to engage within the CARE Court process.

First, the language in WIC 5975(d)(1) still allows an affidavit to be filed with the court that makes a determination about schizophrenia or other psychotic disorder [**emphasis added**] without an examination:

> An affidavit of a licensed behavioral health professional, stating that the licensed behavioral 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 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.

Our national code of ethics, which is included within our scope of practice (BPC 2936), expressly prohibits any assessment without an examination of the individual – and directly requires them to limit their conclusions in instances when examination is "not practical" [**emphases added**]:

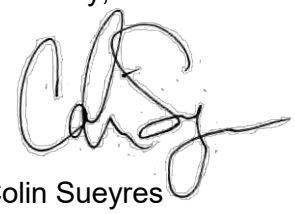
> [P]sychologists provide opinions of the psychological characteristics of individuals **only after they have conducted an examination of the individuals adequate to support their statements or conclusions**. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and **appropriately limit the nature and extent of their conclusions or recommendations**.

Second, which also informs on the first point, is that the bill still does not contain language indemnifying providers from civil or criminal prosecution like is contained in the LPS Act. Both

WIC 5154 and WIC 5550 contain language that applies to individuals involved in the LPS Act (such as submitting information or making claims). Specifically, licensed professionals participating in making determinations about an individual under a 72-hour hold, participating in "filing a complaint" or, importantly when it comes to CARE Courts, "participating in a judicial proceeding" holds that they are presumed to be acting in good faith and provided immunity from "any liability, civil or criminal, and shall be immune from any penalty, sanction, or restriction that otherwise might be incurred or imposed." Without some similar language within the CARE Court proposal, it exposes any professional participating in this program to direct civil action on the part of the respondent, family, or advocates. Even if the counties deigned to avoid criminal prosecution, litigious respondents could challenge professionals in court and imperil their licenses – especially if they file affidavits based on non-examination evidence.

We look forward to working with your committee, the authors, and Governor's administration on improving this proposal and resolving our CONCERNS before final passage of the bill. Thank you for your consideration of this important issue. Please do not hesitate to have your staff contact me at (916) 286-7979 ext. 106, or e-mail me at csueyres@cpapsych.org with any questions.

Sincerely,



Colin Sueyres
Director of Government Affairs

cc: Senator Tom Umberg
Senator Susan Talamantes Eggman

Exhibit 6

Pages: RJN-0218 through RJN-0234

County Behavioral Health Directors Association (CBHDA), Written Testimony and Recommendations dated April 16, 2022, submitted to Assembly Judiciary Committee

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

April 16, 2022

Honorable Mark Stone, Chair
Assembly Judiciary Committee
Legislative Office Building
1020 N Street, Room 104
Sacramento, CA 95814

RE: AB 2830 (Bloom) CARE Court - Concerns

Dear Chair Stone:

On behalf of the County Behavioral Health Directors Association (CBHDA) which represents the county behavioral health executives who administer Medi-Cal and safety net services for serious mental health (MH) conditions and substance use disorders (SUDs) in all 58 counties in California, I write to express significant concerns with AB 2830 as amended on April 7th. While CBHDA members welcome new tools to engage individuals with significant behavioral health needs into behavioral health treatment and recovery services through county behavioral health agencies, we are concerned that the approach in CARE Court falls far short of its stated promise, and we respectfully request consideration of our concerns and recommendations outlined below to ensure the paradigm shift contemplated in CARE Courts can be successful.

The proposal has been put forward jointly with the Administration as a new way to deliver mental health and substance use disorder services (SUDs) to the most severely impaired Californians who suffer the impacts of untreated mental illness, including homelessness and incarceration. County behavioral health agencies would be central to the enactment of CARE Court, as the sole entity held responsible by the courts for the creation and implementation of CARE Court plans. As such, we urge your consideration of our concerns and recommendations outlined below.

County Behavioral Health Responsibilities and Accountability: Penalties & Receivership

The premise of CARE Court appears to be that any individual with schizophrenia spectrum or psychotic disorders ought to fall under the responsibility of county behavioral health. Unfortunately, this is not true for how our county behavioral health safety net is structured and financed today.

Under current law, county behavioral health's primary responsibility is to Medi-Cal beneficiaries who meet eligibility criteria for specialty mental health and substance use treatment services. Medi-Cal is a federal entitlement, and counties share responsibility for beneficiaries with Medi-Cal Managed Care Plans (MCP) and Medi-Cal Fee-for-Service (FFS) providers. Despite this shared responsibility, and the need for co-occurring medical, long-term care, and non-specialty mental health services to be coordinated for Medi-Cal beneficiaries across delivery systems, county behavioral health agencies and their services alone are subject to CARE Court oversight and authority, as it is intended to focus exclusively on their specialty behavioral health needs. This limited focus runs counter to the whole person care system transformations currently underway in Medi-Cal, which attempt to more

intentionally engage MCPs in the social determinants work that county behavioral health agencies have been a part of for decades. In addition, for county behavioral health services to be reimbursed through Medi-Cal, the client must meet medical necessity criteria, services must be medically necessary and clients must consent to those services. As a result, counties invest significant resources beyond Medi-Cal in our successful outreach and engagement to bring individuals with significant behavioral health conditions into treatment.

The county behavioral health system's broader services aspirational North Star does exist in current law, but it is conditioned on the availability of resources. Under the Bronzan-McCorquodale Act, county behavioral health agencies are provided with a mission to serve any Californian with serious mental illness, "to the extent resources are available," and counties often go beyond the Medi-Cal entitlement responsibilities to offer a more diverse set of options to individuals and communities, when developed jointly with local communities through the Mental Health Services Act (MHSA). These layered aspirational goals and responsibilities come with historically limited funding and categorical spending restrictions, none of which tie resources to actual caseload or need. Instead, county behavioral health has received relatively stagnant realignment funds supplemented with a volatile millionaire's tax.

For the 70% of Californians covered through private or commercial plans, schizophrenia spectrum and psychotic disorders are just as likely, as these medical conditions affect all Californians. County behavioral health may provide a range of services to individuals who are underinsured or not appropriately served through their private insurance plans, particularly for school-based and crisis services, substance use disorder treatment, and other specialty mental health services. County behavioral health is rarely successful today in recouping reimbursement from private insurance, even for covered services.

Through the CARE Court structure, AB 2830 would significantly expand the expectation and responsibility for county behavioral health agencies to prioritize serving any Californians with untreated schizophrenia spectrum and psychotic disorders, regardless of payer resonsibility. The legislation outlines that this new approach as "needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses ***and to local governments with the responsibility to provide behavioral health services***." (Emphasis added). By *expanding* the county behavioral health responsibility to include any and all individuals on the basis of these diagnoses, regardless of payer or available resources, and to hold county behavioral health solely responsible as outlined in AB 2830 appears to attempt to side-step county behavioral health's larger entitlement responsibilities under Medi-Cal, local discretion beyond the Medi-Cal entitlement, or the state's responsibility to adequately resource that expanded set of responsibilities. AB 2830 attempts to do this by establishing a set of expectations, such as permissive language to encourage or suggest certain county behavioral health service offerings while granting courts the ability to court order any county behavioral health services, impose fines and even a receivership, and by increasing the level of responsibility of the county safety net to include all Californians suspected of having certain conditions, without establishing an outright funded mandate, or an appropriation of funds to expand those services. In the court process alone, county behavioral health staff typically spend hours on standby in Mental Health, Drug, or Homeless Courts or consulting with law enforcement and court partners. This time is rarely Medi-Cal reimbursable. As such, the requirement to staff CARE Court activities is likely a reimbursable mandate.

Given our existing severe workforce crisis, adding a significant new programmatic shift in responsibility without new resources will increase workforce exhaustion, lower morale, and undermine the goals of CARE Court to successfully engage individuals into services prior to conservatorship or law enforcement involvement.

AB 2830 also attempts to apply a coercive and punitive approach to compel county behavioral health to assume this broader authority under a threat of significant court-issued penalties and of a possible court receivership. It is often misunderstood that many of the services needed to ensure a successful engagement into behavioral health treatment and long-term recovery are not reimbursable through any insurance, whether public or private coverage. However, those non-entitlement services are typically optional or varied by design. Because the court would potentially have broad discretion to issue these penalties, and could use the receiver to secure the CARE Court court-ordered care at the exclusion of other populations or services for which the county behavioral health safety net has responsibility, this bill could result in a significant shift of finite resources away from other county behavioral health's core Medi-Cal responsibilities, particularly for children and youth, and create significant compliance challenges due to categorical funding restrictions. For example, MHSA funding must be spent in accordance with funding categories and local community plans, and 2011 realignment must be spent specifically on Medi-Cal or other 2011 realignment funding priorities. The impact of these penalties could be compounded as failure to meet Medi-Cal quality, timely access, and provider capacity, and other standards outside of CARE Court could result in additional fiscal penalties and other sanctions.

Recommendations: CBHDA strongly requests removal of the proposed financial penalties and ability for courts to put county behavioral health into receivership given the courts' lack of understanding of, or stake in county behavioral health's Medi-Cal entitlement and other funded responsibilities. The proposed fiscal penalties and receivership would have negative impacts on the very programs and services necessary to prevent the outcomes CARE Court seeks to address, and would divert funding away from the low-income Medi-Cal and uninsured populations who are the primary focus of county behavioral health agencies today. Due to the broader mandate to serve all Californians, regardless of payer, these penalties could shift limited county behavioral health resources to individuals with private coverage and the means to petition the court for CARE Court entry. Finally, counties' ability to move funding from one funding stream to another is extremely limited due to categorical funding restrictions. Inappropriate redirection of funding for services, fines, or penalties could put county behavioral health out of compliance with state regulators.

Recommendation: Provide dedicated state funding to support the expanded staffing and services which will be required for counties to engage in CARE Court, including the trained workforce to engage in the court process, perform clinical evaluations, develop care plans, and expanded service delivery for all Californians regardless of payer. Ideally, CARE Courts would be implemented with sufficient funding and time to build up a new, distinct workforce, rather than redirect our already scarce workforce for this purpose. In addition, considerations would be provided to ensure that CARE Court workers were able to maintain reasonable caseloads to ensure quality engagement with respondents, courts, and successful outcomes. Our understanding is that the Administration proposes new funding for courts, as well as the Department of Aging to implement CARE Court's expanded responsibilities for courts and supporters. The same consideration should be given to adequately funding the new court process and extensive county behavioral health roles required under AB 2830.

CARE Court Behavioral Health Criteria and Equity Considerations

Individuals would qualify for CARE Court, upon a petition from an outside party, based on the following criteria:

1. The person must be over 18 years of age;
2. They must be diagnosed with a schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
3. They must not be clinically stabilized in on-going treatment *with the county behavioral health agency*;
4. The person currently lacks medical decisionmaking capacity.

These criteria include an alarming lack of specificity to help courts, petitioners, respondents and parties to understand who is appropriate for CARE Court involvement and why. For example, under probate law, the conditions under which a court may find a person lacking the capacity for medical decisionmaking are outlined with great detail (Probate Code Section 1880-1898). None of that specificity is provided in AB 2830.

In addition, schizophrenia spectrum and "other psychotic disorders" constitute a broad set of diagnostic criteria which encompasses not only mental health conditions, but also includes a substance or medical-induced psychotic disorders. Under the current version of the DSM, a psychotic disorder which is due to another medical condition is included as part of the definition of what might constitute a psychotic disorder. These might be psychotic disorders resulting from dementia, traumatic brain injury, or other medical conditions which are not treatable through county behavioral health services. Further, AB 2830 is silent on how individuals with these and other significant medical or long-term care needs would have those needs addressed. What will happen to the homeless older adult who needs long-term care for their physical and long-term care needs, for example?

CBHDA would note that the degree to which individuals with drug-induced psychosis could potentially be brought into CARE Court also argues for a much broader understanding the populations and service needs tied to CARE Courts. In particular, California only expanded its Medi-Cal benefits to include residential drug treatment and case management services five years ago as a pilot under the Drug Medi-Cal Organized Delivery System (ODS). While today this pilot covers a majority of Medi-Cal beneficiaries based on population, the lack of additional state funding dedicated to the expanded ODS benefit has meant that many rural and frontier counties have yet to opt-in and offer more limited drug treatment benefits under Medi-Cal. That variation will make the co-occurring SUD treatment elements of this proposal more challenging.

Inclusion of drug-induced psychosis as criteria for CARE Court could also result in individuals with a primary SUD diagnosis coming into CARE Court. This creates problems related to Lanterman-Petris-Short Act criteria, including the new legal presumption created through CARE Court, funding for inpatient resources and access to other treatment requirements that may be mandated but not funded under Medi-Cal. SUD treatment services also require higher levels of confidentiality protections under 42 CFR which would limit the ability of the CARE Court process to engage outside entities, whether supporters, petitioners, or even certain service providers in the process.

These eligibility criteria also create the need for CARE Courts to be designed with equity considerations at the forefront. For example, it is well documented that the largely white profession of psychiatry tends

to inappropriately misdiagnose Black and Latinx individuals with schizophrenia and other psychotic disorder diagnoses. A 2019 study[1] found that Black individuals are more likely to be diagnosed with a psychotic disorder than white individuals, despite no scientific evidence that they are more likely than other populations to have schizophrenia. Researchers found that this misdiagnosis was due to racial bias by clinicians not appropriately screening for and diagnosing depression and mood disorders. Similarly, despite lower rates of drug use than whites, African Americans are more likely to be incarcerated for drug-related offenses due to racial bias in the policing of drug use.

And while CARE Court eligibility do not specify a lack of housing as part of the court participation criteria, the public campaign to discuss the CARE Court framework has focused this almost exclusively as a response to homelessness. Black Californians are also significantly overrepresented in the homeless population. While only 6.5% of Californians identify as Black, they represent 30-40% of the state's homeless population, due in large part to the effects of racial bias and discrimination on access to education, housing, and job opportunities.

We must raise concerns that by attempting to narrow referrals by limiting this court program to schizophrenia spectrum and psychotic disorders, this proposal may unintentionally increase stigma and discrimination towards individuals with significant behavioral health conditions and expand court and justice involvement for populations that already face significant discrimination and disproportionate institutionalization. It is well documented that Black Californians are more likely to be misdiagnosed with these conditions and overpoliced in general. Because CARE Courts set up a court-based structure to compel adherence to a care plan, with a legal presumption for conservatorship, we believe that these equity and disparity considerations must be carefully considered upfront.

Finally, the eligibility criteria for an individual to not be stabilized in treatment with the county behavioral health agency is problematic in that it would create a broad pathway for patient dumping and cost shifting, particularly for private insurance plans. CBHDA questions why stability within the county behavioral health system is included in this criteria, and would strongly suggest that an individual who is stable or actively in treatment with a private commercial plan should not be shifted to the county behavioral health delivery system, particularly without sufficient resources to build out new capacity to support these expanded client populations. Unless this is addressed, we believe this could significantly undermine the state's historic efforts to strengthen parity law for private insurance pursuant to SB 855 (Wiener) Chapter 151, Statutes of 2020.

Recommendation: At a minimum, equity concerns around misdiagnosis as well as other concerns argue for careful data collection, research and evaluation components which specifically identify the race, ethnicity, sexual orientation and gender identity, diagnosis ***and payer status*** of individuals referred to CARE Courts, and their outcomes. These data should be publicly reported annually, and the state should establish an independent quality and oversight review entity, to include peers and clinicians with expertise in schizoaffective disorders and substance use disorders, to provide recommendations for addressing identified disparities as well as to consider referral sources, and the degree to which individuals with private insurance may be routed inappropriately through CARE Court.

