CARE Court: Can California Cities Make it Work?

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TABLE OF CONTENTS

Page

INTRODUCTION[1]

There are many individuals in the state with severe mental illness and other co-occurring disorders who are served primarily by city first responders.[2] First responders welcomed the Community Assistance, Recovery, and Empowerment Act (CARE Act) Program when first announced in May 2022 because it marked the first major advancement in access to mental health treatment since the implementation of the Lanterman-Petris-Short (LPS) Act in 1967.

While emergency medical services (EMS) are often handled by cities, California primarily authorizes counties to service behavioral health needs, regardless of the size of the city within its borders. The hope of the CARE Act was to hold counties accountable for providing services to individuals with the most severe mental illness whose vulnerability causes them to slip through the cracks of the system.[3] With homelessness and untreated mental illness on the rise, California's governor and city mayors have publicly called on counties to do more for those with the most severe mental health needs.[4]

Accompanying this directed request, the state has allocated nearly 300 million dollars a year to support this program.[5] While there is still room for growth, the CARE Act has the

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[1] Special thanks to Norrine Russel Ph.D. for her thoughtful feedback, and to Tyler Wieland, Justina Robinson, Natalia Murphy, Jenna Scott, and Elizabeth Wallin for their critical help in cite checking and editing the extensive footnotes.

[2] *See* E.B. Egart, *The Criminalization of Mental Illness and Substance Use Disorder: Addressing the Void Between the Healthcare and Criminal Justice Systems*, 50 MITCHELL HAMLINE L. REVIEW 1, 19-21 (2024), for a discussion on the prevalence of co-occurring disorders in the general population.

[3] Office of the State Governor, *Governor Newsom Signs CARE Court Into Law, Providing a New Path Forward for Californians Struggling with Serious Mental Illness* (2022), https://www.gov.ca.gov/2022/09/14/governor-newsom-signs-care-court-into-law-providing-a-new-path-forward-for-californians-struggling-with-serious-mental-illness/; and Lisa Halverstadt, *San Diego's CARE Court Isn't Forcing Treatment*, VOICE OF SAN DIEGO (Feb. 27, 2025), https://voiceofsandiego.org/2025/02/27/san-diegos-care-court-isnt-forcing-treatment/.

[4] K. Hwang & A. Ibarra, *'You have a crisis out there': Gavin Newsom scolds counties over delays in mental health law*, CALMATTERS (2023), https://calmatters.org/health/mental-health/2023/12/mental-health-conservatorship-newsom/;
City News Team, *Mayor Gloria in State of the City: We Will Tackle Fiscal Challenges and Keep Moving San Diego Forward*, INSIDE SAN DIEGO (2025), https://www.insidesandiego.org/mayor-gloria-state-city-we-will-tackle-fiscal-challenges-and-keep-moving-san-diego-forward; and
Cal. Health & Human Services Agency (CalHHS), *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes*, slides 51-54 (Nov. 8, 2023), https://www.chhs.ca.gov/wp-content/uploads/2023/11/11082023-CARE-WG-Meeting_slides-posting.pdf.

[5] Governor Gavin Newsom, *California State Budget 2023-24* at 58, https://ebudget.ca.gov/2023-24/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf#page7. In the state budget, the allocation for CARE includes "$128.9 million General Fund in 2023-24, $234 million General Fund in 2024-25, $290.6 million in 2025-26, and $290.8 million General Fund in 2026-27 and annually thereafter for the Department of Health Care Services and Judicial Branch to implement the CARE Act (Chapter 319, Statutes of 2022). Of this amount, $67.3 million General Fund in 2023-24, $121 million General Fund in 2024-25, and $151.5 million in 2025-26 and annually thereafter is to support estimated county behavioral health department costs for the CARE Act, including $15 million one-time General Fund for Los Angeles County start-up funding. For Judicial Branch and legal services funding, see the Criminal Justice and Judicial Branch Chapter for additional information." *Id.;*
M. Tobias & J. Wiener, *California Lawmakers Approved CARE Court. What Comes Next?*, CAL. HEALTH CARE FOUNDATION (Sept. 22, 2022), https://www.chcf.org/blog/california-lawmakers-approved-care-court-what-comes-next/;
Disability Rights California, *Summary of the 2023-24 State Budget* (July 24, 2023), https://www.disabilityrightsca.org/latest-news/disability-rights-californias-summary-of-the-2023-24-state-budget;

potential to bridge the city to county gaps in services for those who need it the most and allow for improved quality of care for those who cannot self-advocate. However, to reach this potential, numerous issues must be addressed.

I. The CARE Act

Senate Bill (SB) 1338, signed into law on September 14, 2022, enacted the CARE Act.[6] It was based on findings that thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, and that advancements in behavioral health treatment make stabilization and in-community healing possible.[7] Recognizing that necessary comprehensive care is often available only after more significant interventions, such as arrest or institutionalization, the legislature acted on the need for a new approach that sought to provide support and accountability to both affected individuals and local governments.[8] Appropriately, this treatment-focused effort was paired with a recognition of significant concerns regarding self-determination and civil liberties.[9]

The CARE Act followed a bifurcated timeline of implementation, requiring seven counties to begin implementation no later than October 1, 2023, with the remaining counties required to do so by December 1, 2024.[10]

Once implemented, the CARE Act established eligibility for the program based on six factors.[11] To be eligible, a person must be over the age of 18.[12] They must currently be experiencing a severe mental illness with a specific diagnosis "identified in the disorder class: schizophrenia and other psychotic disorders", but psychotic disorders due to physical conditions (e.g. traumatic brain injury or autism) are excluded from eligibility.[13] The person must not be clinically stabilized in on-going voluntary treatment.[14] They must either be unlikely to survive safely in the community without supervision with a substantially deteriorating condition, or be in need of services to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to either that person or others, as defined in Welfare and Institutions Code section 5150 (all subsequent statutory references are to the Welfare and Institutions Code unless specifically noted).[15] Participation in a CARE Plan or CARE Agreement must be the "least restrictive alternative necessary to ensure the person's recovery and stability."[16] Finally, it must be "likely that the person will benefit" from participation in the CARE Plan or CARE

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and Disability Rights California, *Summary of the Governor's Proposed 2024-25 Budget* (Jan. 31, 2024), https://www.disabilityrightsca.org/latest-news/disability-rights-californias-summary-of-the-governors-proposed-2024-25-budget#1.

[6] SB 1338, 2022 Leg., Reg. Sess. 2021-22 (Cal. 2022).

[7] *Id.* § 1(a)-(b).

[8] *Id.* § 1(c).

[9] *Id.* § 1(d)-(e).

[10] Cal. Welf. & Inst. Code § 5970.5. The first cohort of counties, which began implementation of the CARE Act on October 1, 2023, included the Counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco. *Id.* subd. (a).

[11] Cal. Welf. & Inst. Code § 5972.

[12] *Id.* subd. (a).

[13] *Id.* subd. (b).

[14] *Id.* subd. (c).

[15] *Id.* subd. (d).

[16] *Id.* subd. (e).

Agreement.[17] Notably, while the chaptered CARE Act narrowly limits eligibility, the Legislature has demonstrated its intent to eventually expand the program.[18]

Under the CARE Act, the "respondent" is "the person who is subject to the petition for the CARE process."[19] Proceedings may be commenced in the respondent's county of residence, the county in which they are found, or the county in which they face criminal or civil proceedings.[20]

The "petitioner" is the person[21] who files the CARE Act petition using the Judicial Council CARE-100 petition form.[22] If that person is not the director of a county behavioral health agency, the petitioner has the right to file the CARE-100 petition but will be replaced by the county behavioral health agency director at the initial hearing.[23] Most notably for cities, first responders who have had multiple previous interactions with the respondent are eligible to file petitions for CARE Court. [24] First responders may also submit a petition based on multiple detentions and transportations per section 5150.[25] Under the CARE Act, the definition of "first responder" includes peace officers, firefighters, paramedics, emergency medical technicians, mobile crisis response workers, and homeless outreach workers.[26]

Other eligible petitioners include persons the respondent resides with, spouses and family members, directors of a hospital in which the petitioner is hospitalized, directors of public or charitable organizations or agencies who are providing services or have provided services to the respondent in the prior 30 days, licensed behavioral health professionals who have treated or supervised the treatment of the respondent within the prior 30 days, public guardians or conservators of the county in which the respondent is present, directors of county behavioral health agencies, the director of county adult protective services, the director of a California Indian health services program or tribal behavioral health department, and judges of a tribal court in California.[27] Hospital directors may submit a petition based on a potential respondent's hospitalizations, including hospitalization pursuant to either section 5150 or 5250. [28]

In addition, many of these identified persons may act through their designee, and respondents themselves are eligible to file a CARE Act petition on their own behalf.[29] Respondents may also be referred to CARE Act proceedings from assisted outpatient treatment and conservatorship proceedings, with either the county behavioral health director or their designee standing in as the petitioner in the former circumstance, and the conservator being the petitioner in the latter.[30] Respondents may also be referred from misdemeanor proceedings.[31]

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[17] *Id.* subd. (f).
[18] *See* SB 823, 2025 Leg., Reg. Sess. 2025-26 Reg. Sess. (Cal. 2025) (introduced Feb. 21, 2025) (with the goal of adding bipolar I disorder to the CARE Act eligible diagnosis criteria).
[19] Cal. Welf. & Inst. Code § 5971(o).
[20] Cal. Welf. & Inst. Code § 5973(a).
[21] While some court proceedings allow for CARE referrals, petitions can only be filed by persons listed in Cal. Welf. & Inst. Code § 5971(m); *see* Cal. Welf. & Inst. Code § 5978(a).
[22] Cal. Welf. & Inst. Code § 5971(m).
[23] *Id.*
[24] Cal. Welf. & Inst. Code § 5974(f).
[25] *Id.*
[26] *Id.*
[27] Cal. Welf. & Inst. Code § 5974.
[28] *Id*. subd. (c).
[29] *Id.* subd. (l).
[30] Cal. Welf. & Inst. Code § 5978(a).
[31] *Id.* subd. (b).

Pursuant to the requirements of section 5975, the Judicial Council has developed and published a mandatory form, referred to as the CARE-100 petition, for use in initiating the CARE process.[32] The CARE-100 petition requires petitioners to provide information about the respondent, their relation to the respondent, and facts supporting the respondent's eligibility under the CARE Act's criteria, as well as relevant affidavits and evidence.[33]

To establish that a respondent meets the CARE Act criteria, the CARE-100 petition must either be accompanied by an affidavit from a licensed behavioral health professional detailing actual or attempted examinations leading to a determination of eligibility for CARE Court, or evidence that the respondent has been hospitalized involuntarily for at least two intensive treatments pursuant to section 5250, with the most recent instance occurring within the previous 60 days.[34] Petitioners planning to establish a respondent's eligibility for CARE Court with an affidavit from a licensed behavioral health professional must do so by attaching the completed Judicial Council CARE-101 Mental Health Declaration Form[35] to the CARE-100 petition before filing the petition with the superior court.

The CARE Act establishes requirements for CARE Court procedures and hearings, including presumptively private hearings that may be made public only upon an appropriate showing that a public interest clearly outweighs the respondent's interest in privacy.[36] It also includes allowances for certain people to attend the proceedings upon the respondent's request, without waiving the respondent's right to a closed hearing.[37] The respondent must be provided with notice of hearings and copies of court-ordered reports and evaluations. Respondents are entitled to legal representation regardless of their ability to pay, the right to be present at hearings, the right to have a volunteer supporter (when provided by the respondent), to present evidence, to call and cross-examine witnesses, and to appeal decisions.[38]

The CARE Act sets out detailed procedural requirements including an initial assessment of the prima facie showing of the respondent's eligibility for CARE,[39] assessment of the merits of the case,[40] case management hearings,[41] and status review hearings.[42] If the petition was not initiated by a county behavioral health agency and the court finds that the petitioner has made a prima facie showing of the respondent's eligibility for CARE Court, the court will order the county behavioral health agency to investigate and file a written report within 14 court days. This investigation will assess whether the respondent meets the CARE criteria and recommendations about the respondent's ability to voluntarily engage in behavioral health services.[43]

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[32] California Judicial Council, *CARE-100: Petition to Commence CARE Act Proceedings* (2023), https://courts.ca.gov/sites/default/files/courts/default/2024-11/care100.pdf.
[33] Cal. Welf. & Inst. Code § 5975.
[34] *Id.* subd. (d). Involuntary detentions pursuant to Cal. Welf. & Inst. Code § 5150 do not meet this standard.
[35] California Judicial Council, *CARE-101: Mental Health Declaration—CARE Act Proceedings* (2023), https://courts.ca.gov/sites/default/files/courts/default/2024-11/care101.pdf.
[36] Cal. Welf. & Inst. Code § 5976.5.
[37] *Id.* subd. (c).
[38] Cal. Welf. & Inst. Code § 5976. [*Note*: Volunteer supporters are optional and provided by the respondent. There are no provisions requiring that the local government entity provide them.]
[39] Cal. Welf. & Inst. Code § 5977.
[40] *Id.*
[41] Cal. Welf. & Inst. Code § 5977.1.
[42] Cal. Welf. & Inst. Code § 5977.2.
[43] Cal. Welf. & Inst. Code § 5977(a)(3)(B).

Within 5 days of receiving the county's report, if the court determines that the respondent is likely to meet the CARE criteria and that the respondent is not likely to voluntarily engage in services, the court will set an initial appearance and hearing on the merits.[44] Before the initial appearance, the court will appoint legal counsel (e.g., a public defender) to represent the respondent.[45]

If the court finds by clear and convincing evidence that the respondent meets the CARE criteria, it will order the county behavioral health agency to work with the respondent, the respondent's counsel, and the respondent's volunteer supporter (if one is invited to participate by the respondent), to engage the respondent in behavioral health treatment and attempt to enter into a "CARE Agreement."[46] The court will also set a case management hearing within 14 days of the hearing on the merits of the petition.[47] At the case management hearing, if the court determines that the parties are likely to enter into a CARE Agreement, a progress review hearing will be scheduled in 60 days.[48] Alternatively, the county can request dismissal of the case under certain circumstances.