[1] Michael A. Gara, Shula Minsky, Steven M Silverstein, Theresa Miskimen, Stephen M. Strakowski. A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic. Psychiatric Services, 2019; 70 (2): 130 DOI: 10.1176/appi.ps.201800223

Recommendation: In existing law, for conservatorships, medical decisionmaking capacity is defined and includes significant guardrails. Any reference to medical decisionmaking capacity in this new context should be similarly expanded.

Recommendation: Exclude psychotic disorders which are due to a medical condition from the CARE Court eligibility criteria since those conditions cannot be addressed through county behavioral health services.

Recommendation: Establish a workgroup with CBHDA and other interested stakeholders with expertise in SUDs to make specific recommendations on whether to include individuals with a primary SUD diagnosis as part of CARE Court and any special funding, legal, privacy, and other considerations and protections that would be necessary to ensure effective interventions and outcomes for this population.

Recommendation: Expand Drug Medi-Cal Organized Delivery System (ODS) Medi-Cal benefits as a fully funded statewide benefit to include this broader set of SUD services consistently throughout all counties in California as a fully funded Medi-Cal benefit.

CARE Court Referrals/Petitioners

While we understand that the intention behind CARE Court is to target a relatively small population of individuals with specified behavioral health conditions, because high expectations have been set for the potential of CARE Courts across multiple interest groups, without clarifying criteria and appropriate controls on referrals, CARE Courts could easily result in a significant increase in new clients for county behavioral health, and has the potential to serve as a vehicle for cities, providers, plans, and other systems to shift costs and responsibilities for individuals based on their behavioral health condition, establishing a separate and unequal system of care.

AB 2830 specifies that groups of non-clinicians, including roommates, certain family members, certain first responders, including law enforcement, and housing providers could refer individuals to CARE Court. In addition, this bill introduces a new, undefined category of a "qualified behavioral health professional," or their designee, who may petition the court to initiate CARE Court proceedings.

Non-clinicians could easily overwhelm courts with inappropriate referrals, slowing down courts, and ultimately, the provision of CARE Court services, as referrals are evaluated to determine eligibility. In addition, the rise in new, synthetic methamphetamines and other yet to be discovered substances whose effects may mimic psychosis are difficult to predict or control for and may increase legitimate referrals over time.

An additional concern is that AB 2830 places the responsibility for respondent, counsel, supporter, and county behavioral health notice on the petitioner. This is inappropriate in how vague and important this initial notice is, given the strict, and tight timelines associated with CARE Court proceedings.

Recommendation: CBHDA requests that petitioners are given a specified timeline to provide written notice to the respondent, with a parallel requirement and that the courts notify counsel, supporters, and the appropriate county behavioral health agency with enough time to prepare for the initial hearing at least 30 days prior to the initial hearing.

Recommendation: CBHDA requests that the state closely monitor referral rates and sources to evaluate the perceived versus actual need for these services, as well as make funding and programmatic adjustments as needed to adequately resource this initiative.

Recommendation: CBHDA would request consideration of caps, penalties or fines for inappropriate referrals. For example, given that fewer than 30% of individuals experiencing homelessness have a significant mental health condition, referrals from cities for their homeless population should not exceed 20% of a county's annual point in time homeless count.

CARE Court Petition Affidavit/Affirmation

AB 2830 would require a petition to include as a part of their court petition, an affidavit or affirmation that the respondent had been examined by a "qualified behavioral health professional" within three months of the filling of the petition, or that appropriate but unsuccessful attempts had been made to elicit the cooperation of the respondent for an examination, and that based on an examination or review of records and collateral interviews, the respondent meets or is likely to meet the diagnostic criteria for CARE Courts.

CBHDA has several significant concerns with this portion of AB 2830, outlined below:

1. "Qualified behavioral health professional" is undefined, and therefore is it unclear whether the individual would need to be a clinician at all, let alone a licensed or certified clinician with the scope of practice necessary to opine on an individual's diagnosis;
2. Clinicians in good standing do not diagnose individuals who they have not interacted with and therefore could not appropriately determine whether an individual has a certain diagnosis based on review of an undefined set of records and hearsay from interviews;
3. A determination of "is likely to meet diagnostic criteria," is even more concerning, as it also does not reflect any legitimate clinical or ethnical standard;
4. Unlike with protections for clinicians under the Lanterman-Petris-Short (LPS) Act, there are no immunity or liability protections afforded to clinicians who might engage in determining eligibility for CARE Courts;
5. It is unclear what sort of examination the "qualified behavioral health professional" needs to conduct as part of this affidavit/affirmation;
6. "Hospitals" are not defined, therefore it is unclear whether this includes acute psychiatric hospitals and general acute care hospitals, or both.

Recommendation: In our read, the proposed affidavit is intended to serve as a screening process to ensure that the right individuals are identified for participation in CARE Court. Rather than define the types of clinicians who might be eligible to sign off on a petition for a CARE Court referral, CBHDA proposes to require county behavioral health agencies to establish a registry of individuals at the local level who would be certified by the county for the purposes of determining who may be eligible for a CARE Court evaluation. Counties serve in this role currently with respect to substance use disorder professionals and other involuntary treatment laws.

Recommendation: Remove the ability for a qualified behavioral health professional to make a determination or guess regarding eligibility or potential eligibility for CARE Courts based solely on a

review of records and collateral interviews to ensure due process and minimum clinical and ethnical standards for clinicians.

Recommendation: In addition to specifying that both licensed general acute care hospitals, and acute psychiatric hospitals can be considered petitioners, AB 2830 should be amended to require any general acute care hospital that files a petition to include a medical screen and to prohibit all petitioners from referring individuals with a psychotic disorder which is due to a medical condition, as medical conditions are not treatable through county behavioral health services.

Settlement Agreement and Clinical Evaluation

Once a court has determined that an individual meets CARE Court criteria, the court will order the county behavioral health agency to work with the respondent, respondent's counsel, and the supporter to develop a treatment plan, with a case management conference set for 14 days after court finding. Only if a court determined that a settlement agreement was unlikely would the court order a clinical evaluation to be performed by county behavioral health. This type of settlement agreement is new and undefined, therefore, more needs to be included in statute to more clearly state the goals and criteria for the settlement agreement.

Because no clinical evaluation would be necessary to petition CARE Courts, and the requirement for county behavioral health to perform a court-ordered clinical evaluation would only be triggered for an individual the court deemed unlikely to enter into a settlement agreement, CBHDA must express significant concerns that under the structure outlined in AB 2830, an individual could be subject to CARE Court oversight without ever having had an evaluation by a treating clinician within their scope of practice. In addition, the purpose and elements of the settlement agreement are unclear.

Further, while CBHDA advocated to ensure that county behavioral health perform the clinical evaluations for CARE Courts to ensure that the process was streamlined, efficient, and clinically appropriate, we requested this role only if it came with dedicated new funding specific to CARE Courts.

Recommendation: Require that all CARE Court recipients have a clinical evaluation by a board certified psychiatrist or licensed psychologist as part of determining CARE Court eligibility. If these clinical evaluations are to be performed by county behavioral health agencies, ensure that new, dedicated funding is appropriated to build a workforce with a reasonable caseload standard to fulfill CARE Court evaluation, treatment plan, care plan, and service delivery requirements.

Recommendation: Extend provider immunity to clinicians performing eligibility evaluations, consistent with the LPS Act.

Recommendation: Define the purpose and elements of a settlement agreement. If a settlement agreement is meant to reflect a respondent who is willing to enter into services voluntarily, ensure that the individual has medical decisionmaking capacity.

Recommendation: If an individual is unwilling to be screened or evaluated for the purposes of determining CARE Court eligibility, the individual should not be eligible for CARE Court participation, as their engagement in the development of the care plan and court-ordered services is unlikely.

CARE Plan Housing Elements

A care plan for the purposes of AB 2830 is described as an "individualized, clinically appropriate range of behavioral health related services and supports provided by a county behavioral health agency, including, but not limited to, clinical care, stabilization medications, and a housing plan."

AB 2830 specifies that the court will require county behavioral health to offer a specific array of housing options (i.e. housing in clinically enhanced interim or bridge housing; licensed adult and senior care settings; and supportive housing), however, county behavioral health is not currently funded or responsible for ensuring that these options are available to all county behavioral health clients. In fact, housing resources for homeless individuals are typically controlled by other local partners, including cities, who are not subject to CARE Court orders. Some of the housing options outlined in the bill may not be appropriate for the individual clients' needs, and still others may be available through other local partners, but not accessible for county behavioral health clients. Finally, there are some counties in California where none of these options currently exist, and therefore could not be offered.

The development of a housing plan rather than access to actual housing would significantly limit any proposed impact CARE Courts might have, and instead would mirror the current experience of county behavioral health in attempting to address housing needs within the existing limited array of options for county behavioral health clients. CBHDA surveyed counties in early 2022 regarding efforts to house individuals already voluntarily participating in services through Full Service Partnerships (FSPs). Of the more than 12,000 individuals who entered FSPs unhoused in the past year, county behavioral health has been successful in housing roughly half. However, the other half remained *unhoused and in treatment*. Typical reasons our FSP clients remained unhoused included: no housing available in the community, inability to meet credit checks, and other rental criteria, participants were not welcome due to behaviors related to their conditions, e.g., inability to live with roommates.

The range of housing options typically needed to address the high-risk, high-needs population served by county behavioral health is diverse. County behavioral health agencies rely heavily on housing vouchers, which can be difficult to access, board and care facilities which we pay a premium to keep in the market, and permanent supportive housing, recovery residences, rental subsidies, transitional housing, and other tailored housing solutions. Counties have diverted $290 million in local MHSA service dollars since 2019 to finance No Place Like Home permanent supportive housing projects. The California Department of Housing and Community Development (HCD) estimates that county behavioral health agencies will bring 61 new permanent supportive housing projects online in 2022.

CBHDA is deeply appreciative of the Administration's proposal to invest $1.5 billion in stat funding for Bridge Housing targeting county behavioral health clients. However, of the overall $14 billion cited by the Governor as dedicated by the Legislature to address the broader homelessness crisis, CARE Court participants are limited to a housing plan which prioritizes use of the new, yet to be realized $1.5 billion in Bridge Housing for this purpose. The Bridge Housing funding is proposed as competitive grants yet to be approved by the Legislature. Under this model, it will likely take years, well beyond the start of CARE Courts, to realize any net new housing for county behavioral health clients as a result of the Bridge Housing funding as proposed, and investments will be unevenly distributed throughout the state. In addition, the proposed new MCP benefits for housing navigation, services, and supports under CalAIM would not be subject to consideration by the court. Development of a housing plan through county behavioral health, without additional help from the courts to compel cities and local housing

authorities, or Medi-Cal managed care plans to dedicate housing resources will significantly stymie CARE Courts' effectiveness.

Finally, CBHDA would object to the proposed alignment of Bridge Housing funds to CARE Court participants as counties are hopeful that those resources can be used to address the unmet housing needs of our clients actively engaged in treatment services while unhoused. County behavioral health clients should not be routed through a coercive treatment model to access housing, and not all clients with significant mental health or substance use disorder needs would meet CARE Court diagnostic criteria.

Recommendation: Give courts the authority to seek and order housing from local housing authorities, or subject the state's entire $14 billion in housing investments to CARE Court participants.

Recommendation: Ensure access to Medi-Cal managed care plan housing CalAIM-funded Community Supports and PATH benefits for CARE Court participants.

Recommendation: Expand the state's investment of $1.5 billion in Bridge Housing for county behavioral health clients to include more long-term, sustainable housing options, such as permanent supportive housing vouchers, maintenance costs, board and care patches, and other housing services and supports ***as ongoing funding***. Model the Bridge Housing after the successful Project Roomkey and Homekey efforts, rather than competitive grants to ensure housing is brought online more quickly. And do not tie Bridge Housing alone to court ordered CARE plans, as that will almost ensure that other housing resources are not prioritized for this population.

Recommendation: The requirement for county behavioral health to offer specified housing options that may not exist in every region of the state must be removed as it would guarantee immediate non-compliance. While county behavioral health agencies contribute to housing thousands of Californians with significant behavioral health conditions each year, including through using MHSA dollars to finance No Place Like Home bonds, there is no an existing requirement for county behavioral health agencies to offer housing, let alone the specified housing options called out in AB 2830.

CARE Plan Service Elements

Under AB 2830, the court may order modifications to the care plan which are "within the scope of the county behavioral health agency." AB 2830 appears to give courts the authority to order stabilization medications as part of the care plan. In county behavioral health's experience with the various specialty courts funded in-part by county behavioral health, such as drug, mental health and homeless courts, court partners often order services that are inappropriate or not available and not required of county behavioral health.

CBHDA would note that non-county behavioral health services which may be critical to long-term recovery would not be subject to CARE Court orders, such as:

- Medi-Cal physical health services,
- Medi-Cal non-specialty MH services (particularly if the individual has a primary SUD diagnosis),
- Medi-Cal transportation benefits,
- Enhanced Care Management and Community Supports,
- Medi-Cal long-term services and support,

- Regional Center services for individuals with co-occurring intellectual and developmental disabilities,
- Private and commercial insurance for co-morbid physical or long-term care coverage.

CBHDA has concerns regarding the scope of behavioral health services that can be ordered by the court as part of this care plan development. As mentioned, county behavioral health agencies' primary responsibility is for voluntary services provided through the Medi-Cal entitlement. These benefits do vary by county as Medi-Cal includes several key optional benefits, such as Drug Medi-Cal Organized Delivery System (ODS) benefits for residential drug treatment and the new peer support specialist benefit. Because courts will be able to order services that are not a part of that county's core Medi-Cal entitlement to CARE Court participants, courts may attempt to order services that are not available or funded. Even services and supports which can benefit Medi-Cal beneficiaries may not be covered under Medi-Cal or other insurance, such as outreach and engagement, food, and social services. Residential and inpatient level of treatment may also be excluded from Medi-Cal reimbursement under the Institutes for Mental Disease (IMD) Exclusion based on size of facility.

Finally, CARE Court has been presented as a program open to all Californians, regardless of payer status. Any services or supports beyond standard Medi-Cal benefits vary tremendously from county to county due to the discretion of local communities in guiding funding decisions, and the ability of each county to resource additional services and capacity with grants and categorical funding streams. Because courts could order and require those services, with the threat of receivership, any new CARE Court services would need to be fully funded by the state.

Recommendations Limit court orders to standard, medically necessary Medi-Cal benefits and ensure courts are equipped with an understanding of what those are, by county.

Recommendation: Ensure that MCPs are required parties in the development of the care plan for Medi-Cal beneficiaries to leverage the full range of Medi-Cal services on their behalf, including: Enhanced Care Management, Community Supports, PATH funding, the Medi-Cal transportation benefit, physical health services, long-term care, and other services needed for well-being and recovery.

Recommendation: Remove the exclusion which would exempt Knox-Keene licensed Medi-Cal MCPs from reimbursing county behavioral health, and instead ensure that Medi-Cal MCPs reimburse provide CARE Court services for any contracted Medi-Cal beneficiaries, or reimburse county behavioral health for any non-duplicated covered services provided under CARE Court.

Recommendation: Consider expanding Medi-Cal optional benefits such as the peer support specialist benefit and Drug Medi-Cal Organized Delivery System (ODS) to ensure more consistency on quality, impactful optional benefits such as these on a statewide basis.