If a progress review hearing is set, and at that proceeding the court determines it is unlikely that the parties will enter into a CARE Agreement, it will order the county to conduct a clinical evaluation, followed by a clinical evaluation hearing.[49] After this hearing, if the court finds that the respondent meets the CARE criteria by clear and convincing evidence, it will order all parties to jointly develop a "CARE Plan."[50] The court may dismiss the petition without prejudice if clear and convincing evidence does not support that conclusion.[51]

If the parties are ordered to develop a CARE Plan, the court will schedule a CARE Plan review hearing where the parties present their plans to the court and the court will adopt the elements of the CARE Plan that support the recovery and stability of the respondent,[52] including the issuance of any orders necessary to support the respondent's access to necessary services, supports, or prioritization for those supports or services.[53] The court is required to hold a status review hearing within 60 days of issuing the CARE Plan order to detail the progress made by the respondent.[54] This review hearing allows the court to review which services and supports were provided, which were not, if there were any issues with the respondent's adherence to the plan, and any recommendations for necessary changes to make the plan more successful.[55]

CARE Agreements and CARE Plans are both written documents that specify services to support the recovery and stability of the respondent. While CARE Agreements are voluntary agreements, a CARE Plan is a court order.[56] Both a CARE Agreement or a CARE Plan may include the provision of clinical services, behavioral health care, counseling, prioritization for services and supports, medically necessary stabilization medications, and a housing plan. The

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[44] *Id.* subd. (b).
[45] *Id.* subd. (a)(3)(A)(ii) and (a)(5)(C)(ii).
[46] Cal. Welf. & Inst. Code § 5977(c)(2).
[47] *Id.*
[48] Cal. Welf. & Inst. Code § 5977.1(a)(2)(B)
[49] *Id.* subd. (b)-(c).
[50] *Id.* subd. (c)(3).
[51] *Id.* subd. (c)(3)(B).
[52] *Id.* subd. (d)(1)-(2).
[53] *Id.* subd. (d)(2).
[54] Cal. Welf. & Inst. Code § 5977.2(a)(1).
[55] *Id.*
[56] Cal. Welf. & Inst. Code § 5971(a)-(b).

court may order the respondent to take necessary medications where the local agency shows by clear and convincing evidence that the respondent lacks the capacity to give informed consent for the administration; however, there is no legal consequence if the respondent decides not to take them.[57] Under the CARE Act, the court can never force medication or treatment.

During the eleventh month of the program timeline, a one-year status review hearing is held, at which the county behavioral health agency is required to produce a report including information about the respondent's progress with the CARE Plan and a final assessment of the respondent's stability.[58] This report also includes which services and supports were or were not provided over the course of the program, respondent's issues with adherence, if any, and recommended services for next steps.[59] Depending on whether the respondent elects to graduate from the program, elects to remain in the program, or is involuntarily reappointed to the program, the court will, accordingly, issue an order for the respondent and county agency to work cooperatively on a graduation plan or a continuance of the CARE process, for up to one year.[60] Alternatively, based on the report, the court may deny such a continuance.[61]

The CARE Act also contains provisions intended to ensure some accountability for both respondents and counties. The court may terminate a respondent's participation in the CARE process if it determines that the respondent is not participating in the CARE process, or is not adhering to their CARE Plan.[62] Under specified circumstances, the fact that a respondent failed to successfully complete their CARE Plan may be considered by the court in a subsequent hearing under the LPS Act during conservatorship proceedings and may create a presumption that the respondent needs additional interventions beyond those provided by the CARE Plan.[63]

At any point during the CARE process, if the court determines that a county or other local government entity is not complying with its orders, the CARE Act provides that the judge shall refer the non-compliance to the presiding judge or their designee.[64] The presiding judge is entitled to order the local government to show cause as to why it should not be fined.[65] If the presiding judge finds that the local government entity has substantially failed to comply with lawful orders issued by the court under the CARE Act, the local government entity may be fined up to one thousand dollars per day (up to twenty-five thousand dollars total) for each individual violation.[66] All money collected from fines is redistributed back to the local government entity that paid the fine to serve eligible CARE respondents.[67]

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[57] Cal. Welf. & Inst. Code § 5977.1(d)(3).
[58] Cal. Welf. & Inst. Code § 5977.3(a).
[59] *Id.*
[60] *Id.* subd. (a)(3).
[61] *Id.* subd. (a)(3)(C).
[62] Cal. Welf. & Inst. Code § 5979(a)(1). In contrast, there is no adherence requirement for a CARE Agreement.
[63] *Id*. subd. (a)(3). In contrast, there is no similar presumption where a respondent fails to complete a CARE Agreement.
[64] *Id.* subd. (b)(1).
[65] *Id.* subd. (b)(2)(A).
[66] *Id.* subd. (b)(2)(C).
[67] *Id.* subd. (b)(2)(D)(ii).

II. Legislative Attempts to Improve the CARE Act

Since the enactment of the CARE Act, the Legislature has made several attempts to amend the statutory scheme and close or correct gaps in the CARE process. The most notable amendment efforts include SB 35, SB 42, and SB 1400.[68]

A. Senate Bill 35

Chaptered in September 2023, SB 35 clarified requirements for the CARE process and made technical changes to the CARE Act. Most significantly, it added provisions to the Welfare and Institutions Code requiring county behavioral health agencies to provide respondents' protected health information in support of findings reached by the county in its initial written report to the superior court, and exempted counties from civil or criminal liability for the disclosure of such information for the purposes of the CARE process.[69] Similarly, SB 35 also permitted health care providers and covered entities to disclose health information to behavioral health agencies in specified circumstances, and *required* health care providers and covered entities to disclose protected health information to county behavioral health agencies in instances that a provider or covered entity filed a CARE-100 petition or completed a CARE-101 mental health declaration.

B. Senate Bill 42

Prior to the enactment of SB 42 in September 2024,[70] the CARE Act permitted–but did not require–the court to assign ongoing notification rights to the original CARE Court petitioner if they either lived with the respondent or if they were the respondent's close family member (i.e., spouse, parent, sibling, child, grandparent, or an individual standing in loco parentis). SB 42 provided that, unless the court deems it detrimental to the respondent's wellbeing, it is required to provide ongoing notice to the original petitioner if the petitioner lived with the respondent or was a close family member. The bill specified that notice must be provided throughout the CARE proceedings. While a general reason is sufficient when a continuance is granted, a specific reason must be provided if the case is dismissed. However, protected health information may not be disclosed without the respondent's consent.

SB 42 also created an additional pathway for referring eligible individuals receiving involuntary treatment in LPS designated facilities to the less restrictive CARE Act process.

C. Senate Bill 1400

SB 1400 enacted further changes to the CARE process by amending several provisions of the Welfare and Institutions Code and the Penal Code related to "misdemeanor incompetent to stand trial" (MIST) hearings.[71] This bill added a requirement for courts in a MIST hearing to first determine if the incompetent to stand trial individual is eligible for assisted outpatient treatment,

[68] SB 35, 2023 Leg., Reg. Sess. 2023-24 (Cal. 2023); SB 42, Reg. Sess. 2023-24 (Cal. 2024); and SB 1400, Reg. Sess. 2023-24 (Cal. 2024).
[69] Cal. Welf. & Inst. Code § 5977.4(d).
[70] SB 42, 2024 Leg., Reg. Sess. 2023-24 (Cal. 2024).
[71] SB 1400, 2024 Leg., Reg. Sess. 2023-24 (Cal. 2024).

conservatorship, or the CARE process before dismissing a case. For defendants accepted into the CARE process, it provided for the dismissal of criminal charges six months after the date of referral to CARE, unless the defendant's case is referred back to the criminal court prior to the end of the six-month time period. It also expanded annual data reporting obligations to be compiled and reported to the Judicial Council by county behavioral health agencies.

III. Least Restrictive Alternative

According to the CARE Act, participation in a CARE Plan or CARE Agreement is only appropriate if it is the "least restrictive alternative necessary to ensure the person's recovery and stability."[72] A "least restrictive" treatment option embodies the principle that public health measures should interfere with personal freedoms as little as possible.[73]

The inclusion of the court in the CARE Act makes it inherently more restrictive than a completely voluntary program. Thus, while voluntary in itself, a CARE petition should be filed only when other voluntary programs have been insufficient.

There are many voluntary program options, but for those suffering from severe mental illness, the primary county assistance comes in the form of Full-Service Partnership (FSP)[74] programs. These programs provide a full spectrum of community services to support those who can participate voluntarily. There are numerous Evidence-Based Practices (EBPs) that can be utilized in a successful FSP. The main EBPs used in California counties include (1) Assertive Community Treatment (ACT), which uses a team-based model for those with a complex history of behavioral health needs; Forensic ACT (FACT), which focuses on the needs of ACT qualifying individuals involved in the criminal justice system; Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), which assists those with FEP; Individual Placement and Support (IPS) Model of Supported Employment, which offers supports to help individuals maintain employment; and Clubhouse services, which support individuals in their recovery and provide on-site opportunities for skill development and assistance with independence.[75]

While the aforementioned programs have the potential to help individuals with the independent ability and willingness to seek out care, all of these programs are completely voluntary. The initial momentum behind the CARE Act stemmed from a concern for individuals who are unable or unwilling to engage with such programs voluntarily.

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[72] Cal. Welf. & Inst. Code § 5972(e).

[73] Morten F. Byskov, *Qualitative and quantitative interpretations of the least restrictive means*, 33(4) BIOETHICS 11-521 (May 2019), Epub (Jan. 18, 2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6590346/.

[74] Cal. Code Regs, Tit. 9, § 3620 and Cal. Welf. & Inst. Code § 5887;
Over 35,000 individuals per month are engaged in FSP treatment for those with serious mental illness and co-occurring substance use disorder (unverified county data). Cal. Dept. of Health Care Services. (DHCS)*, CARE (Community Assistance, Recovery, And Empowerment Act: Early Implementation: First 8 County CARE Courts, First 9 months, First 90 People*, DHCS LEGISLATIVE REPORT (Nov. 2024) at 12.

[75] BH-Connect Evidence-Based Practice Policy Guide, Draft for Public Comment (Dec. 2024), https://www.dhcs.ca.gov/Documents/EBP-Policy-Guide.pdf.

IV. Initial Versions of the CARE Act

Early versions of the CARE Act were quite different from the Act as we know it today. While this is true of most legislative proposals, subsequent changes made to the CARE Act considerably affected its processes and scope.[76]

The original language proposed was as follows in its entirety (emphasis added):

> SECTION 1.
> Part 1.3 (commencing with Section 5565) is added to Division 5 of the Welfare and Institutions Code, to read:
> PART 1.3. Community Assistance, Recovery, and Empowerment (CARE) Court Program
> 5565.
> (a) The Community Assistance, Recovery, and Empowerment (CARE) Court Program is hereby established to connect a person struggling with untreated mental illness and substance use disorders with a court-ordered CARE plan.
> (b) (1) ***A court may order a person who is the subject of a petition filed pursuant to this section to obtain treatment and services under a CARE plan*** if the court finds that the facts stated in the verified petition are true and established and the criteria set in this section are met, including, but not limited to, each of the following:
> (A) The person is 18 years of age or older.
> (B) ***The person is suffering from a mental illness and a substance use disorder.***
> (C) The person lacks medical decisionmaking [sic] capacity.
> (2) A court may order the person to have a CARE plan for up to 12 months, and may renew the plan for up to another 12 months. The court shall conduct periodic review hearings.
> (3) ***A person who is ordered under a CARE plan who does not complete the plan may be referred to conservatorship*** pursuant to Chapter 3 (commencing with Section 5350) of Part 1, and it shall be presumed that there are no suitable alternatives to conservatorship available to the person
> (c) A petition for an order authorizing a CARE plan may be filed by a family member, county representative, community-based social services provider, behavioral health provider, or first responder in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.
> (d) (1) A CARE plan shall be managed by a CARE team in the community, and may include clinically prescribed and individualized interventions with several supportive services, including, but not limited to, medication and housing.
> (2) The CARE team shall consist of clinical team members, a public defender, and a support person to help make self-directed care decisions.

[76] Early released CARE Court Fact Sheet (March 2022) at 2 https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf, which states "The court-ordered 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 an 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. 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 conservatorship are available."

(e) (1) Each county shall participate in providing services under the program.
(2) ***The court may order sanctions or appoint an agent to ensure the county provides services under the program.***
SEC. 2.
If the Commission on State Mandates determines that this act contains 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.[77]

While all bills evolve as they make their way through the legislative process, the changes made to the CARE Act added numerous new court deadlines for the counties to manage, while removing the previous power of the court to direct the most severely disabled participants to a more structured level of care, when appropriate. The original bill language referenced above granted significant authority to the court allowing it to:

(1) grant court orders for a CARE Plan for individuals suffering from a co-occurring mental illness and substance use disorder and lacking medical decisionmaking [sic] capacity;

(2) refer a CARE participant to the county for an LPS conservatorship if the participant did not complete the plan; and

(3) order sanctions against the county or appoint an agent to ensure the county provided these services.

In contrast to the original language, CARE Plans, while still court-ordered, now only occur after a clinical evaluation review hearing, where the county and/or respondent supplies witnesses and/or reports.[78] Per data collected at the end of the first year of implementation, it appears that not all counties utilize CARE Plans.[79] CARE Agreements are used in the place of CARE Plans to document the respondent's treatment plan. However, sanctions for non-compliant counties and termination for a respondent's lack of adherence to the program can only occur with a CARE Plan, since a CARE Agreement is not a court order.

In every version of the CARE Act, the intent was to supplement the Assisted Outpatient Treatment Demonstration Project Act of 2002 (AOT), also known as Laura's Law, and find a way to help the severely mentally ill who are otherwise not receiving treatment.[80] AOT allows for the county to pursue court-ordered treatment for individuals who meet very restrictive eligibility criteria.[81] In contrast to AOT, which can only be petitioned by the county, the CARE Act allows numerous individuals to serve as petitioner. This original intent to expand the number of eligible petitioners remained in all versions of the CARE Act.