Recommendation: Expand the court's ability to order services from other relevant public systems, such as Regional Centers, aging services and others as needed, to support the respondent's recovery goals.

Recommendation: Ensure appropriate and effective care plans and ensure the integrity of clinical decision-making by prohibiting courts from ordering specific treatment services or modalities, including medications, which are not recommended by county behavioral health. Restrict the ability of the courts

to override the clinical recommendations of treating clinicians or physicians acting within their scope of practice.

Role of Private Insurance

As discussed above, seven out of ten Californians have private coverage of some kind, rather than Medi-Cal. CBHDA is appreciative that AB 2830 includes a requirement for Knox-Keene licensed plans to reimburse for certain covered medical services, in addition to the CARE Court clinical evaluation. However, based on our current experience attempting to recoup reimbursement from private plans, our members are concerned that these plans would have significant discretion to deny county behavioral health claims based on provider type.

In addition, the courts can order a much broader array of services under CARE Court, to include the development of the CARE plan and non-medical and non-insurance services available through county behavioral health. It is unclear whether these services and activities would be reimbursable.

Finally, this section excludes Knox-Keene regulated Medi-Cal Managed Care Plans. CBHDA would argue that MCPs, like private plans, should have expanded obligations under CARE Court, or be required to reimburse for those services that a county behavioral health agency cannot bill to Medi-Cal because the individual does not meet medical necessity criteria for our contracted services.

Recommendation: Ensure that private plans are held accountable for covered physical and behavioral health services for their beneficiaries, consistent with parity law. Require private plans to provide court-ordered services or reimburse county behavioral health for all court-ordered care plan services, including screening and care plan development. In addition, require private plan parity review and enforcement by the appropriate regulator, e.g. Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) for inappropriate CARE Court referrals from private health plans and their contracted providers.

Recommendation: Establish a section in the Insurance Code to parallel the new Health and Safety Code Section 1374.723 which would hold CDI regulated plans responsible for reimbursement of CARE Court services.

Recommendation: Address the potential for providers and private plans to shift responsibility for individuals with significant behavioral health needs on to the county behavioral health system by requiring full reimbursement at their average contracted rate or cost (for non-contracted services) for all CARE Court ordered services by all state regulated health plans.

Recommendation: In addition, require private health plans to participate in continuity of care upon graduation from CARE Court. Clarify that CARE Courts are not intended to replace private plans' responsibility to adequately treat behavioral health conditions under parity law.

CARE Court Timelines

Throughout AB 2830, county behavioral health agencies, legal counsel, and respondents are subject to aggressive timelines for the initial hearing, completion of the clinical evaluation and care plan development. Throughout, parties are typically afforded 14 days to both perform their duties and appear in court, and the proposal rarely allows for hearings to be continued. These timelines would not allow

for sufficient notice and scheduling, let alone the performance of the various clinical evaluation and engagement strategies contemplated within the CARE Court construct.

Lengthening the timeframes is especially important as respondents may not be known to county behavioral health agencies. By comparison, counties typically have court timelines in the 45-60 day range for individuals already known to county behavioral health under assisted outpatient treatment (AOT) and conservatorship statutes. Significant workforce challenges and lack of provider capacity, along with the need to prioritize timely access to services for Medi-Cal beneficiaries should also be factored into the allowed timeframes.

Recommendation: CBHDA strongly recommends providing a reasonable timeline on which to accomplish CARE Court related activities and requests requiring the court to consider requests from the parties to delay or continue hearings to allow sufficient time to engage respondents for the purposes of evaluation and care plan development.

CARE Supporter

AB 2830 would require the California Department of Aging (CDA) to administer a CARE supporter program to provide training on supported decisionmaking for individuals with behavioral health conditions, and on the use of psychiatric advance directives. CDA would develop this training for individual supporters or contracted entities with input from peers, family members, disability groups, providers, and other relevant stakeholders. The CARE Supporter role outlined in AB 2830 would attempt to blend aspects of supported decisionmaking with the CARE Court's more coercive construct, but in doing so, it would undermine the potential benefits of a supported decisionmaking model.

In addition, the professional standards for CARE Supporters are not clearly defined, nor are any processes for respondents to request a change in supporter or file grievances. Finally, the CARE Supporter is not required to adhere to any minimum participation standards, but rather the language in AB 2830 allows for permissive participation in the various court proceedings and processes, as well as language that encourages certain standards to be upheld by supporters, "to the best of their ability and to the extent reasonably possible."

CBHDA is also concerned with the CDA administration of the CARE Supporter role as CDA does not have expertise in behavioral health conditions or services. In particular, CDA would be responsible for developing a training related to both supported decisionmaking for individuals with behaivoral health conditions and on the use of psychiatric advance directives.

Starting in 2021, five counties (Fresno, Mariposa, Monterey, Orange, and Shasta) secured an MHSA Innovation grant to develop a standardized Psychiatric Advance Directive (PAD) template, training resources and a "toolkit" (all in multiple languages), PADs accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures. Additional counties are expected to join in this collaborative; however, PADs are not commonly used tools nationally or in state. CBHDA members are highly supportive of the development of PADs as a standardized tool to engage clients prior to a crisis, however, it will take additional time, training across various clinical settings, including hospitals and other providers, and resources to make them a truly effective tool to support individuals at risk of experiencing a psychotic break.

Recommendation: AB 2830 should be amended to invest in expanding the peer support specialist Medi-Cal benefit as a statewide, funded benefit, instead of attempting to duplicate efforts within a department with little to no behavioral health expertise. Each CARE Court participant could be offered a peer support specialist to assist the individual in achieving and maintaining recovery. If the CDA structure is maintained, at a minimum, CDA should be required to coordinate with county behavioral health agencies on the development of the CARE Supporter training and standards.

Recommendation: Develop a work group to explore the legal, infrastructure and operational changes that will be needed to be addressed in order to bring use of PADs to scale. Again, access to PADs should not be contingent upon involvement in CARE Courts, but we welcome the opportunity for further dialogue and engagement on how to advance the use of PADs in California.

Recommendation: In addition, AB 2830 should be amended to fund supports for family members. Family Psychosocial education and support and family respite have proven to help families with their loved ones along their recovery journey. Not including supports for families is a missed opportunity to strengthen the family supporting a loved one with a chronic condition.

New Legal Presumption

CBHDA is also concerned that AB 2830 would bypass the professional judgement of Public Guardians/Conservators and county behavioral health clinicians by creating a new presumption for LPS Conservatorship for anyone who is found by the court to have failed to comply with the Care Plan developed in this new court process:

"The court may utilize existing legal authority pursuant to Article 4 (commencing with Section 5200) of Chapter 2 of Part 1, to ensure the respondent's safety. The subsequent proceedings may use the CARE proceedings as a factual presumption that no suitable community alternatives are available to treat the individual."

Trained professionals should have the ability to advise the court on the individual's progress and whether conservatorship is appropriate or necessary as the experience of involuntary treatment can further traumatize and harm individuals, particularly when it is not necessary or helpful in their recovery and engagement into services.

Recommendation: Amend AB 2830 to remove the factual presumption that failure to comply with the CARE Court care plan means that no suitable community alternatives are available to treat the individual. Instead, allow public guardians and county behavioral health to make a recommendation related to the value of a potential conservatorship.

Recommendation: Require data collection on the number of individuals referred for conservatorship as a result of unsuccessful CARE Court participation.

DHCS Training, Technical Assistance, and Contracts

Subject to appropriation, under AB 2830, the Department of Health Care Services (DHCS) will provide training and technical assistance to county behavioral health on the CARE court model and statute and data collection. More specificity would be necessary to understand what data collection is referenced

here, and the types of training that would be necessary. County behavioral health agencies finance and participate in a variety of specialty courts today, whether drug, mental health, or homeless courts.

Recommendation: Clarify what data is supposed to be collected under AB 2830 as a part of the DHCS training and technical assistance.

Recommendation: Require DHCS to consult with insurance regulators (DMHC and CDI), CBHDA, courts, and other subject matter experts with expertise in specialty courts in the development of training and technical assistance.

Overarching Concerns

First, implementation of AB 2830 should be delayed to ensure county behavioral health and courts have the time to build up the workforce, infrastructure, and services to support CARE Courts. Extensive policy and rulemaking will also be required to establish the CARE Court model.

Recommendation: Delay implementation of CARE Courts until at a minimum 2025 to allow for complementary housing, infrastructure, workforce and other investments to accrue.

CARE Courts should be evaluated to understand outcomes, any unintended consequences, and to center the voice of the individuals who move through this new court process. Several examples have been provided here, however, given the potential for CARE Courts to usher in a new form of coerced care for individuals with specifically identified psychotic disorders, a rigorous evaluation component is merited, along with a sunset.

Recommendation: Require a rigorous longitudinal evaluation of CARE Court to analyze outcomes and provide recommendations for programmatic challenges, barriers and areas of potential improvement or modification.

Recommendation: Include a sunset to allow for the Legislature and other stakeholders to evaluate and consider changes.

Recommendation: Consider establishing CARE Courts as a pilot limited to interested counties, and evaluate the success or outcomes before establishing CARE Courts statewide.

The privacy and confidentiality of these proceedings must be more explicitly addressed. The CARE Court process will allow for an individual to be brought into court without ever having committed a crime, on the basis of their medical condition.

Recommendation: More must be done to protect respondents' privacy and confidentiality through hearings in closed session with extremely restricted sharing of evaluations, care plans, progress hearing information and court orders.

Today, county behavioral health agencies and the clients we serve will be most significantly impacted by the CARE Courts proposal outlined in AB 2830. We agree that more can be done to address the needs of individuals with significant behavioral health needs, in particular individuals experiencing homelessness and those who are not being helped through their private insurance plans. However,

CBHDA disagrees with the notion that solving for these issues is a matter of prioritization of existing safety net resources by granting the courts a hammer. We believe that the only way for substantial progress to be made in engaging individuals upstream of involuntary treatment and justice involvement will require partnership between the state and county behavioral health agencies, along with more meaningful and targeted investments in service and housing resources dedicated to county behavioral health clients. We respectfully request consideration of our membership's concerns and recommendations on AB 2830 outlined above.

Sincerely,

Michelle Doty Cabrera
Executive Director

Cc: Honorable Members of the Assembly Judiciary Committee
Honorable Richard Bloom, 50th Assembly District
Leora Gershenzon, Deputy Chief Counsel, Assembly Judiciary Committee
Judith Babcock, Senior Consultant, Assembly Health Committee
Gino Folchi, Republican Caucus Consultant
Agnes Lee, Speaker Rendon
Ana Matosantos, Cabinet Secretary, Office of Governor Newsom
Jessica Devencenzi, Deputy Legislative Secretary, Office of Governor Newsom
Jason Elliott, Senior Counselor, Office of Governor Newsom
Dr. Mark Ghaly, Secretary, CalHHS
Marko Mijic, Undersecretary, CalHHS
Stephanie Welch, Deputy Secretary, CalHHS
Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, CalHHS
Kim McCoy Wade, Senior Advisor, Office of Governor Newsom
Jessica Devencenszi, Deputy Legislative Secretary, Office of Governor Newsom
Michelle Baass, Director, DHCS
Jacey Cooper, Medicaid Director, DHCS
Dr. Kelly Pfeifer, DHCS
Susan DeMarois, Director, Department of Aging
Mary Watanabe, Director, DMHC
Martin Hoshino, Administrative Director, Judicial Council
Graham Knaus, Executive Director, CSAC

Exhibit 7

Pages: RJN-0235 through RJN-0239

California Behavioral Health Planning Council, Written Testimony and Recommendations dated April 25, 2022, submitted to Senate Health, Senate Judiciary and Senate Public Safety Committees

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

California Behavioral Health Planning Council

CHAIRPERSON
Noel J. O'Neill, LMFT

EXECUTIVE OFFICER
Jane Adcock

April 25, 2022

Honorable Senator Richard Pan
Senate Health Committee, Chair
1021 O Street, Room 3310
Sacramento, CA 95814

Honorable Senator Thomas Umberg
Senate Judiciary Committee, Chair
1021 O Street, Room 3240
Sacramento, CA 95814

Honorable Senator Steven Bradford
Senate Public Safety Committee, Chair
1020 N Street, Room 545
Sacramento, CA 95814

RE: SB 1338- Community Assistance, Recovery, and Empowerment (CARE) Court Program- OPPOSE

Dear Honorable Senators:

- **Advocacy**
- **Evaluation**
- **Inclusion**

The California Behavioral Health Planning Council (Council) opposes SB 1338 as amended April 7, 2022. This legislation outlines the framework for the Community Assistance, Recovery, and Empowerment (CARE) Court Program. The Council has strong concerns and reccomendations regarding this legislation.

Pursuant to state law, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers and representatives from state departments whose populations touch the behavioral health system. Their perspectives are essential to our view on the challenges and successes of behavioral health services and best practices in California.

The Council agrees there are people across the state who are very ill, who are unaware of their illness and who are suffering unnecessarily. These individuals need and deserve help.

Area of Concern #1: One of the biggest concerns of the Council is the involvement of the county civil court, a judge and a court order for compliance with the Care Plan. With the threat of repercussions on the individual for non-compliance, in the form of possible referral for conservatorship or resumption of legal action, coupled with the involvement of the civil judicial system directly signifies compulsion to submit.

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There is no other way in which an individual will experience going to court, standing before a judge and receiving a court order to do something for up to 12 months as anything but coercion.

The only cause for all of this to happen to an individual is untreated mental illness. No crime has been committed, no threat has been made; they simply have not sought nor maintained necessary care and support to manage their symptoms. We do not do this to people who refuse to stop smoking nor to persons with diabetes who refuse to follow a regimen to control their blood sugar. Both of these health issues will contribute in the individual's possible early death if not treated and yet there are no proposals for court-ordered care.

The Council agrees that there are many people who would benefit from treatment and support. California already uses evidence-based practices for early intervention, outreach services and clinical teams that provide wrap-around supports, all of which are proven effective. Alternatively, there are no studies that prove involuntary or court-ordered treatment is more effective than voluntary.

We believe there are other ways to address the circumstances you seek to resolve without using a court order, without using taxpayer dollars to establish an entirely new infrastructure in 58 county civil courts and without traumatizing persons because of their untreated illness. California has advanced from a strictly medical model, with an emphasis on pathology and medications, to a community-based psychosocial rehabilitation and recovery-oriented model because it is proven more effective.

Area of Concern #2: There are a growing number of unhoused individuals and families in every county of our great state. However, the cause or reason for being unhoused is not untreated mental illness nor substance use. Rather, studies show that unaffordable housing, early trauma and domestic violence, increased cost of living and unexpected medical bills are the major causes of homelessness. Consequently, while homeless, individuals living on the streets become victims of violence, crime, public shame and loss of dignity.

Studies have shown that when offered permanent, affordable housing in a "Housing First" manner which does not require sobriety, mental stability, nor program compliance as a prerequisite for housing, very few individuals or families turn down the offer. California is in an affordable housing crisis. The Governor's prior investments into affordable housing, and current proposal of $1.5B for bridge housing with CARE Court, are significant and will go far in providing needed shelter to the unhoused. It will take time to bring those units to fruition. In the meantime, the Council does not support punishing unhoused individuals with severe mental illness by strong-arming them into court-ordered treatment because we are not able to offer them affordable supportive housing now.

Area of Concern #3: In the late 1990s-early 2000s, the Council conducted a Human Resources Project to document the mental health workforce shortage. This work led to the inclusion of the Workforce Education and Training component in the Mental Health Services Act. We are now more than two decades past that work and hundreds of millions of dollars invested for workforce development but still experiencing a shortage that has risen to crisis levels. We do not have sufficient numbers of graduates from our medical schools and professional clinical programs to fill the need across the myriad of

systems requiring such skills and knowledge. The publicly-funded behavioral health system is not the only system experiencing a severe shortage; and CARE Court proposes a whole new system requiring clinical support within the county civil courts who will compete for the very same workforce.

Area of Concern #4: Where is the data? How big is this bread box? Is CARE Court actually needed in every county? How do we know whether Assisted Outpatient Treatment is effective? What are the outcomes for persons who have been placed on a 72-hour hold? Placed on a 14-day hold? Who have been placed on conservatorship? Have any of these laws resulted in outcomes as originally envisioned? Has data been collected and analyzed on where and how the counties utilize their funding? Is there valid data on the outcomes for the people they serve or the effectiveness of distinct services with different populations? Seeing people living in makeshift tents, hearing statistics of people who died while living on the streets is heartbreaking. Good government establishes policies through the identification of the problem, analysis of the numbers and exploration of options. Data drives good policy and there has been no data presented that supports implementation of CARE Court across California.

While the Council does not view these issues as insurmountable, we do feel they are realities that must be taken into consideration in the design and implementation of any new efforts to address untreated mental illness.

Recommendation #1: Remove the judicial court involvement from the program. The Council acknowledges there are too many Californians living with untreated mental illness, whose lives would be greatly improved or even saved with proper treatment and whose families are desperate for appropriate intervention to save their loved one. All of this can be effectively addressed without the use of court orders or coercion through the "black robe effect." Any hope of trust in the treatment delivery system by the individual brought before the judge would be undone in this process. The Council recommends policymakers continue to engage with and listen to the experts who have lived this circumstance first hand in order to design a program that achieves the solutions you are seeking to solve. Existing laws for LPS and Assisted Outpatient Treatment serve their purpose and require no expansion through CARE Court. This program could be designed to have the referrals made to a specialized unit in each county for rapid evaluation and development of a CARE Plan.

Recommendation #2: An array of affordable housing options are needed to meet individual's needs, including redirecting funding to help sustain Adult Residential Facilities for those that would not thrive in a supportive housing setting. One solution to address this need is to give the courts the authority to seek and order housing from local housing authorities, or subject the state's entire $14 billion in housing investments to CARE Court participants. Additionally, access to Medi-Cal managed care plan housing CalAIM-funded Community Supports and PATH benefits for CARE Court participants is necessary. Lastly, structure the state's investment of $1.5 billion in Bridge Housing to ensure housing is brought on quickly, and expand the program to include more long-term, sustainable housing options, such as permanent supportive housing vouchers, maintenance costs, board and care patches, and other housing services and supports as ongoing funding.

Recommendation #3: Be real about the workforce shortage. The Council does not believe that California can hire its way out of its behavioral health workforce shortage. So rethinking how we use the existing workforce, who delivers services and what we require of the workforce is necessary. Some solutions to address these are already in

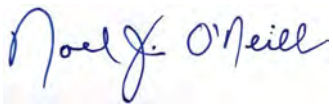
the works including the addition of Certified Peer Support Specialists (Peers) to provide critical engagement and support to persons in recovery. Also, the reduction of administrative burdens such as minute-by-minute billing and documentation requirements. The Council supports the inclusion of Peer personnel in every step of any new program to engage persons who are in need of but not seeking treatment. However, more innovation for new policies and programs as well as evaluation of the effectiveness of workforce development programs operating the last 10 years to determine what is working are also recommended.

Recommendation #4: Take the time to gather and analyze what data is currently available to support informed policy decisions before moving forward with any new programs. Then have all new programs include a mandatory data reporting process of key outcome measures, for annual evaluation, that are identified and designed prior to implementation. Additionally, include annual public reporting of outcomes and demographics of individuals served. We have to stop implementing programs and spending money with no plan for evaluation of effect. California must invest in meaningful data collection, analysis and reporting for its behavioral health system, otherwise we will continue to chase the latest novel idea in an effort to solve chronic problems.

Overall, the Council understands the issues the Governor wants addressed. We ask that some time be taken to thoughtfully craft a solution that is targeted, has voluntary evidence-based practices and will require stringent data reporting for annual evaluation with robust stakeholder engagement.

Thank you for the opportunity to share our viewpoints and ideas. If you have any questions, please contact Jane Adcock, Executive Officer, at (916) 750-1862 or Jane.Adcock@cbhpc.dhcs.ca.gov.

Sincerely,



Noel J. O'Neill, LMFT
Chairperson

Exhibit 8

Pages: RJN-0240 through RJN-0249

Mental Health America, et al., Joint Comment and Recommendations Letter dated March 23, 2022, submitted to Governor Newsom and Secretary Ghaly, California Health and Human Services Agency

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

March 23, 2022

Governor Gavin Newsom
California State Capitol
1021 O Street, Suite 9000
Sacramento, CA 95814-5704

Secretary Mark Ghaly, MD, MPH
California Health & Human Services Agency
1600 9th St Ste 460
Sacramento, CA 95814-6439

RE: Comments and Recommendations Regarding Community Assistance Recovery and Empowerment CARE Court

Dear Governor Newsom and Secretary Ghaly,

The undersigned organizations represent state and national leaders in behavioral health, criminal justice, substance use disorder services, and homelessness policy and advocacy. Mental Health America of California (MHAC), the lead organization of this letter, is a peer-run organization that has been leading the state in behavioral health public policy and advocacy since 1957.

We support the Administration's goal of providing behavioral health services to some of our state's most vulnerable residents through the recently announced Community Assistance Recovery and Empowerment (CARE) Court Program and we appreciate the opportunity to provide input.

Our comments and recommendations are intended to strengthen the plan by ensuring that every individual participating in the program has the greatest opportunity to succeed. While we agree strongly that California must improve access to services for our residents, both housed and unhoused, who live

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with behavioral health challenges, we believe that the best way to get more people into treatment and services is to ensure that there are adequate voluntary, community-based culturally competent behavioral health services and permanent, safe, affordable supportive housing programs that are provided with dignity and compassion.

Below, we offer our suggestions to strengthen the CARE Court program.

Recommendation #1: Services Should be Voluntary

The mission of MHAC is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. In accordance with our mission, we believe that every person deserves access to appropriate, voluntary services within the community that are delivered with compassion and respect for each individual's dignity and autonomy.

While the CARE Court framework includes elements of self-directed care, the overall foundation of the plan puts accountability on both local governments *and* the individual to comply with court-mandated medication and services. The fact that services are court-mandated causes these services to be involuntary, and therefore coercive.

Coercion in behavioral health care can be formal, such as the use of restraints, seclusion, or involuntary hospitalization; or informal, which includes influence or pressure placed on an individual to influence their decisions or choices.[1] Coercion in behavioral health care is often described as a hierarchy of pressures including, at the lower end of the hierarchy: persuasion, interpersonal leverage, inducements; and higher up the hierarchy are threats and compulsory treatment.[2] Coercion can also take the form of perceived coercion[3]--fear by the individual that noncompliance will result in compulsion or forced treatment[4], often referred to as "shadow compulsion" or "the black robe effect".

From the perspective of an individual experiencing a behavioral health challenge, any level of coercion, including perceived coercion reduces the voluntary nature of services by varying degrees, and consequently decreases an individual's trust in the system and in their care providers. Involuntary services are traumatizing and do not take into consideration a person's autonomy or self-determination.

[1] Hotzy, F., & Jaeger, M. (2016). Clinical Relevance of Informal Coercion in Psychiatric Treatment-A Systematic Review. Frontiers in psychiatry, 7, 197. https://doi.org/10.3389/fpsyt.2016.00197
[2] Szmukler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. J Ment Health (2008) 17(3):233–44.10.1080/09638230802156731
[3] Lee, M.H.; Seo, M.K. Perceived Coercion of Persons with Mental Illness Living in a Community. Int. J. Environ. Res. Public Health 2021, 18, 2290. https://doi.org/10.3390/ijerph18052290
[4] Szmukler G (2015) Compulsion and "coercion" in mental health care. World Psychiatry 14, 259.

Two main elements of the CARE Court plan include formal or informal coercive measures. First, the CARE Court process begins with an evaluation followed by immediate involvement of the court system and court-mandated treatment. Attending court is stressful for most people, but for the unhoused or individuals with mental health conditions, being ordered to court, especially for no reason other than the existence of a mental health condition not only causes trauma and stigma, it also impacts the therapeutic relationship[5].

Second, the CARE Court Proposal creates a new presumption under the Lanterman-Petris-Short (LPS) Act that "failure to participate in any component of the Care Plan may result in additional actions…including possible referral for conservatorship with a new presumption that no suitable alternatives exist"[6]: The threat of conservatorship in and of itself causes treatment to no longer be perceived as voluntary.

We firmly believe that, with appropriate outreach and engagement, and active involvement of certified peers, individuals will accept voluntary housing and treatment. A recent study conducted in Santa Clara found that of 400 people offered a permanent home, only one person refused the offer.[7] Data from the Assisted Outpatient Treatment Program (AOT) shows that 75% of individuals who received AOT services accepted those services voluntarily[8]. We believe this number could be further increased with focused and extensive outreach and engagement efforts prior to an individual's mandatory participation in CARE Court.

Unhoused, and particularly unsheltered individuals have been subject to extreme levels of trauma that most of us cannot conceive. Not only does early trauma play a role in many individuals becoming unhoused[9], but the process of becoming unhoused, and the situations leading up to homelessness are traumatic. Furthermore, unhoused individuals are exposed to a multitude of traumatic events, including being victims of personal violence[10], witnessing serious violence[11], and frequent encounters with police which are often unrelated to criminal activity [12]. In addition, court and law enforcement strategies are

[5] See Lee, M.H; Seo, M.K. (2021)
[6] Care Court Frequently Asked Questions, p.3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[7] Maria C. Raven MD, MPH, MSc,Matthew J. Niedzwiecki PhD,Margot Kushel MD, Human Health Research, A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services, September 25, 2020. Available at https://doi.org/10.1111/1475-6773.13553
[8] Laura's Law: Assisted Outpatient Treatment Project Demonstration Project Act of 2002 Report to the Legislature, Department of Health Care Services, May 2021 accessed at: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf
[9] Alison B. Hamilton, Ines Poza, Donna L. Washington,"Homelessness and Trauma Go Hand-in-Hand": Pathways to Homelessness among Women Veterans, Women's Health Issues, Volume 21, Issue 4, Supplement, 2011,Pages S203-S209, ISSN 1049-3867, https://doi.org/10.1016/j.whi.2011.04.005.
[10] Kagawa, R.M.C., Riley, E.D. Gun violence against unhoused and unstably housed women: A cross-sectional study that highlights links to childhood violence. Inj. Epidemiol. 8, 52 (2021). https://doi.org/10.1186/s40621-021-00348-4
[11] Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime Prevalence of Trauma among Homeless People in Sydney. Australian & New Zealand Journal of Psychiatry, 34(6), 963–966. https://doi.org/10.1080/000486700270
[12]Rountree, J., Hess, N., Lyke A. Health Conditions Among Unsheltered Adults in the U.S.. California Policy Lab. Policy Brief. (10/2019) p.7 Accessed at: https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf

more likely to be targeted to people of color, and are more likely to be traumatic to people of color--especially Black men, who are likely to be disproportionately involved with the court system. For this reason, it is essential that a trusting relationship be developed between an unhoused individual and the peer outreach worker, to enable the individual to seek voluntary treatment.

We believe that every person can achieve improvements in their mental wellness but, for our most vulnerable citizens who have been unhoused for longer periods of time, extensive outreach and engagement by a trained peer is necessary to build a trusting relationship. Because peers have "been there," there is less fear of stigma and judgment from those who they are helping. Peer support builds relationships that are based upon mutuality, shared power, and respect[13]. When a trusting relationship which is built on shared power and respect is created between a peer and a person with a behavioral health challenge, that individual will receive services voluntarily, which leads to self-empowerment for the individual. Self-empowerment, in turn, has been shown to improve quality of life, self-esteem, and reduce mental health symptoms[14], and is therefore a key variable of success.

Recommendation #2: Mandate that Certified Peer Support Specialists are Meaningfully Involved at Every Stage of the Process in Every County

In addition to the peer outreach worker, we ask that certified peer specialists be incorporated throughout the entire CARE Court process. The CARE Court framework describes a "Case Worker" and "Supporter" who assists the individual in various aspects of the CARE Court process, however the required qualifications of this supporter are not made clear in the current CARE Court framework. We believe that this Case Worker and Supporter must be a mandated certified peer support specialist in every county and in all circumstances.

Peer support is an evidence-based practice that has been shown to reduce re-hospitalization[15], reduce the number of homeless days[16], and improve quality of life, among many proven benefits. Trained and certified peers with lived experience of homelessness and/or behavioral health conditions are uniquely positioned to provide support and build a trusting relationship with people who are currently unhoused and/or people living with behavioral health conditions.

For the CARE Court program to meet its goal of improving the lives of people with behavioral health conditions, peer support specialists must be actively and meaningfully involved at every stage of the program, beginning with robust initial outreach and engagement efforts designed to encourage voluntary participation, and continuing until the individual completes the program.

[13] Mead S. Intentional Peer Support; 2001. [2020-02-28]. Peer Support as a Socio-Political Response to Trauma and Abuse https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9_DbPm5kSST9_Q/edit

[14] Patrick W Corrigan, Dale Faber, Fadwa Rashid, Matthew Leary, The construct validity of empowerment among consumers of mental health services, Schizophrenia Research,Volume 38, Issue 1,1999

[15] Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers. Accessed at:https://www.nyaprs.org/e-news-bulletins/2013/bergeson-cost-effectiveness-of-using-peers-as-providers

[16] van Vugt, M. D., Kroon, H., Delespaul, P. A., & Mulder, C. L. (2012). Consumer-providers in assertive community treatment programs: associations with client outcomes. Psychiatric Services, 63(5), 477–481. doi:10.1176/appi.ps.201000549.

Recommendation #3: Provide Permanent Supportive Housing Before Services are Mandated

California has adopted the "Housing First" approach, which recognizes that an unhoused person must first be able to access safe, affordable, permanent housing ***before*** stabilizing, improving health, or reducing harmful behaviors[17].According to state statute, "any California state agency or department that funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of homelessness, must incorporate the core components of housing first"[18].

Permanent supportive housing, which follows the Housing First approach, is targeted to individuals with mental health, substance use, or other disabilities who have experienced long-term homelessness. It provides long-term rental assistance in combination with supportive services. Research has shown that individuals, even those with chronic homelessness, remain housed long-term in permanent supportive housing[19]. In a New York program, individuals with prior jail and shelter stays were offered permanent supportive housing through a state program. At 12 months 91% of these people were housed in permanent housing compared to 28% in the control group who were not offered housing through the program[20]. In a Denver supportive housing program, 86% of participants remained housed after one year, and experienced notable reductions in jail stays[21].

To give every individual the best chance of succeeding, it is imperative that individuals who have been found to qualify for the CARE Court program be offered permanent supportive housing and a chance to stabilize and accept voluntary services before any services are court mandated.