Unfortunately, due to strict eligibility criteria, including a requirement of prior hospitalization or serious and violent behavior,[82] AOT is difficult to access.[83] Moreover, even

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[77] SB 1338, 2022 Leg., Reg. Sess. 2021-22 (Cal. 2022) (as amended in Senate on Mar. 3, 2022) (First language replacing non-related, initial placeholder language about theft) (CARE Act original language).
[78] Cal. Welf. & Inst. Code § 5977.1(c)(2).
[79] In the County of San Diego, no CARE Plans have been created. Cassie N. Saunders, *County Highlights First Year of CARE Act Accomplishments*, COUNTY OF SAN DIEGO COMMUNICATIONS OFFICE (Oct. 24, 2024), https://www.countynewscenter.com/county-highlights-first-year-of-care-act-accomplishments/
[80] SB 1338 (2021-2022 Reg. Sess.)
[81] Cal. Welf. & Inst. Code § 5346.
[82] Cal. Welf. & Inst. Code § 5346(a)(4).
[83] Governor Gavin Newsom, *Governor Newsom Delivers State of the State Address on Homelessness* (Feb. 19, 2020), https://www.gov.ca.gov/2020/02/19/governor-newsom-delivers-state-of-the-state-address-on-homelessness/.

though counties are the only approved AOT petitioners, the law allows counties to opt out of the program by resolution of their respective Board of Supervisors.[84] Currently, while 31 counties have opted in, 26 counties have opted out by adopting resolutions.[85] But even in jurisdictions that have opted in, AOT filings remain low. For instance, San Diego County, which adopted AOT in 2015, had obtained AOT for less than a dozen people over a seven-year period.[86]

The stated intent of the CARE Act was "to connect a person struggling with untreated mental illness and substance use disorders with a court-ordered CARE plan."[87] In the originally introduced bill, eligibility included a broad spectrum of mental health and co-occurring substance use disorders, but the final version limited eligibility to "schizophrenia spectrum and other psychotic disorders."[88] Examples of severe mental health diagnosis that could benefit from the CARE Act, but were ultimately excluded, include bipolar disorders and standalone substance use disorders.[89]

The original language also focused on individuals who lacked medical decision-making capacity. This demonstrates an intent to make the original CARE Act an alternative to involuntary conservatorships—as evidenced by the fact that the original CARE Act offered court-ordered outpatient treatment with housing assistance. However, the chaptered version of the CARE Act no longer requires proof that a participant lacks medical decision-making capacity. While the clinical evaluation requires assessing the respondent's capacity to accept psychotropic medication, forced medication administration may not be ordered.[90]

The strong role of the court in the original version was also seen in its power to refer a participant for an involuntary conservatorship under Welfare & Institutions Code sections 5350 et seq. if the participant did not complete the CARE Plan. This court authority was removed in the chaptered version. Under current law, a court can no longer refer a participant for a conservatorship. The court can make an order for a grave disability evaluation pursuant to Welfare and Institutions Code section 5200 (5200-order), but only if the county files a petition making this request.[91]

The court's power to order sanctions against the county was also diluted in the later version of the CARE Act. No details were given with regard to distribution of sanctions collected in the original version, but under the chaptered version, any sanctions deposited to the CARE Act Accountability Fund must be distributed to "local government entities."[92] In the original version, the court was able to appoint an agent to ensure the county provided these services or could sanction the county for failure to comply. However, under the chaptered version, if the county or local government entity fails to comply with a court order, "the court shall report that

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[84] Cal. Welf. & Inst. Code § 5349.
[85] California Department of Health Care Services (HCS), *Assisted Outpatient Treatment: AOT Participation,* https://www.dhcs.ca.gov/formsandpubs/Pages/Assisted-Outpatient-Treatment-Program.aspx (accessed Feb.18, 2024).
[86] Gary Warth, *Since 2015, only 10 people in San Diego have been forced into mental health treatment under Laura's Law,* SAN DIEGO UNION-TRIBUNE (Mar. 20, 2020), https://www.sandiegouniontribune.com/2022/03/20/since-2015-only-10-people-in-san-diego-have-been-forced-into-mental-health-treatment-under-lauras-law.
[87] CARE Act original language, *supra* note 77.
[88] *Id.*; and Cal. Welf. & Inst. Code § 5972(b).
[89] *See* the current DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 5TH EDITION (2013) (DSM 5).
[90] Cal. Welf. & Inst. Code § 5977.1(b)(2).
[91] Cal. Welf. & Inst. Code § 5979(a)(2).
[92] *Id.* subd. (b)(2)(D).

finding to the presiding judge of the superior court or their designee."[93] Then it is the duty of the presiding judge to issue an order to show cause.[94] In other court settings, the court that issues an order initiates and issues its own order to show cause.[95]

V. The Criminal Justice System Approach

Part of the impetus for the introduction of the CARE Act was the inescapable understanding that the current mental health treatment system in California has been insufficient to help the severely mentally ill.[96] Sadly, as a result, many severely mentally ill individuals end up incarcerated rather than conserved. In 1939, the renowned psychiatrist and psychiatric researcher, Lionel Penrose, found an inverse relationship between mental health facilities and

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[93] Cal. Welf. & Inst. Code § 5979(b)(1).
[94] *Id.* subd. (b)(2).
[95] California Rule of Court 2.30: Sanctions for rules violations in civil cases
[96] Auditor of the State of California, *Lanterman-Petris-Short Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Received Adequate Ongoing Care* (July 2020), https://information.auditor.ca.gov/pdfs/reports/2019-119.pdf;
Budget and Legislative Analyst's Office, *City and County of San Francisco Board of Supervisors Budget and Legislative Analyst, Review of Lanterman-Petris-Short (LPS) Conservators in San Francisco* (Jan. 10, 2022), https://sfbos.org/sites/default/files/BLA%20Policy%20Report_LPS%20Conservatorships_011022.pdf;
Anita Chabria, *California's most famous homeless man is dead. His life should guide CARE Court*, LOS ANGELES TIMES (Feb. 2, 2023), https://www.latimes.com/california/story/2023-02-02/la-me-column-mark-rippee-california-care-courts-mental-illness-homeless;
San Diego County Grand Jury 2018/2019, *San Diego Psychiatric Services: Tri-City's Shutdown of Psych Units… Tip of the Iceberg* (filed May 2, 2019), https://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2018-2019/SDPsychiatricServicesReport.pdf;
California Hospital Association, *California's Acute Psychiatric Bed Loss* (Feb. 2019), https://calhospital.org/wp-content/uploads/2021/04/psychbeddata2017.pdf;
Cal. Dept. of Health Care Services (DHCS), *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (2022), https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf;
Amanda Lechner et al., *Bed Checks in Three California Counties* (2020), https://www.chcf.org/wp-content/uploads/2020/04/BedCheckInpatientPsychiatricCareThreeCACounties.pdf;
Crane Friedman, *San Diego City Council Declares Behavioral Health Bed Crisis*, THE OFFICE OF COUNCILMEMBER RAUL A. CAMPILLO (Dec. 5, 2023), https://www.sandiego.gov/sites/default/files/2023-12/San%20Diego%20City%20Council%20Unanimously%20Declares%20Behavioral%20Health%20Bed%20Crisis_2.pdf;
San Diego County Grand Jury, *Long Term Psychiatric Beds* (2015/2016), https://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2015-2016/LongTermPsychiatricBedsReport.pdf;San Diego County Grand Jury, *The Mental Health Services Act In San Diego County: Unspent Funds, Ongoing Needs* (filed June 9, 2016), https://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2015-2016/MHSAinSanDiegoCountyReport.pdf;
The California State Auditor, *Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding* (2018), https://information.auditor.ca.gov/pdfs/reports/2017-117.pdf;
The California State Auditor, *Mental Health Services Act: The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties can Improve Measurement of Their Program Performance* (2010), https://information.auditor.ca.gov/pdfs/reports/2012-122.pdf; and
County of San Diego's Office of Audits and Advisory Services, *Public Administrator/Guardian/Conservator Performance Audit: Final Report* (2020), https://www.sandiegocounty.gov/content/dam/sdc/auditor/audit/fy1920/Public%20Administrator%20Guardian%20Conservator%20Performance%20Audit.pdf.

adult incarcerations.[97] A reduction in mental health facilities results in an increase in adult incarcerations.

Prior to the CARE Act, the primary method for court oversight of behavioral health programming was through the criminal courts.[98] Many criminal cases involve defendants with co-occurring mental health and substance use disorders.[99] Eligible CARE Court respondents fit into the same category.

In California, individuals in the criminal justice system have a substantially higher rate of substance use and other mental health concerns than the general population.[100] Sadly, approximately 75 percent of individuals with untreated mental health issues suffer from co-occurring substance use disorders.[101] Another disappointing fact is that these disorders are often the cause of their incarceration.[102] Given these facts, this unfortunate reality would be true for CARE Act participants as well, since an unstabilized, severe mental health disorder is required for eligibility. Thus, to discuss the criminal justice system's prior intervention strategies, incentivized treatment for substance use disorders must be acknowledged, along with mental health treatment.

Historically, those in the criminal justice system could be encouraged to complete certain mental health treatment programs in lieu of incarceration, even if they did not have the independent ability to voluntarily complete the program without incentive. This process of duress, while not ideal, was fairly effective when used.[103] Mental health and substance use disorder treatment is often made available for offenders who have criminal convictions or cases pending.[104] While these options can improve the outcomes for defendants, many individuals with

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[97] G.G. Grecco & R. Andrew Chambers, *The Penrose Effect and its acceleration by the war on drugs: a crisis of untranslated neuroscience and untreated addiction and mental illness*, 9(1) TRANSL. PSYCHIATRY 320 (Nov. 28, 2019).

[98] S. Silver & E.S. Hancq, *Prevention over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds*, TREATMENT ADVOCACY CENTER RESEARCH REPORT (2024), which states "In 2016, Treatment Advocacy Center wrote, "The reality that an immeasurable number of people with treatable diseases only get treatment when they get sick enough to commit crimes that send them to jail and then to a forensic bed should be a source of national shame and outcry for reform." In the seven years since, the situation has gotten worse. The number of beds per 100,000 people occupied by civil patients has decreased by 17 percent since 2016."

[99] Egart, *supra* note 2, at 19-21.

[100] DHCS, *Assessing the Continuum of Care, supra* note 96, at 10 (2022).

[101] Roger H. Peters & Fred C. Osher, *Co-Occurring Disorders and Specialty Courts*, THE NATIONAL GAINS CENTER, 2 (Apr. 2024) (citing National GAINS Center for People with Co-Occurring Disorders in the Justice System, *The Prevalence of Co-Occurring Mental Health and Substance Use Disorders in Jails*, Fact Sheet Series, Delmar, NY: THE NATIONAL GAINS CENTER (2001)).

[102] Cal. Health & Human Services Agency (CalHHS), *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes*, 17 (Aug. 9, 2023), https://www.chhs.ca.gov/wp-content/uploads/2023/11/CARE-Act-Working-Group-Minutes-Aug-9-2023.pdf;
Lisa Halverstadt, *An Advocate Thought CARE Court Would Be a Lifeline. Then She Used It*, VOICE OF SAN DIEGO (Mar. 4, 2025), https://voiceofsandiego.org/2025/03/04/an-advocate-thought-care-court-would-be-a-lifeline-then-she-used-it/; and
DHCS, *Assessing the Continuum of Care, supra* note 96, at 10 (2022).

[103] Judicial Council of California, *California Drug Court Cost Analysis Study* (May 2006), https://courts.ca.gov/system/files/2024-10/cost_study_research_summary.pdf

[104] Cal. Penal Code §§ 1000 et seq. (pre-conviction diversion programs), 11550(c)(1) (rehabilitation substitution for custody), 1210 et seq. (establishment of post-conviction diversion program), and 11395 (establishment of 2024 Treatment-Mandated Felony Act) are just some examples.

severe mental health issues outside the criminal justice system have no understanding about how to access care.[105]

With recent changes in California law in the last few years, criminal court facilitated treatment is now only available for those committing felonies. While this occurred in part due to the social movement to provide mental health and substance use disorder treatment outside the criminal justice system, the unexpected result is that misdemeanor defendants and non-offenders now often receive less help than those facing criminal felony charges.[106]

The reduction in criminal court-mandated treatment was caused by several factors, two of the primary being the reduction in criminal probation periods,[107] and the decrease in jail terms for non-violent offenders.[108] While the severely mentally ill who commit felonies or are found incompetent to stand trial are sometimes still given mandated treatment,[109] those with lesser sentences are often released without any treatment, mandated or otherwise.[110]

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[105] P. Chodoff, *The case for involuntary hospitalization of the mentally ill*, 133 AM. J. PSYCHIATRY 496-501 (May 1976);
Involuntary hospitalization of the mentally ill as a moral issue, 141(3) AM. J. PSYCHIATRY 384 (1984), https://doi.org/10.1176/ajp.141.3.384;
Ryan P. McCormack et al., *Commitment to assessment and treatment: comprehensive care for patients gravely disabled by alcohol use disorders,* 382 THE LANCET 995 (Sept. 2013); and
J. Silberstein & P.D. Harvey, *Impaired introspective accuracy in schizophrenia: an independent predictor of functional outcomes*, 24 COGN. NEUROPSYCHIATRY 28-39 (Jan. 2019).

[106] Cal. Health & Human Services Agency, *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes*, 5 and 7 (Oct. 16, 2023), https://www.chhs.ca.gov/wp-content/uploads/2023/11/Minutes_CARE-Data-10.16.23.pdf.

[107] Assembly Bill 1950, 2019-2020 Leg., Reg. Sess. (Cal. 2020) (reducing adult probation to a maximum of one year for most misdemeanor offenses and two years for most felonies).

[108] J.L. Streeter, *Homelessness in California: causes and policy considerations,* STAN. INSTITUTE FOR ECON. POLICY RSCH. May 2022); and
Sarah B. Hunter et al., *Impact of Proposition 47 on Los Angeles County Operations and Budget,* RAND RESEARCH REP. 2017), https://www.rand.org/pubs/research_reports/RR1754.html.

[109] Cal. Health & Human Services (Cal.HHS), *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Slides*, 44 (Nov. 8, 2023);
S.B. Holliday et al., *Estimating the Size of the Los Angeles County Jail Mental Health Population Appropriate for Release into Community Services*, 16(2) Rand Health Q. 7 (Aug. 2021);
Jerry L. Jennings & Kevin Rice, The future of jail-based competency treatment: Commentary from 30,000 feet, 1(1) THE ARCHIVES OF PSYCHIATRY 1-6 (Nov. 22, 2022); and
Alex Sizemore et al., *Equity considerations in mental health diversion in California*, 26(3) J. OF OFFENDER REHABIL. 131-150 (Apr. 2, 2024).

[110] *See* Katherine Warburton, *Failure to treat: an American policy perspective,* CNS SPECTRUMS 1-5 (Oct. 28, 2024); Egart, *supra* note 2, at 19-21;
Carly Finkle, *In(Justice) in Riverside: A Case for Change and Accountability,* AM. C.L. UNION FOUND. 2020), http://followourcourts.com/wp-content/uploads/rda-report-022822.pdf;
Jalayne J. Arias et al., *Crime, Incarceration, and Dementia: An Aging Criminal System*, 49(2-3) AM. J. OF LAW & MEDICINE 193-204 (Jul. 2023);
Judy Ann Clausen &, Joanmarie Davoli, *No-One Receives Psychiatric Treatment in A Squad Car,* 54 TEX. TECH L. REV. 645 (2021);
Aviram H. Bottleneck, *The place of county jails in California's COVID-19 correctional crisis*, 2 HASTINGS J. CRIME & PUNISHMENT, 76 (2021);
Jess Bendit et al., *Interrupting the Cycle of Incarceration for Individuals with Mental Illness: An Analysis of Los Angeles County's Rapid Diversion Program* UCLA LUSKIN INSTITUTE ON INEQUALITY AND DEMOCRACY 2021), https://luskin.ucla.edu/wp-content/uploads/2021/07/11RapidDiversionWY.pdf;

When discussing mandated treatment for behavioral health, it is important to note that jail inmates suffer from serious mental illness at a rate 7 percent higher than the general population.[111] Thus, proportionally, individuals with mental health disorders are arrested at a higher rate than those without.[112] As discussed above, co-occurring mental health and substance use disorders in jail inmates are more usual than not, as well. Therefore, to fully analyze the effect of reduction in mandated treatment for behavioral health, it is important to first understand the recent reductions in drug prosecution.

In 2014, Proposition 47, referred to by supporters as the Safe Neighborhood and Schools Act,[113] reformed theft and drug prosecution laws in California. Prop. 47 reclassified several shoplifting, drug use, and possession offenses from felonies to misdemeanors.[114] As such, there are fewer prosecutions and fewer jail terms for those arrested for these charges. This has had a significant impact on the criminal justice system's ability to mandate treatment.

In 2021, California reduced probation periods for misdemeanors from three years to one year. For felonies, most probation periods were reduced from four years to two years.[115] As a result, there is less court supervised time in which to mandate treatment.