Recommendation #4: Analyze and Publicly Report Plans for Addressing the Permanent Housing Needs of CARE Court Participants

Permanent, stable housing is essential to the successful participation in treatment, services and supports of people with behavioral health care needs; the State should analyze and publicly document the projected permanent housing needs for people who may participate in the CARE Court program. That analysis and public documentation should include clear information regarding:

- The projected permanent housing needs of potential CARE Court participants;
- The permanent housing options that are expected to be made available to meet those needs;
- The number of those housing options currently available;
- How additional housing options will be funded, and when they will be available to CARE Court participants; and
- The expectations regarding choice among permanent housing options to be provided to CARE Court participants.

[17] Welfare and Institutions Code § 8255
[18] Welfare and Institutions Code § 8255 (e) and § 8256 (a)
[19] Davidson, C., et al. (2014) "Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use." Psychiatric Services. 65(11), 65(11): 1318-24
[20] Aidala, A.; McAllister, W; Yomogida, M; and Shubert, V. (2013) Frequent User Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report. Columbia University Mailman School of Public Health.
[21] Urban Institute (2021) "Breaking the Homelessness-Jail Cycle with Housing First, accessed at https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first_1.pdf

This information is essential for assessing the viability and potential success of the CARE Court proposal, and the lack of such information currently makes a full assessment of the proposal impossible.

Recommendation #5: Ensure Integrated Care of Behavioral Health – Mental Health and Substance Use Disorder Services

Due to the unique behavioral health care funding streams in California, individuals receiving specialty mental health services who also have a substance use challenge must navigate two separate systems (county mental health plans for mental health and county drug Medi-Cal for substance use disorder) to access services. This system fragmentation often results in lack of care coordination and disruptions in care[22], which ultimately results in inadequate services.

To ensure that every individual who is eligible for CARE Court has the greatest opportunity to succeed, it is imperative that every person participating in the program, and those who are pre-enrollment, but receiving outreach and engagement services, be provided with integrated mental health and substance use care.

Recommendation #6: Address System Gaps and Require an Independent Ombudsperson

We believe strongly in the right of all individuals to have access to voluntary, high-quality health and behavioral health services. Services and supports must be available and accessible, and be representative of the diverse needs of Californians. Before California creates another new program, we must first ensure that appropriate services are available for all who need them.

It is well recognized that California has not fully developed system capacity for the full continuum of behavioral health services [23]. California's lack of system capacity includes workforce shortages[24], lack of diversity in mental health professionals[25], and network inadequacy of County Mental Health Plans[26]. Furthermore, the recent report by the State Auditor found that the continuum of services, from intensive treatment to step-down community-based options, are not readily available for people in need[27]. The same report also found that in San Francisco, only about 5% of individuals with five or more holds over 3 years were connected to intensive aftercare services. In Los Angeles, this number was around 10%.

In addition to lack of available services, individuals who receive Specialty Mental Health Services through a County Plan do not always have a source of independent, unbiased assistance or support to help them access needed services. While individuals with HMO insurance can access assistance from the Department of Managed Health Care (DMHC), and individuals with Medi-Cal Managed Care can

[22] California Health Care Foundation, Behavioral Health Integration in Medi-Cal: A Blueprint for California, dated February, 2019. Accessed at: https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf
[23] California Health Care Foundation, Mental Health in California: For Too Many Care Not There, dated March 15, 2018.
[24] UCSF, Healthforce Center, California's Current and Future Behavioral Health Workforce, February 12, 2018.
[25] Ibid.
[26] Department of Health Care Services, Report to CMS: Annual Network Certification on Specialty Mental Health Services. 2020
[27] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.

receive assistance from the DMHC or the Medi-Cal Ombudsman, individuals receiving Specialty Mental Health Services are limited to the county Patients' Rights Advocate (PRA) or the county appeal and grievance process.

Although PRAs are authorized by statute to assist individuals to "secure or upgrade treatment or other services to which they are entitled"[28], there are no minimum PRA staffing ratios defined in the guidelines which results in inadequate staffing of county Patients' Rights Offices so PRAs spend much of their time representing people at certification review hearings and capacity hearings.[29] Another challenge with PRAs is the inherent conflict of interest which arises from the fact that they are either employees or contractors of the county, so their efforts to assert the rights of an individual requires the PRA to essentially dispute their employer which has resulted in multiple instances of retaliation.[30] Lastly, the California Office of Patients' Rights (COPR) is a contract dually executed by the Department of State Hospitals (DSH) and the Department of Health Care Services, however funding for the COPR contract is provided solely by DSH, which results in a majority of COPR's efforts being geared towards supporting PRAs in state hospitals. Support for the county PRAs is very limited, which results in their limited capacity to assist individuals with access to appropriate specialty mental health services and supports.

Without a PRA or an ombudsperson, the county appeal and grievance process can be intimidating, confusing, and lengthy. Individuals rarely know this assistance is available, much less know how to access the process. In addition, lower income individuals often do not have access to computers or internet access, which makes the grievance and appeal process nearly impossible.

Independent Ombuds serve as a liaison between an individual and their health care payor without fear of retaliation. Research has shown that Ombuds increase accountability[31], increase access to health care[32], monitor the functioning of policies, and much more. We believe that access to an independent and unbiased Ombudsperson or entity, either at the state or county level, would have the dual effect of assisting individuals with accessing appropriate services, and identify local gaps in necessary services prior to crisis.

Recommendation #7: Do Not Expand the Lanterman-Petris-Short (LPS) Act

The LPS Act includes protections intended to protect the civil rights of the individual, including referral, evaluation, multiple certification hearings, an investigation, and a court hearing to determine whether the individual, because of a mental health condition or alcohol use, is a danger to themself or others, or is gravely disabled. Gravely disabled is defined as an inability to provide for his or her basic personal needs for food, clothing, or shelter. If, ***after a hearing***, a person is found to meet one of these

[28] Welfare and Institutions Code § 5500(a)
[29] California Behavioral Health Planning Council, Title 9 County Patients' Rights Advocates, highlighting resource, training, and retaliation issues in county patients' rights programs in California. 10/2017 p. 5
[30] Id. Page 8
[31] Durojaye, E., & Agaba, D. K. (2018). Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. Health and human rights, 20(2), 161–168.
[32] Silva, R., Pedroso, M. C., & Zucchi, P. (2014). Ouvidorias públicas de saúde: estudo de caso em ouvidoria municipal de saúde [Ombudsmen in health care: case study of a municipal health ombudsman]. Revista de saude publica, 48(1), 134–141.

requirements, and if the court finds that they should be detained, they are first placed on 72-hour hold, and then may continue to be placed on successively longer holds, after a certification hearing at each stage, until and if a referral to conservatorship is eventually ordered. A referral to conservatorship requires a comprehensive investigation by an officer, and a determination by the court that a person is gravely disabled, they refuse to accept treatment voluntarily ***and*** that no reasonable alternatives to conservatorship exist.

The creation of a new presumption in the CARE Court program, that noncompliance with ***any*** aspect of the individual's court-mandated plan may result in referral for conservatorship with the new presumption that no alternatives exist[33], effectively bypasses the entire LPS process in a number of ways including, but not limited to:

- ***A presumption that no alternatives exist could be construed to include the implicit presumption that the person is gravely disabled.*** Nothing in the CARE Court framework indicates that grave disability is a requirement for referral to conservatorship from the program;
- An individual who complies with the majority of their court-mandated plan could still be referred for fast-track conservatorship for refusing to comply with a single element of their plan, even if they are receiving services voluntarily;
- This process eliminates the 72-hour, 14-day, and 30-day holds which are created in statute to give the individual a chance to stabilize;
- The presumption does not allow for investigation into other alternatives that may exist.

The new presumption represents a dangerous expansion of LPS law. A recent comprehensive State Audit of LPS protocols and procedures at the county-level was conducted last year[34]. The auditor states: "Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change"[35].

In closing, we strongly support the goal of reducing homelessness and providing mental health services to everyone who needs those services. We believe strongly that individuals can and will succeed when they have access to appropriate services that meet their individual needs.

Thank you for the opportunity to provide comments and recommendations on the CARE Court Framework. We look forward to continuing to collaborate with the Administration as this proposal continues to be developed.

[33] See CARE Court FAQ #8, page 3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[34] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.
[35] Ibid. page 1

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Exhibit 9

Pages: RJN-0250 through RJN-0268

Senate Third Reading (SB 1338), dated August 25, 2022

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

SENATE THIRD READING
SB 1338 (Umberg and Eggman)
As Amended August 25, 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 Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties by October 1, 2023, and the remaining counties 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. Provides that the CARE Act only becomes operative upon DHCS, in consultation with county stakeholders, developing a CARE Act allocation to provide state financial assistance to counties to implement the CARE process.

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).

    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), the court shall dismiss without prejudice, subject to 8).

    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), 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), 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 the county's report supports the petition's prima facie showing that the respondent 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 county's report does not support the petition's prima facie showing that the respondent meets the CARE 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 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 contempt or the accountability measures in 29).

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

21) The issuance of any orders in 20) 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 or designee 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 or designee 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 that local government's 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 or designee, if a county is found to be persistently noncompliant, to appoint a special master 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.

49) Provides immunity to a county, or an employee or agent of a county, for any action by a respondent in the CARE process, except when the act or omission of a county, or the employee or agent of a county, constitutes gross negligence, recklessness, or willful misconduct.

50) Adds a severability clause.

51) Adds chaptering out amendments with SB 1223.

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 percent of the nation's homeless population – over 160,000 – of which 70.4 percent 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 percent of California's homelessness population is severely mentally ill and 17 percent has a chronic substance abuse disorder. (Legislative Analyst's Office, *California's Homelessness Challenges in Context*, *supra*, citing the 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 U.S. 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 or their designee finds that a county or other local government entity is not complying with a court order, the judge may fine the county or other entity up to $1,000 for each day of noncompliance, up to $25,000 per incident; and if the county or other local government entity is consistently noncompliant, the presiding judge may, at the county's or other entity's cost, appoint a special master to secure the compliance. These penalties are subject to due process protections and mitigating factors and any penalty collected must be used to support activities in that county 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 analysis:

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

VERSION: August 25, 2022

CONSULTANT: Leora Gershenzon / JUD. / (916) 319-2334 FN: 0004277

Exhibit 10

Pages: RJN-0269 through RJN-0283

**Senate Committee on Health, Analysis,
Date of Hearing: April 27, 2022**

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 1338
AUTHOR: Umberg and Eggman
VERSION: April 7, 2022
HEARING DATE: April 27, 2022
CONSULTANT: Reyes Diaz

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

SUMMARY: Establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Act for the purpose of providing a court-ordered CARE plan to individuals who have a severe mental illness and meet other specified criteria that includes behavioral health treatment services, a trained supporter to assist the respondent in navigating the process, and identifies an appropriate housing plan.

Existing law:

1) Implements assisted outpatient treatment (AOT, 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 his or her 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 §5346]

2) Establishes the Lanterman-Petris-Short (LPS) Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in county-designated facilities. [WIC §5000, et seq.]

3) Permits a court, after notice to the defendant, defense counsel, and the prosecution, to hold a hearing to determine whether to take specified actions, including referring a defendant to AOT or conservatorship proceedings, as specified. [PEN §1370.01]

4) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). [HSC §1340, et seq.]

5) Requires the Department of Health Care Services (DHCS) to ensure all covered mental health (MH) and substance use disorder (SUD) benefits are provided through Medi-Cal managed care plans, including a county that has opted into the Drug Medi-Cal Organized Delivery System, as specified. [WIC §14197.1]

This bill:

Court process

1) Permits a court to order an individual who is the subject of a petition (respondent) to participate in CARE Court Act proceedings if the court finds, by clear and convincing evidence, that the facts stated in the petition are true and establish that the requisite criteria set forth in this section are met, including all of the following:

    a) The respondent is 18 years of age or older;
    b) The respondent has a diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders;
    c) The respondent is not clinically stabilized in on-going treatment with the county behavioral health agency; and,
    d) The respondent currently lacks medical decision-making capacity.

2) Permits the following persons to file a petition, signed under the penalty of perjury, as specified, to initiate CARE proceedings:

    a) A person 18 years of age or older with whom the respondent resides;
    b) A spouse, parent, sibling, or adult child of the respondent;
    c) The director of a hospital, or their designee, in which the respondent is hospitalized;
    d) The director of a public or charitable organization, agency, or home, or their designee, currently or previously providing behavioral health services to the respondent or in whose institution the respondent resides;
    e) A qualified behavioral health professional, or their designee, who is, or has been, 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;
    g) The public guardian or public conservator, or their designee, of the county in which the respondent is present or reasonably believed to be present; and,
    h) The director of a county behavioral health agency, or their designee, of the county in which the respondent is present or reasonably believed to be present.

3) Requires a petition to contain, among other information, either:

    a) An affirmation or affidavit of a qualified behavioral health professional stating that the qualified behavioral health professional or their designee has examined the respondent within three months of the submission of the petition, or has made appropriate attempts, but has not been successful, in eliciting the cooperation of the respondent to submit to an examination, and that the qualified behavioral health professional had determined that, based on an examination or a review of records and collateral interviews, the respondent meets, or is likely to meet, the diagnostic criteria for CARE proceedings; or,
    b) Evidence that the respondent was detained for intensive treatment pursuant to the LPS Act within the previous 90 days.

4) Requires a court, upon receipt by the court of a petition, to set an initial hearing not later than 14 days from the date the petition is filed with the court, and to appoint counsel and a "supporter," as defined, for the respondent within five calendar days of filing.

5) Requires a court, at the initial hearing, to determine if the respondent meets the CARE criteria within 14 days after the petition is filed with the court. Requires the petitioner to be present, or the matter is dismissed.

6) Requires a court, if it finds that the petitioner has submitted prima facie evidence that the respondent meets the CARE criteria, to order the county behavioral health agency to work with the respondent and the respondent's counsel and supporter to determine if the respondent is required to engage in a treatment plan. Requires a case management conference to be set for no later than 14 days after the court makes its finding.

7) Requires a court, at the evaluation review hearing, to review the evaluation and any other evidence from all interested individuals, including, but not limited to, evidence from the petitioner, the county behavioral health agency, the respondent, and the supporter.

8) Permits a court to either approve the plan as presented and make any orders necessary for the implementation of the plan; order the plan modified to better meet the needs of the parties, approve the plan as modified, within the scope of the county behavioral health agency's services, and make any orders necessary for the implementation of the plan; or, reject the plan and order the parties to continue to work on the plan. Requires a court to set a subsequent hearing for no more than 14 days after rejecting the proposed plan.

9) Specifies that court approval of the CARE plan begins the one-year CARE program timeline. Requires a court to schedule a status conference 60 days after the approval of the CARE plan to review the progress of the plan's implementation and every 180 days thereafter. Requires a court to review intermittent lapses or setbacks experienced by the respondent.

10) Requires a court, at the 11th month of the program timeline, to hold a one-year status hearing to determine whether to graduate the respondent from the program with a graduation plan or reappoint the respondent to the program for another term, not to exceed one year, as specified.

11) Prohibits the respondent from being reappointed to the program if they have successfully completed participation in the one-year CARE program. Permits the respondent to request graduation or reappointment to the CARE program. Permits the respondent to request any amount of time, up to and including one additional year, to be reappointed to the CARE program if at completion of the first year the respondent elects to accept voluntary reappointment to the program.

12) Requires a court to officially graduate the respondent and terminate its jurisdiction with a graduation plan if the respondent requests to be graduated from, or times out of, the program, as specified.

13) Permits a court to fine a county up to $1,000 per day for noncompliance with providing a respondent CARE services. Permits a court to appoint a receiver to secure court-ordered care for the respondent at the county's cost, as specified.

14) Permits a court terminate the respondent's participation in the CARE program if, at any time during the proceedings, the court determines the respondent is not participating in CARE proceedings or is failing to comply with their CARE plan, as specified.

15) Requires respondents to have specified rights, such as to receive notice hearings, to be presented by counsel at all stages of a proceeding, to have a supporter, present evidence, and cross-examine witnesses.

Respondent's CARE supporter

16) Requires the California Department of Aging (CDA) to administer the CARE supporter program, which shall make available a trained supporter to the respondent. Requires CDA to train the supporter on supported decision-making with individuals who have behavioral health conditions and on the use of psychiatric advance directives, with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. Defines "supporter" as a trained adult who assists a respondent, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions.

17) Requires a supporter to do all the following, to the best of their ability and to the extent reasonably possible: support the will and preferences of the respondent; respect the values, beliefs, and preferences of the respondent; act honestly, diligently, and in good faith; and, avoid, to the greatest extent possible, and disclose, minimize, and manage, conflicts of interest. Prohibits, unless explicitly authorized, a supporter from make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury; signing documents on behalf of the respondent; or, substituting their own judgment for the decision or preference of the respondent.

18) Requires a supporter to be bound 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. Specifies that a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion, or mistreatment is not limited, as specified.

Respondent's CARE plan

19) Requires a CARE plan to be created by the respondent, their supporter and counsel, and the county behavioral health agency. Requires the plan to include all of the following components:

    a) Behavioral health treatment, which includes medically necessary MH or SUD treatment, or both;
    b) Requires a county to provide all medically necessary specialty MH and SUD treatment services, if the respondent is enrolled in the Medi-Cal program, as specified, to a respondent when included in their court ordered CARE plan. Permits specialty MH and SUD treatment services to be included in the CARE plan if they are determined to be medically necessary by the clinical evaluation;
    c) Encourages counties are to employ medically necessary, evidence-based practices and promising practices supported with community-defined evidence, which may include assertive community treatment, peer support services, and psychoeducation; and,
    d) A housing plan that describes the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement, as specified. Specifies that the provisions in this bill do not allow the court to order housing or require the county to provide housing.

20) Permits the CARE plan, as part of the provision of behavioral health care, to include medically necessary stabilization medications, including antipsychotic medications, including as long-acting injections, as specified. Prohibits court ordered stabilization medications from being forcibly administered, absent a separate order by the court, as specified.

21) Requires the respondent, in the development and on-going maintenance of the plan, to work with their behavioral health care provider and their supporter to address medication concerns and make changes to the treatment plan. Permits medically necessary stabilization medications to be prescribed by the treating licensed behavioral health care provider. Requires medication support services to be offered.

Coverage mandate

22) Requires a health plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses, to cover the cost of developing an evaluation for the respondent's eligibility for CARE Court and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE plan approved by a court, as specified.

23) Prohibits a health plan from requiring prior authorization for services provided pursuant to a CARE plan approved by a court under the CARE Court program. Permits a health plan to conduct a postclaim review to determine appropriate payment of a claim, and permits denial under specified circumstances. Prohibits services provided to an enrollee pursuant to a CARE plan from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. Prohibits an individual or entity from billing the enrollee or subscriber, or seeking reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE plan. Specifies that these provisions do not apply to Medi-Cal managed care contracts, as specified.

Technical assistance and administration

24) Requires, subject to an appropriation:

   a) DHCS to provide technical assistance to county behavioral health agencies to support the implementation of the requirements in this bill, including trainings regarding the CARE model and statute and data collection;
   b) DHCS to administer the Behavioral Health Bridge Housing program to provide funding for clinically enhanced bridge housing settings to serve individuals who are experiencing homelessness and have behavioral health conditions. Requires individuals who are CARE program participants to be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program; and,
   c) The Judicial Council to provide technical assistance to judges to support the implementation of the requirements in this bill, including trainings regarding the CARE model and statutes, working with the supporter, best practices, and evidence-based models of care for people with severe behavioral health conditions.

25) Permits the California Health and Human Services Agency (CHHSA), DHCS, and CDA to implement, interpret, or make specific provisions in this bill, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action. Permits CHHSA, DHCS, and CDA to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, as specified.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the authors, this bill creates the CARE Court program, which is a proposed framework to deliver MH and SUD services to the most severely impaired Californians who too often languish—suffering in homelessness or incarceration—without the treatment they desperately need. The proposed CARE Court program is a response to the urgent need for innovative solutions for individuals who are suffering with untreated schizophrenia spectrum and psychotic disorders, often unhoused in our communities, and who face high risks for repeated hospitalization, incarceration, institutionalization, conservatorship, and premature death. In California and nationally, comprehensive care, medication, and housing have been clinically proven to successfully treat and stabilize individuals with severe mental illness but are too often available only after arrest or in secure facilities. Therefore, this bill will create a program to connect a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The program provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services, including housing.

2) *CARE Court proposal.* In early 2022, Governor Newsom proposed the CARE Court program, as an alternative to amending the LPS Act, to help connect a person 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 individuals 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, and connection to social services and a housing plan. According to the CHHSA's website, housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent, or in a vehicle. CHHSA states that CARE Court 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. CHHSA further states that CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity, before they enter the criminal justice system or become so impaired that they end up in a LPS conservatorship due to mental illness. CHSSA states that although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions, and the CARE Court proposal aims to connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness. SB 1338

(Umberg and Eggman) and AB 2830 (Bloom) of this Legislative Session implement the CARE Court proposal.

3) *Senate Human Services Committee Comment*. This bill was triple referred to the Senate Human Services Committee, but due to the Covid-19 protocols, the referral to the Senate Human Services Committee was rescinded. The Senate Human Services Committee's comment on portions of the provisions of this bill that relate to their jurisdiction can be found below:

There are a variety of ways in which this proposal crosses into the human services arena, but for the purpose of this comment the focus will be on CDA's administration of the CARE Supporter program and how this proposal intersects with California's existing Housing First policies.

CDA's Administration of the CARE Support Program: Currently, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities, such as Residential Care Facilities for the Elderly or Adult Residential Facilities. CDA contracts with a statewide network of Area Agencies on Aging (who directly administer a number of programs providing supportive services, meals, community involvement, and caregiver support to eligible older adults and their families) and agencies that operate Multipurpose Senior Services Program (which operate Adult Day Health Care Centers and Medi-Cal Community Based Adult Services Program providing direct services to eligible seniors in their communities). CDA also houses the Long-Term Care Ombudsman, whose representatives assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences. None of these ongoing programs seem to directly translate to the requirements of the CARE Supporter program.

As provided for by this bill, the CARE Supporter program requires CDA to make a trained supporter available to the respondent. CDA is required to train the supporter on supported decision making with individuals who have behavioral health conditions and on the use of psychiatric advance directives, with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. Through its work on the Master Plan on Aging, and other efforts, CDA has worked with stakeholders and advocates to create plans related to Alzheimer's and other dementias, but it is unclear as to whether they have any other experience working on behavioral health conditions. It has been suggested that the diagnoses targeted through CARE Court, i.e. schizophrenia spectrum or other psychotic disorders, are similar to Alzheimer's and other dementias in that they impair the individual's decision making ability. However, it seems that the similarities between these two populations may stop there. It is very unclear how experience working with the Alzheimer's population would translate to expertise with or ability to know the needs of unhoused individuals who are severely mentally ill. Moving forward, the authors' offices may wish to work with stakeholders to ensure this bill would not incidentally impact the Alzheimer's disease and other dementias community, as well as work to examine whether CDA truly is the right home for the CARE Supporter program.

Housing First: In 2016, the state's efforts to address homelessness shifted to use Housing First core components. Senator Mitchell authored SB 1380 (Chapter 847, Statutes of 2016), which created the Cal ICH (name changed from HCFC by SB 1220, (Rubio, Chapter 398, Statutes of 2021)) to oversee implementation of the Housing First regulations and coordinate

the state's response to homelessness, as well as create partnerships among state agencies and departments, local government agencies, nonprofits, and federal agencies to prevent and end homelessness in California. SB 1380 also aligned the Housing First guidelines for any state program that provides housing and supportive services to people experiencing homelessness. Housing First means the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

As currently in print, this bill includes a housing plan as part of the respondent's CARE plan. The bill provides for the housing plan to describe the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement. It further provides that the respondent shall have diverse housing options, including, but not limited to, housing in clinically enhanced interim or bridge housing, licensed adult and senior care settings, and supportive housing. Since the bill goes onto state that "counties may offer appropriate housing placements in the region as early as feasible in the engagement process" and that this section "does not allow the court to order housing or to require the county to provide housing," it seems that an individual could be participating in CARE Court, be required to meet certain treatment plan goals and requirements, and yet remain unhoused. Under the existing Housing First framework, the state is supposed to be working with local governments and Continuums of Care to ensure housing is used as a tool in an individuals' overall path to wellness rather than as a reward for recovery, even for those with substance use disorders or severe mental illness.

It seems somewhat unclear how an individual meeting the requirements for participation in CARE Court can truly make progress, in terms of complying with the components of their CARE plan, if they remain unhoused. Additionally, the language of this proposal is currently silent on whether an individual who is housed through the CARE Court program may lose their housing if they fail to comply with their CARE plan, stop taking their psychotropic medications, or experience a relapse. This raises questions in regards to how the program complies with existing Housing First principals, and raises the question of whether it is creating a "Housing Second" model. The authors' offices may wish to consider working with stakeholders to ensure the provisions of the CARE Court align with Housing First, and to seek to address whether components of a CARE plan can be successfully implemented when respondents remain unhoused.

4) *Double referral.* This bill is double referred to the Senate Judiciary Committee. Should it pass out of the Senate Judiciary Committee, it will be referred to this Committee.

5) *Related legislation.* SB 1416 (Eggman) expands the definition of "gravely disabled" to include the inability of an individual to provide for their basic personal needs for medical care for the purpose of involuntarily detaining the individual for evaluation and treatment of a mental health condition, as specified. *SB 1416 passed this Committee by a vote of 9-0 on April 20, 2022.*

SB 1337 (McGuire) requires health plans and insurers to provide coverage of coordinated specialty care for the treatment of first-episode psychosis according to detailed specifications and billing requirements. Requires DMHC, Department of Insurance, and DHCS to create a working group that meets once per month for one year to establish guidelines, and 60 days

after the guidelines are established, regulations to be adopted. *SB 1337 is scheduled to be heard in this Committee on April 27, 2022.*

AB 2830 (Bloom) is identical to this bill. *AB 2830 is pending in the Assembly.*

6) *Support.* NAMI-CA believes that all people should have the right to make their own decisions about medical treatment but states that there are individuals with serious mental illnesses, such as schizophrenia and bipolar disorder, who at times, due to their illness, lack insight or good judgment about their need for medical treatment. In cases like this, a higher level of care may be necessary, but must be the last resort. NAMI-CA members have been calling for reform for their loved ones for years. NAMI-CA believes that the availability of effective, comprehensive, community-based systems of care for persons suffering from serious mental illnesses will diminish the need for involuntary commitment and/or court-ordered treatment. NAMI-CA argues that before we reach the stage of last resort, we must fully fund, build, and staff our community-based system so all who need care can access it long before they reach a crisis level. NAMI-CA is heartened to see that accountability is one of the pillars of the CARE Court framework and believes we must hold the system accountable at all delivery points. The California Hospital Association states that this bill holds great promise of creating new pathways to treatment and housing for the many individuals hospitals see each day who, under the status quo, may otherwise continue to cycle needlessly through periods of crisis, homelessness, failing health, and hospitalization. Hospitals are hopeful that impending behavioral health capital infrastructure and workforce investments will expeditiously create the missing levels of care our communities so desperately need for individuals living with a serious mental illness.

7) *Opposition.* A coalition of opponents, the majority of the listed opposition comprised of advocates that advance and protect the civil rights of Californians living with disabilities, experiencing homelessness, and involved in the criminal legal system, argues that the CARE Court framework is unacceptable for a number of reasons:

- It does not guarantee housing as a solution to address homelessness;
- Evidence shows that adequately resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment;
- It will perpetuate institutional racism and worsen health disparities;
- There are flaws in this bill's reliance on a person's lack of capacity to make medical decisions;
- Use of the terms "supportive decision-making" and "supporter" reflects a misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court; and,
- Critical terms and concepts are not defined in this bill or elsewhere in California law.

The coalition in opposition further states that CARE Court is a system of coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives. CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction, and is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness. While the coalition in opposition agrees 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. The coalition in opposition argues that California law is very clear about the process to determine whether a person lacks capacity to make medical decisions, which includes the right to a court hearing, that must be followed, and this bill does not require any of these steps. Instead, it allows unacceptable shortcuts.

The Drug Policy Alliance (DPA), not part of the coalition described above, argues similar points regarding institutional racism and needed investments for housing and community-based services. DPA also states that though this bill does not name substance use as a criterion for qualification for CARE Court, both Governor Newsom's statements and information about the plan released by CHHSA notably do. Regardless, despite not articulating people using drugs as a target population for CARE Court, people on the streets dealing with addiction will almost certainly be swept into these proceedings. This inevitability is due in large part to the broad category of people who can petition to force an individual into CARE Court proceedings, as well as the incredibly low threshold for triggering an initial hearing on the petition. The current process outlined in the CARE Court proposal will lead to people who have no expertise in healthcare attempting to make complex medical determinations, which they will undoubtedly get wrong at least some, if not most, of the time. Therefore, DPA believes that instead of the person who has been forced into CARE Court getting treated with true care, dignity, and properly tailored support, they will undergo the stressful experience of undergoing a confusing and intimidating court process. CARE Court sends a message to vulnerable people dealing with myriad struggles that they are wrong, because things don't end up in court when they are right. DPA states California can and must do better.

8) *Letters of concerns.* A coalition of county representatives (California Association of Public Administrators, Public Guardians, and Public Conservators; California State Association of Counties; County Behavioral Health Directors Association; County Welfare Directors of California; Rural County Representatives of California; and Urban Counties of California) expresses their concerns with the understanding that additional collaboration and technical work is required. This coalition states that CARE Courts require significant engagement from counties—especially county behavioral health and county public defenders—from beginning to end, and members have raised some questions regarding the language in this bill, such as:

- How will the proposed statutory CARE Court timelines be integrated so that they are consistent and achievable?
- How will the processes related to petitioning, settlement, development of a CARE Court treatment plan, and graduation or failure from the program be refined?
- Will the required levels of evidence be standardized throughout the process?
- Will continuity of services be ensured upon graduation?
- Will additional details regarding the provision of housing by all levels of government, including counties, cities, and continuums of care be included?
- How will the state estimate and provide resources for the integral role of counties in CARE Courts, including state mandated services and any new responsibilities subject to Proposition 30?
- Is the civil court system the proper venue for engaging those who initially lack medical decision- making capacity?

- Are CARE Courts potentially redundant considering the robust mental health, drug, and other specialty courts currently operating in most counties?
- Could the state implement CARE Courts as an opt-in pilot project to test and improve the process, gauge the resources required for scalable success, and gather data to determine if the outcomes align with the policy intent?