Over the last few decades, one of the court strategies to incentivize treatment has been the use of Drug Courts. Completion of Drug Court requires at least 18 months of participation.[116] Successful participation in Drug Court can mean a termination of probation or a dismissal of the entire criminal conviction.[117]

Collaborative Drug Courts have proven success records, with 17 percent lower recidivism rates than non-participating defendants.[118] Collaborative Behavioral Health Courts use similar strategies and also boast lower recidivism rates and higher rates of treatment service utilization

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Sandra M. Leotti & Erin Slayter, *Criminal legal systems and the disability community: an overview*, 11(6) SOCIAL SCIENCES 255 (2022); and
Rebecca Bedard et al., *Elderly, detained, and justice-involved: the most incarcerated generation*, 25 CUNY L. REV. 161 (2022).

[111] Peters & Osher, *supra* note 101, at 2 (citing Lamb H.R. & Weinberger L.E., *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49(4) PSYCHIATRIC SERVICES 483-492 (1998)).

[112] Peters & Osher, *supra* note 101 (citing H.J. Steadman et al., *A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons,* 50(1) PSYCHIATRIC SERV. 1620-3 (Dec. 1999)).

[113] *California Proposition 47, Reduced Penalties for Some Crimes Initiative,* BALLOTPEDIA, https://ballotpedia.org/California_Proposition_47,_Reduced_Penalties_for_Some_Crimes_Initiative_(2014) (last visited Feb. 2025).

[114] Aaron Arnold et al., *Drug Courts in the Age of Sentencing Reform*, CENTER FOR COURT INNOVATION (2020), https://www.innovatingjustice.org/sites/default/files/media/documents/2020-03/report_sentencingreform_03262020.pdf.

[115] Assem. Bill 1950, 2019-2020 Leg., Reg. Sess. (Cal. 2020) (created the reduced adult probation terms).

[116] Super. Ct. of Cal., *Drug Court*, SUPER. CT. OF CAL. (accessed Mar. 4, 2025), https://www.sdcourt.ca.gov/sdcourt/criminal2/criminalsubstanceabuse/criminaldrugcourt#:~:text=Upon%20successful%20completion%20of%20the,drug%20charge%20may%20be%20dismissed.

[117] *Id.*

[118] Jud. Council of Cal., *California Drug Court Cost Analysis Study* (May 2006), https://courts.ca.gov/system/files/2024-10/cost_study_research_summary.pdf;
John R. Gallagher et al., *A qualitative interpretive meta-synthesis (QIMS) of women's experiences in drug court: Promoting recovery in the criminal justice system, 22(3)* J. OF SOCIAL WORK PRACTICE IN THE ADDICTIONS 212-32 (July 2022); and
M. Gottschalk, *The opioid crisis: the war on drugs is over. Long live the war on drugs*, 6(1) ANNUAL REVIEW OF CRIMINOLOGY 27, 363-98 (Jan. 2023).

for participants.[119] Unfortunately, given the complexity of intervention for individuals with severe co-occurring disorders, success rates in collaborative courts are lower for those with co-occurring mental health and substance use disorders.[120] While reported success rates in this program vary, data shows that participants receive treatment and experience progress that they otherwise would not have received. There are still numerous gaps in the system of care for treating co-occurring disorders,[121] and while discussions about the need for treatment have been ongoing for decades, investments in the area of substance use disorder treatment, such as the Drug Medi-Cal Organized Delivery System (DMC-ODS), only started as recently as 2016.[122]

Despite proven record of success in these collaborative programs, the criminal justice system changes mentioned above have reduced participation in these programs dramatically. According to a Center for Court Intervention study from 2020, [123] 67 percent of California Courts surveyed reported declines in their caseloads post-Prop. 47, with the average reporting a 24 percent decrease.[124] Those facing non-violent charges and charges for drug use—now classified as misdemeanors with only one year probation periods—no longer receive the benefit of the Drug Court Program. Due to this decrease in the number of eligible defendants, participation in Drug Court expanded to those with a history of violence.[125]

Less arrests are occurring overall, due to the changes in criminal penalties mentioned above and the movement to have non-law enforcement personnel respond to situations involving mental health disorders. As a result, individuals with untreated behavioral health disorders, often complicated by drug use, are not mandated to complete treatment, cannot independently access and participate in treatment, and thus, receive no treatment. Facing these decreases in criminal mandated treatment, no equivalent increase in non-criminal mandated treatment has occurred.

Recognizing the resultant reduction in mandated treatment and the resultant increase in misdemeanor crimes, voters adopted Proposition 36 in 2024. Titled "The Homeless, Drug Addiction and Theft Reduction Act," Prop. 36 reversed some of the changes initiated by Prop. 47. This new law became effective as of December 18, 2024, and created Treatment-Mandated Felonies, for what the bill termed "hard drugs," in cases involving an offender with two prior drug-related convictions. The definition of "hard drugs" excludes hallucinogens, lysergic acid

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[119] Dale E. McNeil, PhD, & Renee L. Binder, M.D., *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395-1403 (2007), https://sf.courts.ca.gov/system/files/2215.pdf; Marie-Helene Goulet et al., *Effectiveness of forensic assertive community treatment on forensic and health outcomes: a systematic review and meta-analysis,* 49(6) CRIMINAL JUSTICE AND BEHAVIOR 838-852 (June 2022), https://journals.sagepub.com/doi/full/10.1177/00938548211061489.

[120] Peters & Osher, *supra* at 101, 2 (citing T.W. Haywood et al., *Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders*, 152 AM. J. OF PSYCHIATRY 856-861 (1995) and other works).

[121] SB 367, 2025 Leg., Reg. Sess. 2025-26 (Cal. 2025) (as amended on March 24, 2025); K. Warburton, *Failure to treat: an American policy perspective,* CNS SPECTRUMS 1-5 (Oct. 28, 2024); and Egart, *supra* note 2.

[122] Cal. Health & Human Services (CalHHS), *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes,* 3-6 (Nov. 6, 2024) (reflects the Keynote address by Brian Hurley, MD, MBA, FAPA, DFASAM, Medical Director, *Substance Abuse Prevention and Control*, County of Los Angeles, Dept. of Public Health on CARE for People with Co-Occurring Disorders), https://www.chhs.ca.gov/wp-content/uploads/2025/02/CARE-11.6.24-Working-Group-Minutes.pdf.

[123] Arnold et al., *supra* note 114 at 2.

[124] *Id.*

[125] McNeil et al., *supra* note 119.

(LSD), other psychedelic drugs, and most stimulants.[126] The previous law did not contain these exclusions, which shows that Prop. 36 is narrower in scope than the law it replaced. That being said, with the potential for new felony sentences, it may have a significant impact on arrests, prosecution, and collaborative court participation.

With the potential for the criminal justice system to once again mandate treatment, the question becomes whether individuals should receive treatment through the criminal justice system or through civil options. The CARE Act has the potential to influence these unknown potentials. If the CARE Act can be successful in California, the seriously mentally ill will have more options to receive court oversight for treatment, thereby hopefully reducing the commission of mental health and substance use disorder related crimes. However, if the state truly wants to move mental health treatment out of the criminal justice system, more opportunities for access to the mental health system are necessary.

VI. Untreated Mental Health Disorders in California

While Senate Bill 43 recently expanded the definition of grave disability to include severe substance use disorders, it did not increase access to the mental health system. Thus, though the need for severe substance use disorder treatment remains a problem, the state has not improved access to higher levels of care, especially ones involving the courts.[127]

While a small percentage of individuals with co-occurring disorders have been helped by the criminal justice system in the past, California has seen an undeniable surge in calls for individuals experiencing mental health crises.[128] Although there are numerous reasons for this increase in the demand for mental health services, California's growing homeless population is one of the largest contributing factors. California holds 12 percent of the nation's population, but is home to 30 percent of the nation's homeless.[129] According to a 2023 study published by the University of California, San Francisco, out of 3,200 adults surveyed experiencing homelessness in California, 82 percent of responding participants reported having a serious mental health condition at some point in their lives.[130] While financial reasons, incarceration, and other traumas have all led to an increase in homelessness,[131] the overall lack of access to mental health treatment must be explored.

According to the California Department of Health Care Services, "the rate of serious mental illness in California has increased by more than 50 percent from 2008 to 2019."[132] Movements in the nation complain that the criminal justice system cannot and should not be the

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[126] Cal. Health & Safety Code § 11395(e).
[127] Paul Sisson, *County says few detained under new definition of grave disability*, SAN DIEGO UNION TRIBUNE (Feb. 18, 2025), https://www.sandiegouniontribune.com/2025/02/16/county-says-few-detained-under-new-definition-of-grave-disability/.
[128] DHCS, *Assessing the Continuum of Care, supra* note 96, at 8 (2022).
[129] M. Kushel, T. Moore et al., *Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness*, UCSF BENIOFF HOMELESSNESS AND HOUSING INITIATIVE (2023) at page 4
[130] *Id*. at 7.
[131] *Id.* at 5 (revealing that nine of ten participants, out of 3,200 surveyed, reported losing their last housing in California, 72 percent reported having experienced physical violence, and 19 percent became homeless after being released from jail or prison. Low household incomes and increased housing costs also contributed to homelessness).
[132] DHCS, *Assessing the Continuum of Care, supra* note 96, at 37 (2022).

primary intervener in this area.[133] The need for available mental health services is critical, with 280,000 individuals calling California's new 988 Suicide and Crisis Lifeline in its first year.[134] That is double the volume of calls any other state has received and shows the severity of the problem that California is wrestling.[135]

In California, 43 percent of surveyed individuals seeking mental health services also reported it was "somewhat or very difficult to secure an appointment with a provider who accept[ed] their insurance."[136] However, only 15 percent of the same individuals surveyed felt the same way about appointments for physical health services.[137] This disparate access has prompted efforts to ensure parity between physical and mental health benefits. Notably, Medi-Cal covered individuals have nearly double the rate of serious mental illness and substance use disorders than those with other sources of insurance.[138]

Opponents of the CARE Act cited the desire for self-determination and voluntary treatment without court oversight or mandates. Opponents mainly consisted of disability rights groups and counties.[139] Proponents consisted of cities and families of individuals unable to access care. They cited human dignity and the hope that vulnerable individuals could finally get access to mental health treatment through this new program.[140]

Likely due to strong opposition, all references to the potential for the CARE Act to force treatment were removed from the final version as codified. While the CARE Act references the

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[133] Esther Anene et al., *Revisiting Research Safety Protocols: The Urgency for Alternatives to Law Enforcement in Crisis Intervention*, 74(3) PSYCHIATR. SERV., 325-328 (Mar. 1, 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10027434/.

[134] Anabel Sosa, *'A lifesaving tool': California's new mental health crisis line sees a surge in calls*, CALMATTERS (Jul. 19, 2023), https://calmatters.org/health/mental-health/2023/07/988-hotline-california-mental-health/.

[135] *Id.*

[136] DHCS, *Assessing the Continuum of Care, supra* note 96, at 10 (2022).

[137] *Id.*

[138] *Id.* at 11.

[139] Disability Rights Cal., *SB 1338 (Umberg) – Disability Rights California Information on CARE Act,* DISABILITY RIGHTS CAL. (Feb. 7, 2023), https://www.disabilityrightsca.org/latest-news/sb-1338-umberg-disability-rights-california-information-on-care-act;
Jim Wood, *Opposition to CARE Court (SB 1338) as Amended June 16, 2022*, HUMAN RIGHTS WATCH (June 24, 2022), https://www.hrw.org/news/2022/06/24/opposition-care-court-sb-1338-amended-june-16-2022; and
Cal. State Association of Counties, *CARE Courts/SB 1338,* CAL. STATE ASSOCIATION OF COUNTIES, https://www.counties.org/node/20254.
County concerns, https://www.counties.org/node/20254.

[140] LegiScan, *Bill Sponsors: CA SB1338 | 2021-2022 | Regular Session,* LegiScan https://legiscan.com/CA/sponsors/SB1338/2021;
NAMI Cal., *Care Act*, https://namica.org/care/;
City of San Diego, *Mayor Gloria Joins Governor for Signing of CARE Court Legislation,* CITY OF SAN DIEGO (Sept. 14, 2022), https://www.sandiego.gov/mayor/mayor-gloria-joins-governor-signing-care-court-legislation; and
see Cal. Health & Human Services (CalHHS), *Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes,* 2, 11, 14, & 21 (Nov. 8, 2023), https://www.chhs.ca.gov/wp-content/uploads/2023/12/CARE-Act-Working-Group-Minutes-Nov-8-2023.pdf, reflecting the Public Comment Statement of Lauren Rettagliata, author of *Housing that Heals*, member of the California Health & Human Services Agency CARE Act Working Group, and family member of someone with a serious mental illness and substance use disorder. Rettagliata opined that agreements should make housing dependent on required treatment because the mentally ill often lack insight into their own needs. The Working Group also contains a Public Comment Statement from "Tanya," who filed a CARE petition for her son, but says voluntary medication and giving him choices will not work because he suffers from auditory hallucinations and will make the wrong choices.

power of 5200-orders, as discussed above, it is referenced as "existing legal authority," and not a CARE Act power. Under Welfare and Institutions Code sections 5200 et seq., counties have the power to ask courts for a grave disability evaluation through a 5200-order petition process. A 5200-order for evaluation can never force treatment, but can allow a gravely disabled individual, who cannot be helped by the voluntary nature of the CARE Act process, to potentially obtain needed services through the LPS system. If the individual is, in-fact, found to be gravely disabled, services can then be mandated through the LPS system, but only after a referral from a professional in charge of an LPS facility or their designee. Currently, the power to file 5200-order petitions remains solely in the hands of counties. The court itself cannot issue such an order on its own motion. Thus, in form and in practice, CARE Court is an exclusively voluntary program, and if the county does not seek a 5200-order, one cannot be ordered. As Sacramento County's Judge Brown has stated, "…[A CARE Plan] is a court order to have a person get involved in treatment and work with a treatment professional. There is no power for the court to order someone to a hospital setting with CARE Court."[141] In response to opponents' earlier concerns, a CARE Plan, if ordered, directs the county to act, but not the respondent.[142]

Ironically, news articles paint a different picture of the CARE Act, contributing to the confusion over the power and use of the Act in practice. Recent articles still reference forced or compelled treatment, which is not the practice of the CARE process as codified.[143]

As mentioned above, the CARE Act was not the first civil program to use non-criminal court oversight to encourage participation in mental health treatment. AOT is a similar, nationally used program, where the court can be petitioned to encourage the respondent to engage in treatment. The CARE Act was set up similarly to AOT, by offering court-ordered voluntary treatment, with the "black robe effect" of the judge's presence being the only means to motivate compliance. AOT has been successful in some states, such as New York (with an average of 1500 petitions a year and 96 percent of petitions granted),[144] but not nearly as successful in California (with an average of 2,000 petitions a year and approximately 50 percent of petitions granted).[145] Of note, state laws vary. For example, in New York, numerous petitioners can file for AOT, but in California, only counties have this ability.[146]

Under California's AOT law, eligibility requires the very high threshold of multiple, failed mental health holds. This is likely one of the reasons for the low number of petitions. In a

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[141] Devin Trubey, *Inside Sacramento County Care Court: The first few months in review*, ABC10 (Jan. 20, 2025), https://www.abc10.com/article/news/local/sacramento/inside-sacramento-county-care-court/103-54072256-e72d-49b9-be2d-9f50e3fd30f0.