The county coalition also expresses strong opposition to the proposed penalties and court-ordered receivership for counties that fail to meet the court's undefined expectations in this bill. The ability of county behavioral health to respond to increased demand for clinicians to engage in CARE Court, or for services that go beyond existing Medi-Cal entitlement services, will depend entirely on the state's willingness to fund these new activities. Allowing the court to order services beyond counties' existing contracted obligations under Medi-Cal and other regulatory and statutory requirements could result in fines, penalties, and corrective action across multiple existing regulatory frameworks and sets a dangerous precedent for a publicly funded safety net system acting as an arm of the state. Also, penalizing the very system that is attempting to provide the services is counterproductive at best. Counties are committed to working with all stakeholders to implement CARE Courts in a conscientious and sustainable manner to achieve Governor Newsom's vision of early intervention and assistance for some of the most vulnerable Californians.

The California Psychological Association (CPA), not part of the county coalition described above, expresses concerns about language in this bill that provides for psychologists to involve themselves at multiple points, including the ability to serve as a petitioner, provide court attestation to initiate proceedings, or provide the clinical assessment of the respondent. However, unlike statute within the LPS Act, there is no safe harbor provision for any professional operating within the program. The risk exposure to these professionals demands the need for statutory immunity from criminal and civil liability, both for involvement and lack of involvement with the CARE Court program. CPA also sees potential difficulties in creating an overly burdensome process with aggressive timelines for providers working in Medi-Cal and county behavioral health facilities, arguing that CARE Courts would further strain California's precarious public behavioral health delivery system, unless there are significant investments into workforce development and financial support for licensed behavioral health professionals within Medi-Cal, including psychologists.

A second coalition with concerns (California Alliance of Child and Family Services, California Association of Alcohol and Drug Addiction Program Executives, California Association of Social Rehabilitation Agencies, and California Council of Community Behavioral Health Agencies) largely echoes the concerns expressed by the county coalition and additionally is concerned that CARE Court does not include some critical protections and safeguards outlined in AOT, which authorizes a court to order an individual with a mental illness in counties that have not opted-out onto court-ordered services. AOT eligibility criteria is more specific than CARE Court and critically requires that an individual has been offered an opportunity to participate in a treatment plan, and the person continues to fail to engage in treatment, and that participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability. This coalition further states that while CARE Court is not intended to be a silver bullet solution to homelessness, likely a significant portion of the individuals in CARE Court will be experiencing homelessness or housing insecurity. The coalition states it is also important to note that research from Dr. Margot Kushel of UC San Francisco indicates that half of all

individuals experiencing homelessness today are over the age of 50 with half of this population having their first experience of homelessness after they turned 50 years old. There is a significant percentage of this population who have geriatric conditions beyond their biological age, and the coalition questions if the CARE plan designed within the CARE Court model includes adequate access to primary care and physical health care services.

9) *Policy concerns.* The CARE Court proposal largely is modeled after the AOT court process with some timelines and processes that go beyond what is required in AOT, particularly:

   a) Allowing a petition to include an affirmation or affidavit from a qualified behavioral health professional that an examination on the respondent was conducted within the previous three months;
   b) Allowing one 14-day intensive treatment episode within the last 90 days to be used as evidence that a respondent should be considered for CARE Court; and,
   c) Permitting a court to modify a CARE plan to better meet the needs of the parties.

   Additionally, background information for the CARE Court proposal recognizes that a respondent will have lapses and setbacks over the period of the CARE plan, and this bill requires a court to review those intermittent lapses and setbacks. However, there is no provision that specifies a respondent would not be penalized.

   Concerning the health care service plan contract provision, this bill is not clear that it would apply to only covered services offered by a plan, or if it's an expansion, nor does it specify that a health care service plan can require services to be provided by in-network providers.

10) *Amendments.* To address the concerns mentioned above, the authors may wish to consider the following amendments:

   a) Require a petition to include an affirmation or affidavit from a qualified behavioral health professional that an examination was conducted on the respondent within the previous 14 days of submission of the petition;
   b) Require three previous intensive treatment episodes within the last 90 days with the most recent episode having occurred within the previous 14 days as evidence that a respondent should be considered for CARE Court;
   c) Specify that a court is permitted to modify a CARE plan to better meet the needs of the respondent pursuant to the CARE plan; and,
   d) Specify that a respondent's lapses and setbacks alone should not preclude them from participating in any treatment services or make them ineligible for housing options that have been ordered in the CARE plan.
   e) Specify that the health care service plan is required to provide covered services, and that the health care service plan can require services to be provided by an in-network provider if one is available and qualified to provide the services.

SUPPORT AND OPPOSITION:

Support: Bay Area Council
Building Owners and Operators Association
California Hospital Association
Civic Center and Mid-Market Community Benefit Districts
Golden Gate Restaurant Association
Hotel Council of San Francisco

NAMI-CA
San Francisco Chamber of Commerce
San Francisco Partnership
San Francisco Travel Association
Union Square Alliance

Oppose: American Civil Liberties Union California Action
Anti-Police Terror Project
Bay Area Legal Aid
Bazelon Center
Cal Voices
California Advocates for Nursing Home Reform
California Association of Mental Health Peer-Run Organizations
California Care First Coalition
Caravan4Justice
Corporation for Supportive Housing
Decarcerate Sacramento
Disability Rights Advocates
Disability Rights California
Disability Rights Education and Defense Fund
Disability Rights Legal Center
Drug Policy Alliance
Funders Together to End Homelessness
Housing California
Housing is a Human Right Orange County
Human Rights Watch
Justice in Aging
JusticeLA
Justice2Jobs Coalition
La Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Love and Justice in the Streets
Mental Health Advocacy Services
Mental Health America of California
Mental Health First
National Health Law Project
National Homelessness Law Center
New Life Ministries of Tulare County
People's Budget of Orange County
Project Amiga
Psychologists for Social Responsibility
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld LLP
Sacramento Homeless Organizing Committee
Sacramento LGBT Community Center
Sacramento Regional Coalition to End Homelessness
San Bernardino Free Them All
San Francisco Pretrial Diversion Project

San Francisco Public Defender's Office
Starting Over, Inc.
Street Watch LA
The Coelho Center for Disability Law, Policy, and Innovation
The Justice Teams Network
The SmithWaters Group
Western Center on Law and Poverty
Western Regional Advocacy Project
One individual

-- END --

Exhibit 11

Pages: RJN-0284 through RJN-0295

California Behavioral Health Directors Association, Written Comments and Recommendations dated March 25, 2022, submitted to Secretary Mark Ghaly, California Health and Human Services Agency

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

March 25, 2022

Secretary Mark Ghaly, MD
California Health and Human Services Agency
1215 O Street
Sacramento, CA 95814

RE: CARE Court Proposal

Dear Secretary Ghaly:

On behalf of the County Behavioral Health Directors Association (CBHDA) which represents the county behavioral health executives who administer Medi-Cal and safety net services for serious mental health (MH) conditions and substance use disorders (SUDs) in all 58 counties in California, I write to provide the following comments on the Community Assistance, Recovery & Empowerment (CARE) Court proposal introduced by the Administration on March 3rd. This letter outlines a variety of considerations and concerns which we believe are necessary to resolve in order to achieve CARE Courts' ambitious goals.

CARE Court has been discussed as a solution to homelessness, upstream engagement for individuals who do not meet conservatorship criteria, and a prevention measure to stem the growth in individuals with felony charges found incompetent to stand trial (IST). The proposal has been put forward as a proposed framework and paradigm shift to deliver mental health and substance use disorder services to the most severely impaired Californians who suffer the impacts of untreated mental illness, including homelessness and incarceration. County behavioral health agencies would be central to this proposal, as the entity held responsible by the courts for the implementation of CARE Court plans, and as such respectfully request consideration of our concerns and recommendations outlined below.

Funding for County Behavioral Health Services
County behavioral health will require new funding to implement CARE Courts in any meaningful and successful way. CARE Courts would require county behavioral health to incur new expenses and to divert already scarce clinicians and staff to engage with the court in the development of care plans, as well as potential engagement with a new client population. While we understand that the intention is to target a relatively small population of individuals with certain identified conditions, because high expectations have been set for the potential of CARE Courts across multiple interest groups, without clarifying criteria and appropriate controls on referrals, CARE Courts could easily result in a significant redirection of staff and other resources, impacting our ability to fund our core Medi-Cal entitlement and other vital upstream prevention and early intervention strategies.

Given our current workforce shortage, adding a significant new programmatic responsibility without new resources will increase workforce burnout, and undermine the goals of CARE Court to successfully engage individuals into services prior to conservatorship or law enforcement involvement.

Today, county behavioral health staff typically spend hours on standby in Mental Health, Drug, or Homeless Courts or consulting with law enforcement and court partners. This time is rarely Medi-Cal reimbursable. As such, the requirement to staff CARE Court activities is likely a reimbursable mandate. In addition, if CARE Court is considered coercive, questions may arise about whether Mental Health Service Act (MHSA) funding can be used for these expanded services, and counties would need to rely on realignment funds which are already oversubscribed.

While the Administration has cited this year's growth in funding for county behavioral health as evidence of sufficient funding for county behavioral health services, counties' ability to grow funding is based on the temperamental millionaire's tax, and each of our funding streams come with different funding parameters and restrictions. In addition, county behavioral health funding from various sources is not linked to growth in the Medi-Cal population and their needs, or the cost of doing business. It is well documented that the trauma and stress of the pandemic have resulted in increased SUD and mental health needs across the whole population. None of this increased demand for services within the Medi-Cal population is accounted for in how funding is structured. County behavioral health alone cannot predict nor prevent the social determinants of significant behavioral health crisis or need, including the impact of anti-gay and transgender policies in other states, structural racism, the global pandemic, social media, or lack of housing. Adjustments to revenues do not come with inflation that increases the cost of sustaining a specialty network, including workforce salary and benefit costs. More must be done to acknowledge that external factors may increase demand for specialty behavioral health services and to resource our public behavioral health safety net accordingly.

- **Recommendation:** CBHDA requests that, at a minimum, the Administration adequately fund county behavioral health for increased staffing and service costs related to CARE Courts to ensure that CARE Courts do not exacerbate our existing workforce crisis and to support quality care plan development and implementation.

Equity

Currently, the CARE Court construct identifies individuals with either schizophrenia spectrum or psychotic disorders who lack medical decision-making as eligible for CARE Courts. This category is inclusive of individuals with drug-induced psychosis. These eligibility criteria create the need for CARE Courts to be designed with equity considerations at the forefront.

For example, it is well documented that the largely white profession of psychiatry tends to inappropriately misdiagnose Black and Latinx individuals with schizophrenia and other psychotic disorder diagnoses. A 2019 study[1] found that Black individuals are more likely to be diagnosed with a psychotic disorder than white individuals, despite no scientific evidence that they are more likely than other populations to have schizophrenia. Researchers found that this misdiagnosis was due to racial bias and clinicians not appropriately screening for and diagnosing depression and mood disorders. Similarly, despite lower rates of drug use than whites, African Americans are more likely to be incarcerated for drug-related offenses due to racial bias in the policing of drug use.

[1] Michael A. Gara, Shula Minsky, Steven M Silverstein, Theresa Miskimen, Stephen M. Strakowski. A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic. Psychiatric Services, 2019; 70 (2): 130 DOI: 10.1176/appi.ps.201800223

We must raise concerns that by attempting to narrow referrals by limiting this court program to schizophrenia spectrum and psychotic disorders, this proposal may unintentionally increase stigma and discrimination towards individuals with significant behavioral health conditions and expand court and justice involvement for Black Californians, who are more likely to be misdiagnosed and overpoliced. Because CARE Courts set up a court-based structure to compel adherence to a care plan, with a legal presumption for conservatorship, we believe that these equity and disparity considerations must be carefully considered upfront.

- **Recommendation:** At a minimum, the concerns around misdiagnosis argue for careful research and evaluation components which specifically identify the race, ethnicity, sexual orientation and gender identity, and payer status of individuals referred to CARE Courts, and their outcomes. These data should be publicly reported annually, and the state should establish an independent quality and oversight review entity, to include peers and clinicians with expertise in schizoaffective disorders and substance use disorders, to provide recommendations for addressing identified disparities.

Another equity consideration relates to the disparate resources and misaligned regulations for mental health and substance use disorder (SUD) treatment services, even within Medi-Cal. Inclusion of drug-induced psychosis as criteria for CARE Court could result in individuals with a primary SUD diagnosis coming into CARE Court. This creates problems related to Lanterman-Petris-Short Act criteria, including the new legal presumption created through CARE Court, funding for inpatient resources and access to other treatment requirements that may be mandated but not funded under Medi-Cal. These challenges are especially pronounced when the SUD is primary without an additional mental health diagnosis to support additional mental health services and supports.

- **Recommendation:** Establish a workgroup with CBHDA and other interested stakeholders with expertise in SUDs to make specific recommendations on whether to include individuals with a primary SUD diagnosis as part of CARE Court and any special funding, legal, and other considerations and protections that would be necessary to ensure effective interventions and outcomes for this population.

- **Recommendation:** Expand Drug Medi-Cal Organized Delivery System (ODS) Medi-Cal benefits as a fully funded statewide benefit to include this broader set of SUD services consistently throughout all counties in California as a fully funded Medi-Cal benefit.

Referrals

While we appreciate that the proposal has been designed to target a relatively small population, based on diagnostic criteria and lack of capacity to make medical decisions, we are concerned that referrals into CARE Courts could be higher than anticipated, as cities, family members, and other stakeholders have viewed this as a means to address homelessness and broader systemic challenges with access to behavioral health treatment, particularly for those with commercial insurance.

Non-clinicians could easily overwhelm courts with inappropriate referrals, slowing down courts, and ultimately, the provision of CARE Court services, as referrals are evaluated to determine eligibility. In addition, the rise in new, synthetic methamphetamines and other yet to be discovered substances whose

effects may mimic psychosis are difficult to predict or control for and may increase legitimate referrals over time.

In discussions with CalHHS, there has also been a suggestion that CARE Courts could serve as a diversion from Lanterman-Petris-Short (LPS) conservatorship, although details on how this would function are lacking. CBHDA would appreciate understanding more about this concept.

- **Recommendation:** Given the already significant impacts on court alienists due to competency doubts, CBHDA recommends clearer communication to community stakeholders regarding the goals and target population for CARE Courts. The state's emphasis on CARE Courts as a response to homelessness is harmful in that it reinforces inaccurate assumptions that behavioral health conditions are the primary driver of homelessness in California, and that mental health treatment alone is needed to address our homeless crisis.

- **Recommendation:** In addition, should cities or other referral entities attempt to make mass referrals of individuals experiencing homelessness, CBHDA would request consideration of caps, penalties or fines for inappropriate referrals. For example, given that fewer than 30% of individuals experiencing homelessness have a significant mental health condition, referrals should not exceed 20% of a county's annual point in time homeless count.

- **Recommendation:** Finally, CBHDA requests that the state closely monitor referral rates and sources to evaluate the perceived versus actual need for these services, as well as make funding and programmatic adjustments as needed to adequately resource this initiative.

Clinical Evaluation

Courts would be responsible for assessing eligibility for CARE Courts through a clinical evaluation. CBHDA is concerned with this element of CARE Courts, given the struggles the courts have faced in providing adequate oversight of quality alienist evaluations when competency to stand trial is in doubt. During the IST Solutions Workgroup in the Fall, stakeholders learned that alienists are hired by the courts in haphazard ways with no clinical or quality oversight, leading to consistently unreliable IST determinations. The work group identified that these problems were due to: low alienist pay, a lack of training and clear standards for clinicians (e.g. alienist certification requirements), and the court's lack of quality and clinical oversight ability. For example, alienists often failed to even provide a diagnosis in their IST court reports. CBHDA members are especially concerned that the current 730 court evaluator panels lack the training and ability to appropriately diagnose and recommend services to CARE Court participants.

In addition, since the passage of SB 317 (Stern) Chapter 599, Statutes of 2021, which creates a glidepath to diversion or dropped charges for misdemeanor ISTs, the courts have been overwhelmed by an influx of new doubt declarations for individuals with misdemeanor charges. For example, the County of San Francisco reported that requests for IST evaluation shot up from roughly *ten per year to five to seven per week* for individuals charged with misdemeanors since the law went into effect in January, completely overwhelming the already stretched capacity of court alienists. CBHDA members in other regions of the state confirmed similar sharp increases in misdemeanor IST referrals since the start of the year.

- **Recommendation:** In light of these challenges, CBHDA strongly suggests shifting responsibility for clinical evaluation for criteria to county behavioral health, along with the necessary funding to build the clinical workforce needed to evaluate and assess CARE Court participants. While county behavioral health also faces significant workforce challenges post-pandemic, county behavoral health clinicians will have the expertise to accurately determine eligibility based on clinical need and other eligibility factors, as well as knowledge of the range of services and supports available to participants. If county behavioral health is not provided with the responsibility and funding to perform evaluations, we urge you to consider the development of a wholly new panel of specially trained evaluators with expert knowledge of specialty behavioral health conditions and local resources rather than rely on the current panel of court experts.

- **Recommendation:** In addition, county behavioral health clinicians will be able to both evaluate referrals and conduct the assessment which will eventually inform the development of the behavioral health care plan. This strategy of frontloading assessment as part of the clinical evaluation was an idea that was presented as part of the DSH IST Solutions workgroup and could be revisited to more efficiently use the time of county behavioral health clinicians involved in clinical evaluations for CARE Court purposes.

Supporter

CARE Courts rely on a modified supported decision-making process to provide individuals who meet CARE Court criteria with assistance in understanding, considering, and communicating decisions, as well as providing the participant with the tools to make self-directed choices to the greatest extent possible. Questions remain about who could be eligible to participate as a supporter and the scope of supporter responsibilities, and whether and how a supporter would be provided with training, compensation, or professional standards. The role of certified peers in facilitating recovery is well-documented and should not be lost, regardless of the ultimate design of the supporter. Providing appropriate training and support to supporters to ensure fidelity to the supported decision-making model, will be important. Any professional supporter role should be housed within county behavioral health to ensure participants benefit from certified peer supports with an understanding of the services and supports available to the participant.

- **Recommendation:** Fully fund California's Medi-Cal peer support services as a statewide benefit to ensure that CARE Court participants have adequate access to peer support services, whether as court supporters, or a complementary specialized support for the participant's recovery.

- **Recommendation:** Develop and fund training for supporters, courts, and county behavioral health to ensure fidelity to the supported decision-making model.

- **Recommendation:** Fund supports for family members. Family Psychosocial education and support and family respite have proven to help families with their loved ones along their recovery journey. Not including supports for families is a missed opportunity to strengthen the family supporting a loved one with a chronic condition.

Care Plan Elements
CBHDA understands that the purpose of this model is to attempt to avoid conservatorship and law enforcement involvement through engagement into development of a care plan and an advanced directive with assistance from a supporter along with county behavioral health. The three core elements of the CARE Court care plan are:

1. Behavioral health treatment
2. Medications
3. Housing

Behavioral Health Treatment
CBHDA has numerous questions regarding the scope of behavioral health services that can be ordered by the court as part of this care plan development. First, it is important to understand whether the courts will be able to order behavioral health services that are not a part of that county's Medi-Cal entitlement to CARE Court participants. Because county behavioral health agencies serve as the Medi-Cal plan for specialty mental health and substance use disorder services, our counties are required to provide any medically necessary covered benefits to eligible Medi-Cal beneficiaries. However, due to how Medi-Cal specialty behavioral health services have been developed at the state level, often services and supports which can benefit Medi-Cal beneficiaries may not be covered under Medi-Cal or other insurance, such as outreach and engagement, food, and social services. Residential and inpatient level of treatment may also be excluded from Medi-Cal reimbursement under the Institutes for Mental Disease (IMD) Exclusion based on size of facility. Medi-Cal also includes several key optional benefits, such as Drug Medi-Cal Organized Delivery System (ODS) plan benefits for residential drug treatment and case management and the new peer support specialist benefit. Finally, CARE Court has been presented as a program open to all Californians, regardless of payer status. Any services or supports beyond standard Medi-Cal benefits vary tremendously from county to county due to the role of local communities in guiding funding decisions, and the ability of each county to resource additional services and capacity with grants and categorical funding streams.

- **Recommendations on Care Plan Behavioral Health Services:** Limit courts to standard Medi-Cal benefits and ensure courts are equipped with an understanding of what those are.

- **Recommendation:** Require commercial plans to provide court-ordered services or pay county behavioral health at cost for care plan services.

- **Recommendation:** Fund additional behavioral health services and supports which may not be reimbursable under Medi-Cal but necessary to achieving care plan goals.

- **Recommendation:** As already noted in our comments, CBHDA would also request consideration of expanding Medi-Cal optional benefits such as the peer support specialist benefit and Drug Medi-Cal Organized Delivery System (ODS) to ensure more consistency on quality, impactful optional benefits such as these on a statewide basis.

Mental Health Advance Directives
The CARE Court Framework also includes the adoption of a mental health advance directive. Starting in 2021, five counties (Fresno, Mariposa, Monterey, Orange, and Shasta) secured an MHSA Innovation

grant to develop a standardized Psychiatric Advance Directive (PAD) template, training resources and a "toolkit" (all in multiple languages), PADs accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures. Additional counties are expected to join in this collaborative; however, PADs are not commonly used tools nationally or in state. CBHDA members are highly supportive of the development of PADs as a standardized tool to engage clients prior to a crisis, however, it will take additional time, training across various clinical settings, including hospitals and other providers, and resources to make them a truly effective tool to support individuals at risk of experiencing a psychotic break.

Recommendation: Develop a work group to explore the legal, infrastructure and operational changes that will be needed to be addressed in order to bring use of PADs to scale. Again, access to PADs should not be contingent upon involvement in CARE Courts, but we welcome the opportunity for further dialogue and engagement on how to advance the use of PADs in California.

Medication

With respect to the medication component, while psychiatric medications can be instrumental in stabilization and and treatment of psychiatric disorders, this category also has limitations. First, CBHDA members question whether the court could direct physicians to prescribe medications in light of physician autonomy in clinical decision making?

- **Recommendation on Medications:** Restrict the ability of the courts to override the clinical recommendations of treating physicians.

Housing Plan

The CARE Court care plan would also include a plan for housing participants. Often, housing barriers for individuals with significant behavioral health needs are as much on the housing provider side as they are with our clients. CBHDA surveyed counties in early 2022 regarding efforts to house individuals already voluntarily participating in services through Full Service Partnerships (FSPs). Of the more than 12,000 individuals who entered FSPs unhoused in the past year, county behavioral health has been successful in housing roughly half. However, the other half remained *unhoused and in treatment*. Typical reasons our FSP clients remained unhoused included: no housing available in the community, inability to meet credit checks, and other rental criteria, participants were not welcome due to behaviors related to their conditions, e.g., inability to live with roommates.

CBHDA is deeply appreciative of the Administration's proposal to invest $1.5 billion in Bridge Housing targeting county behavioral health clients, yet we are concerned that the current design of CARE Courts would fall short of adequately addressing the long-term housing needs of participants. Many CARE Court participants are likely to require 24/7 staffed housing options over many years in order to succeed in remaining stably housed. In addition, some unhoused CARE Court participants will likely require a higher level of support than intensive case management available under Medi-Cal and their need for subsidized housing and housing supports will continue beyond the timeframe for the proposed Bridge Housing proposal as these are chronic conditions.

Furthermore, CBHDA must note here that development of a housing plan, without additional help from the courts to compel cities and local housing authorities, or Medi-Cal managed care plans to dedicate housing resources will significantly stymie CARE Courts' effectiveness.

CBHDA would have liked to see additional accountability and tools to compel housing authorities to prioritize the needs of our clients as well. Finally, we would object to restricting proposed Bridge Housing funds to CARE Court participants as counties are hopeful that those resources can be used to address the immediate needs of our clients actively engaged in services while unhoused. CBHDA is concerned that requiring county behavioral health to develop a housing plan within existing resources will result in outcomes similar to what we see with our FSP participants today.

- **Recommendations on Housing Plan:** Give courts the authority to seek and order housing from local housing authorities for CARE Court participants.

- **Recommendation:** Align the court's authority over housing authorities with that afforded to them for oversight of behavioral health services.

- **Recommendation:** Ensure access to Medi-Cal managed care plan housing Community Supports benefits for CARE Court participants.

- **Recommendation:** Expand the state's investment of $1.5 billion in Bridge Housing for county behavioral health clients to include more long-term, sustainable housing options, such as permanent supportive housing vouchers, maintenance costs, board and care patches, and other housing services and supports as ongoing funding.

Other Health Plans

CBHDA is also unclear about why other services and supports are not identified as necessary to the goals and outcomes of CARE Court. For example, Medi-Cal managed care plans (MCPs) have responsibility for the Medi-Cal non-specialty mental health, enhanced care management, community supports, transportation, and physical health benefits. For the CARE Court target population, their unmet physical health needs are more likely to contribute to early mortality than their mental health conditions. Commercially insured beneficiaries, likewise, have existing health plans who are likely already responsible for the delivery of a range of health and behavioral health services. Again, CBHDA fails to see how the MCP and commercial plans' responsibilities to attend to those needs can be viewed as separate.

- **Recommendation on Broader Medi-Cal Benefits and Services:** CBHDA would request that CARE Courts be designed with this disparity and parity of services in mind to expand the care plan to include accountability for Medi-Cal MCP services to be delivered, whether it is a non-specialty mental health service for a person with a SUD, or physical health services and the all-important transportation benefit or others.

- **Recommendation on Commercial Plans:** Ensure that commercial plans are held accountable for covered physical and behavioral health services for their beneficiaries, and require commercial plans to reimburse county behavioral health at cost for additional services provided through the county behavioral health agency under CARE Court.

Other Connected Systems and Services

In addition to a broader range of Medi-Cal services, some of our more challenging clients have co-occurring developmental disabilities or other conditions that cannot be addressed through county behavioral health services, such as individuals with long-term care needs, and intellectual and developmental disabilities.

- **Recommendation on Broader Connected Systems and Services:** A work group may be necessary to better analyze and understand the various systems that may be required to assist with helping the target populations to succeed in CARE Courts, whether Regional Centers, aging, long-term care or other services.

Court Ordered Services

County behavioral health agencies have extensive experience with court-ordered behavioral health services across multiple specialty courts throughout the state, and have experience with court attempts to weigh in on treatment modalities and care plan specifics, particularly with respect to medications.

- **Recommendation:** Ensure appropriate and effective care plans and ensure the integrity of clinical decision-making by prohibiting courts from ordering specific treatment services or modalities, including medications.

Sanctions

CARE Court proposes to sanction and even appoint a court agent to direct county behavioral health resources for failing to provide court-ordered services.

Although county behavioral health plans are required to offer and provide Medi-Cal specialty mental health and substance use disorder services, any services that are funded and available beyond Medi-Cal may not be available in every county. Even with guaranteed reimbursement, failure to provide a service that is not offered under the standard Medi-Cal benefits package will present unique challenges, particularly if contract providers are not readily available in that jurisdiction, or counties must prioritize Medi-Cal entitlements. Under CARE Court, a county without the resources needed to comply with the court ordered plan would be further financially penalized, diverting funding from the county's core Medi-Cal entitlement responsibilities and subjecting them to further fiscal sanctions from other regulators, such as DHCS. Furthermore, the degree of COVID-19's impact on new demand and eligibility for county behavioral health services, along with related workforce shortages, may legitimately constrain counties' ability to meet the court's expectations. Questions remain about the nature of the sanctions which could be ordered and their purpose.

- **Recommendation:** Remove the proposed sanction from the CARE Court framework as it would in no way contribute to the creation of programs or services that do not exist today.

- **Recommendation:** Should sanctions remain a component of care courts, they should be expanded to include other responsible entities, such as those responsible for housing, MCPs, commercial insurance payers, and others.

New Legal Presumption
CBHDA is concerned that this proposal would bypass the professional judgement of Public Guardians/Conservators and county behavioral health clinicians by creating a new presumption for LPS Conservatorship for anyone who is found by the court to have failed to comply with the Care Plan developed in this new court process. Trained professionals should have the ability to advise the court on the individual's progress and whether conservatorship is appropriate or necessary as the experience of involuntary treatment can further traumatize and harm individuals, particularly when it is not necessary or helpful in their recovery and engagement into services.

- **Recommendation:** Revise CARE Court to remove the automatic presumption that failure to comply with the CARE Court care plan is indicative of the need for conservatorship. Instead, allow public guardians and behavioral health to make a recommendation related to the value of a potential conservatorship.

Implementation Timeline
Implementation should be delayed to ensure county behavioral health and courts have the time to build up services and staffing to support CARE Courts, including the additional infrastructure under the Behavioral Health Continuum Infrastructure Program and Community Care Expansion program which launched this year.

- **Recommendation:** Delay implementation of CARE Courts until at a minimum 2025 to allow for complementary housing, infrastructure, workforce and other investments to accrue.

CARE Court Outcomes & Evaluation
CARE Courts should be evaluated to understand outcomes, any unintended consequences, and to center the voice of the individuals who move through this new court process. Several examples have been provided here, however, given the potential for CARE Courts to usher in a new form of coerced care for individuals with specifically identified psychotic disorders, a rigorous evaluation component is merited, along with a sunset.

- **Recommendation:** Require a rigorous longitudinal evaluation of CARE Court to analyze outcomes and provide recommendations for programmatic challenges, barriers and areas of potential improvement or modification.

- **Recommendation:** Include a sunset to allow for the Legislature and other stakeholders to evaluate and consider changes.

- **Recommendation:** Require data collection on the number of individuals referred for conservatorship as a result of unsuccessful CARE Court participation.

Today, county behavioral health agencies and the clients we serve will be most significantly impacted by the CARE Courts proposal. Because of the central role of county behavioral health, CBHDA appreciates the consideration of our membership's input on this iteration of the proposal and moving forward. We agree that more can be done to address the needs of individuals with significant behavioral health needs and in particular individuals experiencing homelessness. However, CBHDA disagrees with

the notion that solving for these issues is a matter of prioritization of existing resources and court oversight. We believe that the only way for substantial progress to be made in engaging individuals upstream of involuntary treatment and justice involvement will require partnership between the state and county behavioral health agencies and look forward to our continued engagement as key stakeholders in the development of CARE Courts.

Sincerely,

Michelle Doty Cabrera
Executive Director

Cc: Marko Mijic, Undersecretary, CalHHS
Stephanie Welch, Deputy Secretary, CalHHS
Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, CalHHS
Kim McCoy Wade, Senior Advisor, Office of Governor Newsom
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