[142] As discussed below in Section VII, there is a conflict with this process that grants sanctionable court orders against the county, since only counties can initiate CARE Plan hearings.

[143] *See* Christine Mai-Duc, *California Falling Short of Enrollment Goal as Mental Health Courts Roll Out Statewide*, CAL. HEALTHLINE (Nov. 27, 2024), https://californiahealthline.org/news/article/mental-illness-california-care-court-gavin-newsom-counties/; and
Jeanne Kuang, *Families have high hopes for Gavin Newsom's CARE Courts. Providers want to lower expectations,* CALMATTERS (Aug. 28, 2023), https://calmatters.org/housing/2023/08/care-court-california-start/.

[144] New York State Office of Mental Health, *AOT Reports: Program Statistics* (accessed Feb. 20, 2025), https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&page=Program%20Statistics%20-%20Petitions%20Filed&nquser=BI_Guest&nqpassword=Public123

[145] Cal. Dept. of Health Care Services (DHCS), *Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002* (2023), https://www.dhcs.ca.gov/Documents/2022-Lauras-Law-Assisted-Outpatient-Treatment-Demonstration-Project-Act-of-2002.pdf.

[146] N.Y. Consolidated Laws, Mental Hygiene Law § 9.60(e).

letter to the state auditor, the Los Angeles County Department of Mental Health identified the need for state law to recognize that not all individuals who qualify for a 5150 hold will qualify for additional holds. [147] Thus, AOT begs the question: how is an individual consistently released from the hospital without psychiatric help supposed to show failed holds to initiate court ordered mental health treatment? The California State Auditor's 2019 report highlights the significant number of individuals placed on multiple 5150 holds. However, without transitioning to inpatient psychiatric hospitalization, these short-term involuntary holds are not a factor in deciding AOT eligibility.

This issue is especially true for individuals suffering from co-occurring disorders. For instance, when an individual with an underlying untreated psychiatric disorder comes to the emergency department with alcohol intoxication, it is not uncommon for the patient to be released after their intoxication has resolved.[148] The cycle then continues with no access to care and no eligibility for AOT.[149]

The CARE Act was the first program of its kind in California to allow many individuals to petition the court directly. Like AOT in New York, it is not limited to county petitions alone. While only those with schizophrenia are currently eligible for the CARE Act, it also has a lower threshold for eligibility than AOT, with involuntary inpatient hospitalization being a consideration—but not a necessary requirement—for eligibility.

VII. How *City of Grants Pass v. Johnson* Affects City Use of CARE Court

With the recent U.S. Supreme Court decision in the case of *City of Grants Pass v. Johnson*[150] (*Grants Pass*) and the timely implementation of the CARE Act, California cities now have another opportunity to pivot away from criminal prosecution toward civil proceedings. The *Grants Pass* decision has already impacted individuals experiencing homelessness, including those individuals with mental health conditions.[151] This 2024 decision allows cities to arrest and fine individuals for sleeping outside, even if there are no shelter beds available. Since this

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[147] Auditor of the State of Cal., *Lanterman-Petris-Short Act California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care, Letter to Auditor from County of Los Angeles Dept. of Mental Health,* 87 (July 2020), https://information.auditor.ca.gov/pdfs/reports/2019-119.pdf.

[148] Carolin Kilian et al., *Stigmatization of people with alcohol use disorders: An updated systematic review of population studies*, 45 ALCOHOL CLIN. EXP. RES. 899-911 (May 10, 2022), https://doi.org/10.1111/acer.14598

[149] Auditor of the State of Cal., *supra* note 147;
Gary Warth, *Since 2015, only 10 people in San Diego have been forced into mental health treatment under Laura's Law*, SAN DIEGO UNION TRIBUNE (March 20, 2022), https://www.sandiegouniontribune.com/2022/03/20/since-2015-only-10-people-in-san-diego-have-been-forced-into-mental-health-treatment-under-lauras-law/;
Tooba Naveed, *California California's CARE Act: A Step Forward for Mental Healthcare, or a Step Back for Individual Liberties?,* 55 UNIV. OF THE PACIFIC L. REV. 1 (2023), https://scholarlycommons.pacific.edu/cgi/viewcontent.cgi?article=1488&context=uoplawreview;
Paul S. Appelbaum, *Ambivalence codified: California's new outpatient commitment statut*e, PSYCHIATRIC SERV. (2003), https://doi.org/10.1176/appi.ps.54.1.26; and
Andrea Reynoso, *Is California Committed?: Why California Should Take Action To Address The Shortcomings Of Its Assisted Outpatient Commitment Statute*, 88 SOUTH. CALIF. L. REV. 4 (May, 2015), https://southerncalifornialawreview.com/wp-content/uploads/2018/01/88_1021.pdf.

[150] *City of Grants Pass v. Johnson* (*Grants Pass*), 603 U.S. 520 (2024).

[151] Theresa Clift & Phillip Reese, *Sacramento quietly ramped up criminal citations to homeless people, 'I can't afford to pay it'*, THE SACRAMENTO BEE (Feb. 03, 2025), https://www.sacbee.com/news/local/article295387299.html

decision, criminal citations for unlawful camping have increased in some California cities.[152] While cities have been using police to respond to homelessness through punitive civil and criminal penalties for some time,[153] theoretically, they now have the new option of utilizing CARE Court to intervene with unmet needs, instead of prosecuting individuals for unlawful camping.

A. *Grants Pass* Overview

In *Grants Pass*, unhoused plaintiffs sued the Oregon town of Grants Pass in federal court, arguing that its camping ban violated the Eighth Amendment's protections against cruel and unusual punishment.[154] The City of Grants Pass enacted ordinances barring people from sleeping outside in public using a blanket, pillow, or even a cardboard sheet to lie on.[155]

The six conservative justices on the Supreme Court disagreed with plaintiffs' arguments. Writing for the majority, Justice Neil Gorsuch opined, "The Court cannot say that the punishments Grants Pass imposes here qualify as cruel and unusual." In her dissent, Justice Sonia Sotomayor accused her colleagues of criminalizing the very condition of being homeless, calling on the court to "prohibit punishing the very existence of those without shelter."[156]

The *Grants Pass* ruling overturns several decisions by the Ninth Circuit, which has jurisdiction over western states, including California. In 2018, the U.S. Court of Appeals for the Ninth Circuit held in *Martin v. City of Boise* that cities cannot punish people for sleeping outside without providing adequate shelter options.[157] The Ninth Circuit then reinforced that decision in 2022 when it struck down Grants Pass' camping ban, siding with the plaintiffs. These rulings established some protections from aggressive removal of homeless encampments in western states. *Martin v. City of Boise* has effectively been overruled by *Grants Pass*.

B. *Grants Pass* Decision and CARE Court

Beginning in late 2024, California's rollout of CARE Court and the *Grants Pass* decision overlapped. The Supreme Court issued the *Grants Pass* decision on June 28, 2024, and CARE Court began in the majority of California counties on December 1, 2024. With CARE Court, California cities now have the opportunity to pivot from criminal prosecution of charges such as unlawful camping, public nudity, and trespassing, to civil proceedings—where California counties must try to offer shelter and support under the CARE Act. Many jurisdictions, including California cities, have sought quick fix responses that can remove individuals off a corner, using

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[152] Robbie Sequeira, *Many More Cities, Including Several in Southern California, Ban Sleeping Outside Despite Lack of Shelter Space*, TIMES OF SAN DIEGO (Jan. 29, 2025), https://timesofsandiego.com/life/2025/01/29/many-more-cities-including-several-in-southern-california-ban-sleeping-outside-despite-lack-of-shelter-space/; and Megan Vaz, *After Supreme Court's contentious homelessness ruling, what's next for California cities?*, THE SACRAMENTO BEE (July 3, 2024), https://www.sacbee.com/news/politics-government/article289705924.html.

[153] Trevor Morgan & Kathleen Quinn, *Homelessness charges spiked in Modesto before court ruling. What's behind the increase?*, THE MODESTO BEE (Dec. 21, 2024), https://www.modbee.com/news/politics-government/article297010089.html.

[154] *Grants Pass*, 603 U.S. 520 (2024).

[155] Marisa Kendall, *Supreme Court gives cities in California and beyond more power to crack down on homeless camps*, CALMATTERS (June 28, 2024), https://calmatters.org/housing/2024/06/california-homeless-camps-grants-pass-ruling/.

[156] *Grants Pass*, 603 U.S. at 592.

[157] *Martin v. City of Boise*, 920 F.3d 584 (9th Cir. 2019).

the threat of law enforcement.[158] However, because merely shifting people around after a removal does not solve homelessness, the lack of treatment remains a problem. This is where cities and counties can utilize the CARE process to obtain treatment for these individuals.

In 2024, Sacramento County reported a 41 percent decrease in homelessness since 2022.[159] Sacramento County achieved this dramatic progress by increasing temporary housing capacity by 84 percent and permanent housing slots by 29 percent.[160] Local officials say that Sacramento County's decline in homelessness follows a drop in homeless populations in nearby counties. In 2023, Yuba and Sutter Counties experienced a 10 percent drop in homelessness over the past year, while other recent counts show a 6 percent decrease in Placer County and a 2 percent decrease in Nevada County. San Francisco also saw a recent 7 percent decline in its homeless population.[161] Yet, these numbers reflect a pre-*Grants Pass* era. California cities and counties can now arrest and fine individuals for sleeping outside, even if they have nowhere else to go.[162] The dissenting justices in the *Grants Pass* decision raised the concerns that there are tens of thousands of unsheltered individuals in the United States who are the victims of poverty, there is a grave shortage of affordable housing, and there are many who suffer from underlying physical, mental health, and substance use conditions. The dissenting justices understandably questioned where these individuals are supposed to go.[163]

C. Considerations after *Grants Pass*

The *Grants Pass* decision does not directly impact CARE Court; rather, it gives cities the option of seeking treatment instead of punishment for individuals suffering from mental health conditions. Thus, California cities can now reconsider whether the *Grants Pass* ruling of criminalizing poverty, homelessness, and mental illness is a solution to removing individuals from the streets. Cities may also consider whether using the CARE process for individuals to obtain supportive housing, peer support services, and mental healthcare are evidence-based interventions that could prevent and end homelessness for those with mental health conditions.

VIII. Challenges for Cities with the Current CARE Act

While the CARE Act was implemented with promises of better access to mental health treatment with court oversight, critical limitations inherent in the program have blocked many opportunities for success.

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[158] Camille Squires, *"Designed to be Cruel": How Grants Pass Will Ramp Up the Policing of Homelessness*, BOLTS (July 2, 2024), https://boltsmag.org/grants-pass-ruling-homelessness/

[159] Darrell Steinberg, *How the Grants Pass ruling gives California a shot at a better law to address homelessness*, CALMATTERS (June 28, 2024), https://calmatters.org/commentary/2024/06/homeless-grants-pass-supreme-court/

[160] Chris Nichols, *Sacramento County's unhoused population drops 29%, bucking recent trends*, CAPRADIO (June 5, 2024), https://www.capradio.org/articles/2024/06/05/sacramento-countys-unhoused-population-drops-29-bucking-recent-trends/.

[161] *Id.*

[162] *Grants Pass*, 603 U.S. 520 (2024).

[163] *Id*. at 564-566.

A. CARE Act Dismissals Have No Codified Alternate Pathway to Care

CARE Act petitions are dismissed when (1) the respondent's petition does not meet the prima facie burden,[164] (2) the respondent is enrolled or is likely to enroll in voluntary treatment,[165] (3) the respondent does not appear for court,[166] or (4) the respondent does not voluntarily cooperate with the process.[167]

Petitions that do not meet the prima facie burden can be returned to the petitioner for refiling.[168] However, there is no exact process to refile and notify the court that a prior petition was filed. Notification of the case's refiled status is done manually in the narrative section of the CARE-100 petition. For a refiling, there is also a possibility that the county could accuse a petitioner of a bad faith filing.[169] This can theoretically happen if the county disagrees with the changed circumstances alleged by the petitioner. If this conflict occurs, a court hearing on the merits of the petition may be necessary, but is not discussed in the CARE Act itself. Thus, it is up to the judge's discretion.

Notably, the County Behavioral Health Directors Association (CBHDA) recommended limiting referrals from cities for homeless respondents because it opines that only 30 percent or less of individuals experiencing homelessness have severe mental health conditions. [170] CBHDA's recommendation included a suggestion that "inappropriate referrals" should result in caps, penalties, or fines. However, the recommendation was based on limiting the percentage of referrals made, rather than whether the petition met the prima facie burden required by the CARE Act.

Cities and counties may also differ in how they evaluate whether an individual is enrolled and stable, or likely to enroll in voluntary treatment.[171] The question becomes, how long someone must be enrolled in a program to be considered stable. If someone is likely to enroll, but has a history of dis-enrolling, does that make them eligible for the CARE process? Is the respondent's longitudinal history taken into account? Given that the CARE Act is still in its early days, these questions could potentially be addressed in future legislative amendments. As the CARE Act is a voluntary program, counties determine whether the respondent is "voluntary enough" for a recommendation of petition dismissal. CARE Act data requirements could highlight this type of petition dismissal as a missed opportunity.

Additional resources for counties to locate the unhoused could decrease petition dismissals for the third reason discussed above—the respondent does not appear for court. But the fourth reason for petition dismissal—the respondent does not voluntarily cooperate with the

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[164] Cal. Welf. & Inst. Code § 5977(a)(2).
[165] *Id.* subd. (a)(5)(A).
[166] *Id.* subd. (b)(2).
[167] CARE Agreements are created with voluntary participation. While CARE Plans can technically be created following a hearing pursued by the County, no CARE Plans have been created in San Diego County. San Diego County has stated they have created nearly double the CARE Agreements compared to the other pilot counties combined. Cassie N. Saunders, *County Highlights First Year of CARE Act Accomplishments*, COUNTY OF SAN DIEGO COMMUNICATIONS OFFICE (Oct. 24, 2024), https://www.countynewscenter.com/county-highlights-first-year-of-care-act-accomplishments/.
[168] Cal. Welf. & Inst. Code § 5977(a)(2).
[169] Cal. Welf. & Inst. Code § 5975.1(a).
[170] CBHDA, *Letter to Assembly Judiciary Committee Regarding AB 2830 (Bloom) CARE Court - Concerns* (April 16, 2022) at 7, https://www.disabilityrightsca.org/system/files/file-attachments/003-Exhibits%20Vol%201%20%281-11%29.pdf at 227.
[171] Cal. Welf. & Inst. Code § 5977(a)(5)(A).

process—goes to the heart of the problem with overall access to care. Often, a refusal to voluntarily cooperate is linked to the severity of a respondent's untreated mental illness.

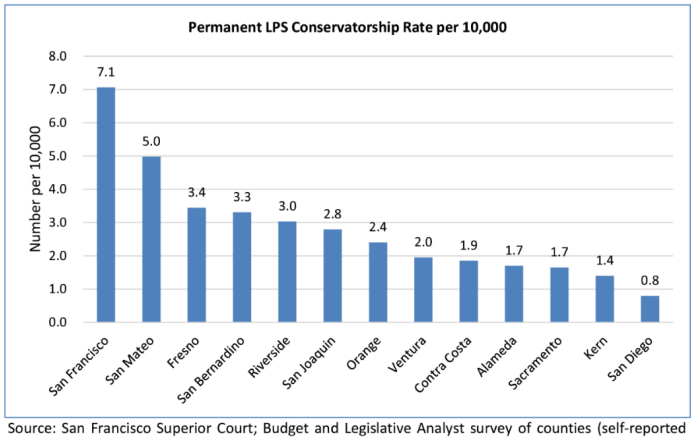
The ironic truth is that the more severe the mental illness, the less likely the CARE process can assist.[172] A dismissal for lack of engagement leaves the respondent in the same bad situation they were in prior to the filing of the CARE petition. They remain untreated while the petition is pending, and they continue to refuse voluntary care after it is dismissed. As a result, individuals with severe mental illness who are unable or unwilling to engage often do not receive mental health care. Many return to cycling between the streets, hospitals and jail.

Some individuals who refuse treatment due to mental illness may meet the eligibility requirements for LPS conservatorships.[173] While involuntary conservatorships are available outside the criminal justice system through the Welfare and Institutions Code under the LPS Act,[174] obtaining access to care in that system is incredibly challenging. Unfortunately, there is little consistency in how counties use this option to mandate care. See chart below, labeled as Appendix V: California Counties and LPS Conservatorship Caseload.[175]

Appendix V: California Counties and LPS Conservatorship Caseload

We surveyed the largest counties in California (excluding Los Angeles and Santa Clara) on new and renewed permanent LPS conservatorship caseload in FY 2020-21. Based on self-reported data from the 13 counties responding to the survey, the total permanent LPS conservatorship caseload per 10,000 population ranged from 0.8 in San Diego County to 7.1 in San Francisco, as shown in Exhibit 16 below.

Exhibit 16. Range of Permanent LPS Conservatorship Cases per 10,000 Population Among 13 of the Largest California Counties (FY 2020-21)



Source: San Francisco Superior Court; Budget and Legislative Analyst survey of counties (self-reported data)

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[172] "Grave disability among individuals with schizophrenia remains widespread despite anti-psychotic medications and their effects on psychosis. Evidence indicates that nearly 80 percent of individuals with schizophrenia have persistent deficits in social functioning…" Juliet Silberstein, BA & Philip D. Harvey, PhD, *Impaired Introspective Accuracy in Schizophrenia: An Independent Predictor of Functional Outcomes*, 24 COGN. NEUROPSYCHIATRY 1, at 28-39 (Jan. 2019) (citing D. Wiersma et al., *Social disability in schizophrenia: its development and prediction over 15 years in incidence cohorts in six European centres*, 30 PSYCH. MED. 5, 1155–1167 (2000)); and
Cal. Health & Human Services Agency, *supra* note 4, at slides 31-34, which reflects the presentation by Katherine Warburton DO, Statewide Medical Director, California Department of State Hospitals on *How We Serve and Support*, https://www.chhs.ca.gov/wp-content/uploads/2023/11/11082023-CARE-WG-Meeting_slides-posting.pdf.

[173] Cal. Welf. & Inst. Code § 5352.

[174] *Id.*

[175] City and County of San Francisco Board of Supervisors Budget and Legislative Analyst Office, *Memorandum on Review of Lanterman-Petris-Short (LPS) Conservatorship in San Francisco* (Jan. 10, 2022) at 31.

Welfare and Institutions Code section 5150 allows peace officers and certain county approved professionals to initiate involuntary holds up to 72 hours for an assessment[176] when an individual is gravely disabled.[177] An individual is deemed gravely disabled when they are unable to manage their food, shelter, clothing, personal safety, or necessary medical care due to a mental health disorder, a severe substance use disorder, or a combination of both.[178] This hold[179] can sometimes result in a referral to the county for an LPS conservatorship investigation.

This referenced definition of grave disability reflects a recent expansion in eligibility with the passing of SB 43 (effective Jan. 1, 2024). However, counties were given the option to postpone the effective date for this expanded definition of grave disability for up to two years if they chose. To illustrate, San Francisco County began implementation of SB 43 immediately on January 1, 2024, while San Diego and Sacramento Counties delayed until January 1, 2025. Regardless of the implementation dates or the fact that the definition was expanded, limitations in access to care under the LPS Act system remained unchanged.

Aside from a 5150 hold, the only other way for a patient to gain access to the LPS Act system of care is through a court order. As discussed above, a 5200-order can mandate that a grave disability evaluation be completed,[180] however the Code does not empower the court to initiate this order on its own motion. The Code requires review of "a petition pursuant to this article,"[181] in which only counties are authorized to file these petitions.[182] Under the Code, any individual can request that the county investigate and petition for an order.[183] But the consequences of the county's failure to respond to such a request are not addressed. It appears the only recourse for someone requesting a 5200 petition from the county and receiving no response would likely be a Writ of Mandamus.

While the CARE Act does not contain any ability to make direct referrals for LPS conservatorships, the court retains the existing authority to use 5200-orders,[184] after notice is given to the respondent and after termination of the CARE process.[185]

While the CARE process was conceived as a voluntary alternative to involuntary conservatorships, the CARE Act recognized that the community it sought to serve may require a higher level of care. How those referrals are being made is currently unknown. All proceedings pursuant to the CARE Act are confidential[186] and the use of 5200-orders by counties to obtain grave disability evaluations is not currently part of the CARE Act data reporting requirements.[187] Of note, given the confidentiality of CARE Act clinical information, without exception, the

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[176] An "assessment" is defined by Cal. Welf. & Inst. Code § 5150.4 as "the determination of whether a person shall be evaluated and treated pursuant to Section 5150."
[177] Cal. Welf. & Inst. Code §§ 5008(h) and 5150.
[178] Cal. Welf. & Inst. Code §§ 5150 and 5008(h).
[179] A 5150 hold can also be initiated for an individual who is a danger to self or danger to others. However, that hold is strictly limited to individuals suffering from a mental health disorder and cannot transition into an LPS conservatorship. Cal. Welf. & Inst. Code § 5150.
[180] Cal. Welf. & Inst. Code § 5206.
[181] *Id*.
[182] Cal. Welf. & Inst. Code § 5202.
[183] Cal. Welf. & Inst. Code § 5201.
[184] Cal. Welf. & Inst. Code § 5200. An "evaluation" is defined under Cal. Welf. & Inst. Code § 5008(a), and "consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem."
[185] Cal. Welf. & Inst. Code § 5979(a).
[186] Cal. Welf. & Inst. Code § 5976.5(e).
[187] Cal. Welf. & Inst. Code § 5985.

county behavioral health professional evaluating the CARE Act respondent pursuant to a 5200-order would be missing critical information related to making a determination of grave disability created through CARE Act intervention.[188] Without information on statewide 5200-order numbers, there is limited insight into civil interventions for CARE Act respondents when the standard support is insufficient.

In direct response to these concerns, Senate Bill 367, filed by Senator Allen on February 13, 2025, and sponsored by both the California State Association of Psychiatrists and the City of San Diego, included a provision which would allow a CARE Court judge to order a direct referral to the county officer providing LPS conservatorship investigations.[189] The CARE Court judge's inability to independently order a 5200 evaluation or include confidential CARE process documentation is also being addressed.

B. City First Responder Filings Are Different Than County or Family Filings

By the end of the first 9 months of implementation, the eight counties implementing the CARE Act received 557 petitions.[190] The dismissal rate was 39 percent, with 217 petitions being dismissed without a CARE Agreement or CARE Plan.[191] In contrast, the dismissal rate for first responder petitions in one county was 75 percent.[192] Implementation has been costly, especially considering the tens of millions invested and the low number of CARE Agreements or CARE Plans granted.[193]

These statistics only tell part of the story, however.[194] While county behavioral health departments and public conservators started out as the least likely to use CARE Court, their use has increased dramatically in the second year of implementation.[195] Additionally, families and

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[188] Cal. Welf. & Inst. Code § 5976.5(e).

[189] SB 367, 2025 Leg., Reg. Sess. 2025-26 (Cal. 2025) (as amended on March 24, 2025). In addition to CARE Court judges, SB 367 also seeks to include treating physicians, treating psychiatrists, and others as qualified to refer patients to the county agency providing probate conservatorship investigations. While CARE Act confidentiality laws significantly limit what information CARE Court judges can disclose with such a referral, amendments to the law could rectify that limitation if desired.

[190] DHCS, *CARE: Early Implementation*, *supra* note 74, at 6 (Nov. 2024).

[191] *Id*. at 6-8. There are numerous reasons CARE Act Petitions are dismissed, including, but not limited to, failure to locate, refusal to engage in a CARE Agreement, failure to meet the prima facie burden, ineligible mental health diagnosis, and/or the likelihood the respondent will voluntarily enter treatment without CARE Court intervention. Of note, petitions decreased by 13.8 percent between the last two quarters, but dismissals increased by 9.3 percent. This summary reports petitions filed statewide as: Quarter 4, 2023 (190), Quarter 1, 2024 (197), Quarter 2, 2024 (170). Dismissals: Quarter 4: 2023 (37), Quarter 1: 2024 (86), Quarter 2: 2024 (94). *Id.;* and *see* Mai-Duc, *supra* note 143.

[192] In the County of San Diego, with first responders accounting for 19 percent of the petitions filed, 12 of the 48 petitions filed by first responders received CARE Agreements. Lisa Halverstadt, *City of San Diego Urging CARE Court Reforms*, VOICE OF SAN DIEGO (Mar. 13, 2025). [Note: 17 percent were dismissed because of the respondent's refusal to engage but other cases were dismissed because voluntary engagement was successfully obtained. There is currently no regular data on the post-dismissal outcomes for respondents.]

[193] *See California State Budget 2023-24, supra* note 5, at 58.

[194] Families have been the leading group of petitioners. DHCS, *CARE: Early Implementation*, *supra* note 74, at 11 (Nov. 2024).

[195] *Id*.; and Halverstadt, *supra* note 3 (Feb. 27, 2025).

first responders have expressed discontent with the lack of elevated levels of care for respondents who are not successful in CARE Court.[196]

The differences in accessibility for families, counties, and city first responders make sense when each petitioner experience is examined. Families file CARE petitions because they have been unable to access care for their loved one through traditional channels. City first responders file petitions because county referrals and outreach have been insufficient to encourage the respondent to access care on their own.[197] Through the CARE process, courts have the opportunity to become the newest partners to families and first responders. But with many dismissals and the lack of court ordered CARE Plans in some counties, this may become another missed opportunity.[198]

For city first responder petitions and family petitions, it is not uncommon for the individual with severe mental illness to refuse to cooperate.[199] In contrast, county petitions to CARE Court are sometimes made as an alternative to a conservatorship proceeding already in progress.[200] It is not surprising that county referrals would make up the majority of CARE Agreements in practice. Referral from a conservatorship process may incentivize the respondent to accept the CARE Agreement. Thus, it is not unexpected to see larger county numbers than any other applicant. In this way, the county is the only petitioner with a carrot and stick approach. The carrot is obviously the benefits of the CARE process, while the perceived stick is the alternative, undesired conservatorship.

As explained above, the CARE Act requires an individual to be (1) experiencing a severe mental disorder[201] and (2) not be stabilized in ongoing voluntary treatment.[202] The Code also requires that the respondent be either "unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating" or "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 used in Section 5150."[203] Highlighting these eligibility factors demonstrates the severity of need that must be proven to make a prima facie case.

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[196] Halverstadt, *supra* note 3 (Feb. 27, 2025); Halverstadt, *supra* note 102 (Mar. 4, 2025). https://voiceofsandiego.org/2025/03/04/an-advocate-thought-care-court-would-be-a-lifeline-then-she-used-it/.

[197] *See* articles on city first responder efforts to engage individuals in treatment outside of the criminal justice system, often focusing on the high utilizers of EMS. Examples include: Anthony Tadros et al., *Effects of an Emergency Medical Services–based Resource Access Program on Frequent Users of Health Services,* PREHOSPITAL EMERGENCY CARE: OFFICIAL JOURNAL OF THE NATIONAL ASSOCIATION OF EMS PHYSICIANS AND THE NATIONAL ASSOCIATION OF STATE EMS DIRECTORS (June 19, 2025); and
James V. Dunford et al., *Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources*, ANNALS OF EMERGENCY MEDICINE, Vol. 47, Iss. 4, 2006, at 328-336 (Apr. 2006).

[198] Halverstadt, *supra* note 3 (Feb. 27, 2025).

[199] County of San Diego reports that 18 percent of CARE Act petitions are dismissed due to refusal to engage. *Id.*

[200] Mai-Duc, *supra* note 143. "San Diego County's program has been among the most robust, with 221 petitions filed since it launched in October 2023, although a third of the county's participants were already under conservatorship. Irvine said 76 of the state's 100 CARE Plan participants are from the county." [*Note*: The authors of this article recognize the inaccuracies inherent in news articles on complicated legal issues. This article refers to CARE Plans in the County of San Diego, but the article should have said CARE Agreement.]

[201] Cal. Welf. & Inst. Code § 5972(b), citing 5600.3(b)(2).

[202] *Id.* subd. (c).

[203] *Id.* subd. (d).

While the court can take any facts into account in making a prima facie determination, counties may interpret these factors differently from courts and cities. Thus, a county evaluation post-prima facie case to the court may differ dramatically from the city's assessment.

As an example, high utilization of emergency medical services (EMS) is the "canary in the coal mine" for an individual that is not clinically stable. It can serve as an early warning that something is wrong and their physical, mental health, substance use, or basic needs are not being met.[204] However, high utilization of EMS is currently not a mandatory factor taken into account when evaluating whether a patient is a good fit for the CARE process. Theoretically, a patient's use of EMS could even increase the likelihood of a CARE petition dismissal if the county evaluates them as able to access care by their historical ability to receive emergency medical services.

Another challenge in implementing the CARE Act is that the phrase "stabilized in ongoing voluntary treatment" is not defined. Verbal willingness to engage in, or current enrollment in an ACT program may need to be questioned when contrasted with the fact that someone is calling 911 more than 20 times a year. Connection and enrollment are not always the same as participation and stabilization. Additionally, reliance on 911 cannot be a lifeline for survival for someone who otherwise meets the criteria for the program. Oversight by the judge and proactive county intervention are the reasons the CARE process has the potential to make a difference in some people's lives. However, stability is not defined in the code, so there can be inconsistency in how it is applied from county to county.

In evaluating the CARE Act eligibility process, cities and counties do not always share similar interests. As discussed in section VIII(A) above, the County Behavioral Health Directors Association (CBHDA), after recognizing that almost 30 percent of the homeless population suffer from severe mental illness, recommended limiting city referrals to the CARE process for homeless respondents to a similar percentage. [205] The idea included a recommendation that inappropriate referrals should result in caps, penalties, or fines for city petitioners and paid no heed to whether petitions meet the prima facie burden already required by the CARE Act. This implication appears to highlight a lack of understanding of the unique needs of city petitions, and a disconnect in county-city stakeholder discussions.

Cities maintain EMS systems, but when behavioral health needs surpass emergency status, cities which contract with the county for behavioral health services may require county intervention with unmet behavioral health needs. In some instances, over-reliance on EMS can show lack of sufficient county engagement, but cities are not authorized to provide most behavioral health services independently, even if funding were abundant. With no mandate that cities be included in county CARE Court implementation meetings, city concerns like EMS overutilization, may not have been taken into consideration.

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[204] Tadros et al., *supra* note 197; Dunford et al., *supra* note 197;
Hemal K. Kanzaria et al., *Frequent Emergency Department Users: Focusing Solely On Medical Utilization Misses The Whole Person,* 38 HEALTH AFFAIRS 11, 1866–1875 (2019); and
B.S. Ku et al., *Factors associated with use of urban emergency departments by the U.S. homeless population*, 125 PUB. HEALTH REP. 3, 398-405 (May-June 2010), https://pmc.ncbi.nlm.nih.gov/articles/PMC2848264/, which states "Homeless people who seek care in urban EDs come by ambulance, lack medical insurance, and have psychiatric and substance abuse diagnoses more often than non-homeless people. The high incidence of repeat ED visits and frequent hospital use identifies a pressing need for policy remedies."

[205] CBHDA, *supra* note 170, at 4 and 7.

C. Individuals with Untreated Severe Mental Illness May Not Engage Voluntarily

Though the CARE Act's goal is to help the most severely mentally ill, the current model only helps those who suffer from the mildest forms of severe mental illness and are fortunate enough to have support.[206] While the parameters as to who qualifies for the CARE process appear aimed at the most severely mentally ill, some argue these are the individuals who are most difficult to reach with the current process.[207] The phrase "likely to deteriorate without care," describes a patient who desperately needs help, but also increases the likelihood that they will refuse the voluntary pathway offered through the CARE process.

This is more common than not for city first responder petitions. For respondents who lack resources and the support of family or friends, city first responders are often the only line of support in their lives. Following a CARE petition, the CARE team attempts to initiate voluntary compliance from resistant respondents.[208] For families and other petitioners unable to reach their loved one, this is a critical and a powerful tool to potentially engage them. Unfortunately, this approach is not as effective for city first responder petitions. CARE team outreach is much the same government outreach that has proven unsuccessful prior to the petition's filing. And the county FSP and housing programs offered are the same programs that the respondent has refused to engage with previously. Repeated engagement by community paramedics, homeless outreach workers, members of law enforcement, and/or EMS are often offered generously for months, and sometimes years, before a city first responder petitioner takes the extra time and effort to seek assistance by filing a CARE petition.[209] Consequently, when a city first responder has been unable to voluntarily engage a respondent, common sense dictates it unlikely they will agree to a CARE Agreement.

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[206] Help for respondents with severe untreated mental health disorders, including schizophrenia, who are resistant to accepting help, has often been sought through California policy. Hope was renewed with AOT, but few individuals were helped in California. Carrie Arnold, *How do you treat someone who doesn't accept they're ill?*, BBC (2014), https://www.bbc.com/future/article/20180806-how-do-you-treat-someone-who-doesnt-accept-theyre-ill; and California Health & Human Services Agency, *CARE Working Group Meeting*, YOUTUBE (May 17, 2023) at 3:38:15-3:40:25, https://www.youtube.com/watch?v=zhrEK3oZAOQ.

[207] CARE Working Group Meeting, *Public comment from Tanya Fedek*, who submitted a CARE Act petition for her son, "asked that there be service provider accountability and records of engagement attempts, better information sharing, and audits of cases before they are dismissed…. She said her son's case has been closed and he never received services or was offered appropriate housing. The LCSW that was assigned to him did not have the proper knowledge to address his case. He is now hospitalized… She said the patients should not suffer just because the process is still being ironed out." Cal. Health & Human Services Agency (CalHHS), *California Health and Human Services Agency Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes*, 21 (Feb. 14. 2024), https://www.chhs.ca.gov/wp-content/uploads/2024/04/CARE-Working-Group-Minutes-Feb-14-2024.pdf.

[208] Halverstadt, *supra* note 3 (Feb. 27, 2025).

[209] *See* articles on city first responder efforts to engage individuals in treatment outside of the criminal justice system, often focusing on the high utilizers of EMS. Tadros et al., *supra* note 197; and Dunford et al., *supra* note 197.

While the use of court-ordered CARE Plans was anticipated in the CARE Act, the actual use of CARE Plans varies from county to county, as previously mentioned.[210] CARE Agreements and CARE Plans are very different, however.[211]

With a CARE Plan, a participant is expected to *adhere* to the Plan, or face termination.[212] In contrast, a participant can be dismissed for failing to *participate* in a CARE Agreement even if they are not *adhering* to the agreement in part because it is not a court order.[213] Technically, even if a participant goes to jail, they can still be listed as "participating" in the county's statistics, even though their circumstances make adherence to the CARE Agreement impossible. As there is no definition of "participation," mere enrollment in a CARE Agreement may be sufficient depending on county interpretation.

Without a CARE Plan, there is no CARE Act presumption for LPS conservatorship filings, if that eventually becomes necessary.[214] A CARE Plan allows the potential for a presumption of grave disability should an LPS conservatorship be sought post-dismissal.[215] No such presumption attaches to a CARE Agreement. Therefore, using CARE Agreements alone is only a partial implementation of the CARE Act by counties. The most vulnerable respondents may eventually fail to comply with the CARE Act because their needs require a higher level of care.[216] With a CARE Agreement, the codified presumption for the most vulnerable that only attaches to CARE Plans cannot be utilized. A public defender would most certainly object if a behavioral health professional attempted to highlight a patient's lack of participation in a CARE Agreement as a presumption of grave disability.

Another challenge for the severely mentally ill is that the FSP agencies, such as ACT programs, used in CARE Agreements and CARE Plans are the same FSPs that have not adequately engaged those respondents to date. While the Department of Health Care Services (DHCS) reimburses county behavioral health agencies for outreach efforts, DHCS does not reimburse the county-contracted ACT agencies for outreach activities. These ACT agencies are also the same programs the city first responders have been encouraging respondents to enter.

Alternative and higher intensity contract oversight for CARE Act designated FSP programs may help convince more respondents to participate and, thus, achieve a higher level of success. But this begs the question, if all county-contracted FSP programs received the same level of contract oversight as the CARE Court FSP program, would court supervision be necessary?

Severe untreated mental illness and the expectation of voluntary participation in the CARE Act program should not be assumed, especially for city first responder petitioners who generally take extensive efforts to engage a respondent prior to filing a CARE petition. Changes

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[210] *See* Halverstadt, *supra* note 3 (Feb. 27, 2025), reporting that the County of San Diego does not use CARE Plans; and *see also* Devin Trubey, *Inside Sacramento County Care Court: The first few months in review*, ABC10 (Jan. 20, 2025), https://www.abc10.com/article/news/local/sacramento/inside-sacramento-county-care-court/103-54072256-e72d-49b9-be2d-9f50e3fd30f0 (reporting that the County of Sacramento intends to use CARE Plans).
[211] Cal. Welf. & Inst. Code §§ 5971(a), (b) and 5979(a); and Halverstadt, *supra* note 3 (Feb. 27, 2025).
[212] Cal. Welf. & Inst. Code § 5979(a)(1).
[213] *See* Cal. Welf. & Inst. Code § 5971(a) and (b); and Judicial Branch of California, *California Courts Self-Help Guide, About the CARE Act, What are CARE Agreement and CARE Plans?*, https://selfhelp.courts.ca.gov/care-act/about (accessed Feb. 17, 2025).
[214] Cal. Welf. & Inst. Code § 5979(a)(3).
[215] *Id.*
[216] Halverstadt, *supra* note 3 (Feb. 27, 2025); and Halverstadt, *supra* note 102 (Mar. 4, 2025).

to how counties engage respondents and the addition of alternative FSPs with greater county oversight may hold the key to better access.

D. The CARE Act's Inherent Conflicts of Interest

There is an unavoidable conflict of interest in the CARE Act's mandate that a county behavioral health services agency ("county BHS") must replace all non-county BHS petitioners at the first hearing.[217] Families and first responder petitioners generally file a CARE petition when standard county BHS are not adequately servicing a respondent's needs, and the respondent remains untreated. Once a CARE Agreement or a CARE Plan is approved, the county BHS agency is obligated to provide the needed services. If county BHS does not fulfill their duties under a CARE Plan, then financial sanctions are theoretically possible.

In contrast, a CARE Agreement is a voluntary agreement between the respondent and county BHS, rather than a court order.[218] Therefore, the primary and near-exclusive use of CARE Agreements may be because there is a financial disincentive for counties to create CARE Plans, even when a CARE Agreement is not likely to be successful. While an individualized, autonomy-focused approach is certainly preferred, an autonomy-only approach for CARE respondents may be used to conceal the more central motivation of cost avoidance. For every respondent named in a CARE petition, the voluntary county services have proven inaccessible or unsuccessful thus far.[219] If a county BHS agency initiates a CARE Plan and fails to provide these services, the county can be fined.[220] There is no similar potential for fines related to a CARE Agreement violation since it is not a court order. Thus, this creates an understandable and inherent disincentive to create a robust CARE Plan. Unfortunately, the limited pursuit of CARE Plans may be a missed opportunity for some respondents whose petitions are otherwise dismissed. Of note, however, even with a higher use of CARE Plans, there is no evidence that it would improve outcomes for those otherwise dismissed for failure to engage, since the entire program remains voluntary.

CARE petitions may also be dismissed when respondents are voluntarily willing to engage in treatment.[221] However, while some respondents may express their verbal willingness to engage in treatment,[222] respondent willingness may sometimes be more indicative of knowing how to avoid the system, rather than a true readiness for voluntary treatment.[223] Oddly, as the CARE Act is currently written, a respondent's *likelihood* to engage, rather than a demonstration of sustained participation, is enough for county BHS to recommend dismissal from the CARE process.[224] This codified dismissal option is surprising, however, considering an element of CARE process eligibility is that the "person is not clinically stabilized in on-going voluntary treatment."[225] A *likelihood* that a respondent will engage in treatment cannot be equated to

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[217] *See* Cal. Welf. & Inst. Code § 5977 (b)(6)(A).
[218] *See* Cal. Welf. & Inst. Code §§ 5971(a)-(b); and Judicial Branch of California, *supra* note 213.
[219] Petitions through the CARE Act can only be filed when CARE Court represents the least restrictive alternative. Cal. Welf. & Inst. Code § 5972(e).
[220] Cal. Welf. & Inst. Code § 5979(b).
[221] Cal. Welf. & Inst. Code § 5977(a)(5)(A).
[222] *See id.*
[223] Angela Fagerlin, PhD, *When patients lie*, AAMC (June 4, 2019), https://www.aamc.org/news/viewpoints/when-patients-lie.
[224] *See* Cal. Welf. & Inst. Code § 5977(a)(5)(A).
[225] *See* Cal. Welf. & Inst. Code § 5972 (c).

stability in on-going treatment. Treatment for a short period of time does not necessarily mean stability, even if the attempt is voluntary.[226] Substance use relapse is extremely common and directly affects prolonged engagement.[227] However, the CARE Act does not specify what stabilization in treatment means, and the *likelihood* language is explicit. Thus, there is an inherent conflict in the eligibility criteria for the CARE process and the potential justification for a petition's dismissal.

This ambiguity related to stabilization is especially true for petitions filed by city first responders. A city first responder may submit a CARE petition when an individual is only two weeks into treatment in order to help them sustain their care. Unfortunately, under the vague language discussed above, county BHS may deem that person "stabilized" from the moment they engage with a provider. Given the discretion held by each county, prior history of failed treatment attempts and the respondent's high utilization of 911 may or may not be enough to overcome that conclusion, as discussed above. While all facts are taken into consideration by the CARE team, the CARE Act does not require the consideration of such factors in judging stabilization. City first responders can list all relevant details in the CARE-100 form[228] and report them again to the court at the first hearing, but nothing in the CARE Act stops the case from dismissal if county BHS reports to the court that the respondent is *stabilized* in their opinion. Petitioners have no right to request an evidentiary hearing to counter the county BHS agency's position.

As discussed above, all petitioners,[229] even a self-filing respondent, are removed from their role as petitioner after the initial hearing.[230] The county BHS agency is then substituted in as the petitioner.[231] Under recent amendments, the court can allow family or roommates to stay involved to the degree that the respondent consents.[232] A voluntary supporter may assist the respondent in understanding their choices, but this role does not involve advocacy.[233] While city first responders may serve as voluntary supporters, they do not have any options for continued notifications about the status of the CARE petition.

E. City Departments Cannot File CARE Petitions

While city first responders are eligible to file CARE petitions, the city departments that employ them are not eligible petitioners under the CARE Act.[234] Some eligible first responder

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[226] J.F. Kelly et al., *How Many Recovery Attempts Does it Take to Successfully Resolve an Alcohol or Drug Problem? Estimates and Correlates From a National Study of Recovering U.S. Adults*, 43 ALCOHOL CLIN. EXP. RES.7, 1533-1544 (July 2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6602820/.
[227] *Id*.
[228] Cal. Welf. & Inst. Code § 5975(c).
[229] There is an exception to allow some family or co-resident petitioners to continue to participate or receive ongoing rights of notice. Cal. Welf. & Inst. Code § 5977(b)(6)(B). However, there is no similar option for city first responder petitioners. *Id.*
[230] Cal. Welf. & Inst. Code § 5977(b)(6)(A).
[231] *Id.*
[232] Cal. Welf. & Inst. Code § 5977(b)(6)(iii).
[233] Cal. Welf. & Inst. Code §§ 5980-5981. Every CARE respondent is appointed legal counsel to protect their rights through the process. Cal. Welf. & Inst. Code §§ 5976(c) and 5981.5. However, the information they receive consists of reports from county BHS and their client alone. Thus, conflicts and problems in treatment may not be easily observed. While some legal counsel may be more vocal than others in the CARE process, legal counsel does not have a codified role in assessing the quality or effectiveness of treatment.
[234] Cal. Welf. & Inst. Code § 5974(f).

petitioners, such as homeless outreach workers,[235] want to seek help for potential respondents, but may be uncomfortable being named as the petitioner in court. The legal process can be intimidating, and city first responders may have limited experience utilizing the courts. Additionally, confusion over the filing process (particularly e-filing) and the steps involved in the CARE process may also stop city first responders from independently filing CARE petitions—particularly due to inaccurate news reporting on how the CARE Act works.

Cities may benefit if changes, similar to those made to Gun Violence Restraining Order (GVRO) filing requirements, were adopted by the CARE Act. When GVROs were first introduced, only an individual officer could file a GVRO as the petitioner, rather than the law enforcement agency that employed the officer. This created problems and hesitation in filings.[236] Due to advocacy by the San Diego City Attorney's Office, changes in the law now permit law enforcement agencies to file GVROs, as long as they are accompanied by affidavits from knowledgeable officers as to the merits of the filing.[237] While only law enforcement officers are listed as appropriate petitioners for filings,[238] the law now clarifies that a "petition brought by a law enforcement officer may be made in the name of the law enforcement agency in which the officer is employed."[239] This model has proven effective, and is also reflected in Judicial Council GVRO forms.[240]

City first responders are not yet permitted to file CARE petitions in the name of their city department under the CARE Act. This may at least partially explain the initial data indicating that cities are not filing nearly as many petitions as expected.[241]

F. Challenges for City First Responders in Completing the CARE-101 Form

Currently, CARE petitions require both a CARE-100 petition form[242] (filled out by the original petitioner[243]) and a CARE-101 form[244] (completed by a licensed behavioral health professional).[245] Some petitioners have expressed frustration that the CARE-100 petition is so complicated to fill out.[246] And unfortunately, many persons authorized to initiate a CARE petition do not have access to a licensed behavioral health professional to complete the CARE-101. This means petitioners, including city first responders, may see themselves as unable to file

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[235] Cal. Welf. & Inst. Code §§ 5171(i) and 5974(f).
[236] Author's Interview with Nicole Crosby, former Chief of the San Diego Office of the City Attorney's Gun Violence Response Unit on Mar. 13, 2025.
[237] *Id.*
[238] Cal. Penal Code § 18170.
[239] Cal. Penal Code § 18109.
[240] Judicial Branch of California, *Petition for Gun Violence Restraining Order (GV-100)* (Jan. 1, 2025), https://www.selfhelp.courts.ca.gov/jcc-form/GV-100.
[241] Halverstadt, *supra* note 192 (Mar. 13, 2025), which states that County of San Diego data shows only 19 percent of petitions in the initial 15 months were from first responders. [*Note*: Outcome data is not available.]; and DHCS, *CARE: Early Implementation*, *supra* note 74, at 11 (Nov. 2024).
[242] Judicial Branch of California, *Petition to Commence CARE Act Proceedings (CARE-100)* (Sept. 1, 2024), https://selfhelp.courts.ca.gov/jcc-form/CARE-100.
[243] Cal. Welf. & Inst. Code § 5975(a)-(c).
[244] Judicial Branch of California, *Mental Health Declaration-CARE Act Proceedings (CARE-101)*, (Sept. 1, 2024), https://selfhelp.courts.ca.gov/jcc-form/CARE-101.
[245] Cal. Welf. & Inst. Code § 5975(d)(1).
[246] CalHHS, *supra* note 207, at 3 (Feb. 14. 2024), which reports that CalHHS Deputy Secretary Stephanie Welch heard complaints from CARE Court pilot counties, that "the petition itself is complex and difficult to fill out."

a CARE petition.

The CARE Act uses the definition for a "licensed behavioral health professional" found in Welfare and Institutions Code section 4096(j) for *Programs for Seriously Emotionally Disturbed Children and Court Wards and Dependents*.[247] Here, behavioral health professionals are used to certify that a child has been assessed for serious emotional disturbance criteria.[248] Section 4096(j) defines a *licensed behavioral health professional* as

> a physician licensed under Section 2050 of the Business and Professions Code, a licensed psychologist within the meaning of subdivision (a) of Section 2902 of the Business and Professions Code, a licensed clinical social worker within the meaning of subdivision (a) of Section 4996 of the Business and Professions Code, a licensed marriage and family therapist within the meaning of subdivision (b) of Section 4980 of the Business and Professions Code, or a licensed professional clinical counselor within the meaning of subdivision (e) of Section 4999.12.[249]

Regrettably, this definition is only a partial list of behavioral health professionals that could be qualified to assess a potential respondent for the CARE process. For instance, if the assessor is a licensed physician assistant under the supervision of a physician, or a licensed psychiatric-mental health nurse practitioner, though they may possess the medical qualifications necessary to perform the CARE-101 assessment, they are not authorized to complete the CARE-101 form. The CARE Act authorizes a licensed behavioral health practitioner to designate a designee to perform the assessment,[250] and physician assistants and nurse practitioners can be utilized in this regard. However, the CARE-101 Judicial Council form does not currently reflect that option. Thus, unless a petitioner compares the CARE-101 form to the Welfare and Institutions Code, they would not know that such a designation is permissible. While this issue is correctable on future forms, the process will still require multiple signatures—one from the designee assessor and one from the licensed behavioral health professional. Of note, the Judicial Council offered adequate opportunity for anyone to comment on the form before it was approved. This was a nuance not easily seen prior to implementation and use.

Since cities often contract with counties to provide behavioral health services, the requirements of the CARE-101 form remain a hurdle to the submission of petitions for many cities. Cities have the option to spend funds to employ or contract licensed behavioral health professionals to complete the CARE-101 forms, or hope the court waives the requirement and orders the county to complete the CARE-101 assessment.[251] While the county can authorize its behavioral health personnel to collaborate with city petitioners and complete CARE-101 assessments for city first responder petitions, counties are not mandated to do so, and county approval of such efforts is variable. Further, a court's waiver of the CARE-101 requirement is not established in the CARE Act and remains at the discretion of the CARE Court judge.

There is an alternative to the CARE-101 affidavit requirement, but it requires proof of

[247] Cal. Welf. & Inst. Code §§ 4094-4096.6.
[248] Cal. Welf. & Inst. Code § 4096(j).
[249] Cal. Welf. & Inst. Code §§ 4096(j) and 5971(l).
[250] Cal. Welf. & Inst. Code § 5975(d)(1).
[251] CalHHS has offered to connect cities with licensed behavioral health professionals for assistance with CARE-101 assessments. Judicial Branch of California, *supra* note 244.

two 14-day involuntary hospital stays, the last one within the past 60 days.[252] This is a rare occurrence, and this benchmark is usually not met. Family and city first responders generally submit CARE Act petitions because the LPS system has failed to hold the mentally ill respondent past the 72-hours allowed under a 5150 hold.[253] Notably, a 5150 hold does not count toward this alternative requirement since it is less than 14 days. As discussed above, AOT has similar requirements[254] that have proven difficult to meet.[255]

Even submitting the CARE-100 and CARE-101 forms to the court can be a challenge for eligible petitioners. There is no simple portal for encrypted filing and not all counties allow for electronic submittal of CARE Act petitions.[256] For counties that do offer this service, filing electronically can be confusing for non-lawyers, with a filer having to choose between one of many possible vendors. To their credit, the California Health and Human Services Agency has conducted targeted outreach to encourage hospital filings to address this problem and has a Resource Center on their website.[257]

G. CARE Act Data Requirements Only Tell a Partial Story

The CARE Act's data requirements[258] tell part of the story, but they may be missing critical data. Specifically, the CARE Act measures activities and progress for admitted participants but does not require any data collection related to the activities or progress of respondents dismissed without a CARE Agreement or CARE Plan. Senate Bill 1400 (2024) partially addressed this gap by codifying requirements for additional data, including but not limited to, data related to county outreach and engagement activities, the number of days between a petition and its disposition, and the number of contacts made to county BHS agencies about individuals eligible for the CARE process. [259]

However, the CARE Act's data requirements still do not require counties to collect or report data pertaining to the following categories:

- The number of petitions in each petitioner category and their respective dismissal rates.[260]

[252] Cal. Welf. & Inst. Code § 5975(d)(2).
[253] Several family stories expressing frustration with this consistent occurrence have been expressed during public comment at CARE Act Working Group Meetings, but they are too numerous to list. *See* Halverstadt, *supra* note 102 (Mar. 4, 2025); and
see also The Office of the Governor of California*, Press Release: Governor Newsom's New Plan To Get Californians In Crisis Off The Streets And Into Housing, Treatment, And Care*, 2 (Sept. 26, 2024).
[254] Cal. Welf. & Inst. Code § 5346. AOT is similar to the CARE Act and the AOT court has no means to force treatment or medication compliance.
[255] *See* Cal. Welf. & Inst. Code § 5346(a)(4); and Newsom, *State of the State, supra* note 83.
[256] California Courts, *Self Help Guide: How to file the CARE petition* (accessed April 15, 2025), https://selfhelp.courts.ca.gov/care-act/how-to-file.
[257] California Health & Human Services (CalHHS), *CARE Act Resource Center* (accessed April 15, 2025), https://care-act.org/.
[258] Cal. Welf. & Inst. Code § 5985.
[259] SB 1400, *supra* note 71.
[260] Halverstadt, *supra* note 192 (Mar. 13, 2025), stating that County of San Diego data shows only 12 of 48 first responder filed petitions resulted in CARE Agreements.

- The number of CARE Act respondents given an order for a grave disability evaluation pursuant to section 5200 at any point in the process.[261]
- The number of individuals who were referred to an FSP after dismissal or termination from the CARE process.
- The number of individuals who enrolled in an FSP after dismissal or termination from the CARE process.
- The number of dismissed or terminated individuals who were able to maintain enrollment in an FSP for at least one-year post-enrollment.

While additional data collection could be seen as a burdensome requirement, these significant gaps in data collection make it difficult for the state to hold local jurisdictions accountable for their provision of behavioral health services.

H. CARE Act Confidentiality Rules May Block Access to Care

The detailed clinical evaluations and reports of a respondent's progress created throughout the CARE process are strictly confidential.[262] These evaluations could be helpful for ongoing care in different environments, but due to the CARE Act's confidentiality rules, "[a]ll reports, evaluations, diagnoses, or other information filed with the court related to the respondent's health shall be confidential" and may not be shared by the county with anyone.[263]

This confidentiality requirement is far beyond that of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996[264] or the California Confidentiality of Medical Information Act (CMIA).[265]

If CARE Act evaluations could be shared with treatment providers, who are already subject to HIPAA and CMIA confidentiality rules, an argument can be made that a CARE Act dismissal could still offer some benefit to the respondent, due to the data that may have already been collected. As stated above, 39 percent of CARE Act petitions do not result in a CARE Agreement or a CARE Plan.[266] In some counties those numbers are even lower.[267] In many situations, this can mean that respondents continue to cycle through the system without access to care. If the evaluations and reports completed throughout the CARE process could subsequently be shared with other treatment providers for the purposes of providing treatment, the time, effort, and resources spent on CARE petitions that do not result in CARE Agreements or CARE Plans could still be well worth it. However, under the current confidentiality restrictions, evaluations performed for the purposes of the CARE process cannot be shared with other service providers,

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[261] Cal. Welf. & Inst. Code § 5200 is a court order for a grave disability evaluation. It can be ordered by any superior court judge. *Id.*
[262] Cal. Welf. & Inst. Code § 5971(f).
[263] *See* Cal. Welf. & Inst. Code § 5976.5.
[264] 45 C.F.R. §§ 160-169.
[265] Cal. Civ. Code §§ 56.10-56.16.
[266] DHCS, *CARE: Early Implementation*, *supra* note 74, at 7 (Nov. 2024).
[267] In San Diego, as of Sept. 24, 2024, 67 percent of CARE Act respondents never receive a CARE Agreement or a CARE Plan. County of San Diego Health & Human Services Agency, *Behavioral Health Services Director's Report* (Oct. 2024), https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/NOC/bhab/2024-october-bhab-meeting-materials/general-meeting/October%202024%20Director%27s%20Report.pdf#:~:text=September%2024,%202024%20.%20TO:%20Behavioral%20Health%20Advisory.

even if they could be otherwise disclosable under HIPAA or CMIA laws. Notably, other states' confidentiality rules are not as rigid.[268]

As mentioned above, without the ability to access CARE Act clinical information, any behavioral health professional evaluating a deteriorating CARE Act respondent pursuant to a 5200-order could be missing helpful information.

IX. Pending Legislation

Ideas to improve the CARE process and address many of the gaps identified in this article are in active discussion. In addition to SB 35, SB 42, and SB 1400 discussed above in section II, new legislation that would further alter the CARE Act landscape has emerged in the 2025-2026 legislative cycle.

Senate Bill 367,[269] initiated by Senator Allen, seeks to allow a CARE Court judge to make referrals directly to the county for conservatorship investigations. Current law gives the CARE Court judge no authority to refer a case to any other agency or department. Further, confidentiality rules block the sharing of information, even for the wellbeing of the respondent. This bill would allow a CARE Court judge to issue a court order authorizing the sharing of CARE information with the county officer investigating LPS conservatorships for that specific purpose.

Senate Bill 331,[270] initiated by Senator Menjivar, seeks to allow petitioners to maintain their role in CARE proceedings with the consent of the respondent. Under current law, the petitioner is replaced by the director of the county behavioral health agency in all cases at the first hearing.[271] Under this bill, the petitioner could maintain their role as petitioner throughout the proceedings and would work with county behavioral health agencies to enter into CARE Agreements with respondents. This bill would also require county behavioral health agencies to provide training for the electronic submission of CARE related forms.

Senate Bill 823,[272] initiated by Senator Stern, seeks to include bipolar I disorder as an eligible diagnosis under the CARE Act. Under current law, eligibility is limited to individuals with a diagnosis of schizophrenia spectrum or other psychotic disorders.[273]

Senate Bill 27,[274] initiated by Senator Umberg, seeks to hold the initial appearance hearing on the petition and the prima facie determination concurrently, if existing criteria for those hearings are met.

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[268] Some states have exceptions for disclosure when mentally ill patients are a danger to others or for purposes of substance use disorder treatment. *See* N.H. Rev Stat § 172:8-a (2023), https://law.justia.com/codes/new-hampshire/2023/title-xii/chapter-172/section-172-8-a/; and *see also* N.Y. Mental Hygiene Law § 9.46 (2013), https://codes.findlaw.com/ny/mental-hygiene-law/mhy-sect-9-46/.
[269] SB 367, 2025 Leg., Reg. Sess. 2025-26 (Cal. 2025) (as amended on March 24, 2025).
[270] SB 331, 2025 Leg., Reg. Sess. 2025-26 Reg. Sess. (Cal. 2025) (as amended on Mar. 24, 2025).
[271] Cal. Welf. & Inst. Code § 5977(b)(6)(A).
[272] SB 823, *supra* note 18.
[273] Cal. Welf. & Inst. Code § 5972(b).
[274] SB 27, 2025 Leg., Reg. Sess. 2025-26 Reg. Sess. (Cal. 2025) (introduced Dec. 2, 2024).

CONCLUSION

The intent behind the CARE Act is to bridge systemic gaps in mental health treatment for the most vulnerable. The State of California is motivated to make this new program work and has allocated 300 million dollars annually to support infrastructure related to the CARE Act.

Some CARE participants have already been helped by the CARE process, but others have returned to cycling between the streets, hospitals, and jails after their petitions are dismissed. Early reported numbers reveal that this may be more common for city first responder cases than county referrals. As discussed throughout this paper, the current version of the CARE Act has some challenges in the effectiveness of its processes. Whether cities can make it work will likely depend on how the law develops and evolves to address these limitations.