CARE Act

Community Assistance, Recovery, and Empowerment Act

Understanding Bipolar I with Psychotic Features

The Community Assistance, Recovery, and Empowerment (CARE) Act process outlined in **California Welfare and Institutions Code (W&I Code) sections 5970 – 5987** is a civil court process that offers multiple pathways to treatment for **eligible adults**.

Per updates in Senate Bill 27, as of January 1, 2026, bipolar I with psychotic features is an eligible diagnosis. The goal of this brief is to help county behavioral health teams, legal professionals, and system partners understand this mood disorder and how it fits into the goals and processes of the CARE Act.

Bipolar I and CARE Act Eligibility

Senate Bill (SB) 27 expanded the diagnostic criteria for the CARE Act. Originally, CARE Act eligibility required a diagnosis of schizophrenia spectrum and other psychotic disorders. SB 27 adds bipolar I disorder with psychotic features as an **eligible diagnosis** for CARE, effective January 1, 2026.

Eligibility for CARE includes **additional criteria** regarding the person's current engagement in treatment, level of functional impairment, and certain safety and risk criteria. Having an eligible diagnosis is not sufficient on its own for acceptance into CARE. Not all individuals with bipolar I will meet the other CARE criteria, and other less restrictive alternatives may be more appropriate for receiving treatment.

According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5-TR), approximately 1.5% of adults in the U.S. have been diagnosed with bipolar I

disorder in the last year. Among these individuals, there is a smaller subset with psychotic features that take place during extreme mood episodes; these individuals may also present with symptoms and functional impairments that closely resemble those seen in chronic psychotic conditions.

Notably, bipolar I disorder with psychotic features shares substantial symptom overlap with schizoaffective disorder, bipolar type (another CARE-eligible diagnosis), including the presence of mood episodes accompanied by psychosis. Including bipolar I with psychotic features as an eligible diagnosis, helps ensure that individuals with comparable clinical profiles have equitable access to the structured care, services, supports and court oversight provided through CARE.

Diagnosis & Clinical Features of Bipolar I Disorder with Psychotic Features

Bipolar I disorder differs from the psychotic disorder class of illnesses in that it is classified as a mood disorder. It is characterized by episodes of mania, depression, and sometimes both (referred to as "mixed" episodes). The onset of bipolar disorder usually occurs in late adolescence or early adulthood.

According to the DSM-5-TR, a diagnosis of bipolar I disorder requires at least one manic episode in the individual's lifetime. Additionally, symptoms of this disorder, including mood disturbance, must cause significant impairment in functioning or require hospitalization.

Psychotic symptoms may emerge only during extreme mood episodes (e.g., during an acute manic phase or major depressive episode) and resolve when the mood episode resolves. In between mood episodes, individuals do not experience persistent hallucinations or delusions. This contrasts with schizophrenia and schizoaffective disorder, where psychosis is the defining feature and can be continuous.

The psychotic symptoms of bipolar I tend to be more responsive to treatment than the primary symptoms of schizophrenia. Many individuals who experience psychosis during a manic or depressive episode can achieve full remission of psychotic symptoms with proper treatment.

During a manic episode of bipolar I, individuals may exhibit an abnormally elevated or irritable mood along with increased energy and activity. These mood disturbances are typically severe enough to cause marked impairment in social or occupational functioning.

Manic episodes often involve symptoms such as:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep.
- Pressured or rapid speech.
- Racing thoughts (sometimes referred to clinically as "flight of ideas").
- Distractibility.
- Increased goal-directed activity.
- Psychomotor agitation.
- Impulsive involvement in high-risk activities.

Depressive episodes can also occur in bipolar I disorder, which are characterized by:

- Depressed mood, hopelessness.
- Lack of pleasure/interest in activities (anhedonia).
- Low energy/appetite, sleep disturbance.
- Suicidal thoughts/ideation.

The duration of untreated episodes can range from weeks to months, and most individuals with bipolar I will experience multiple episodes (mania, depression, or mixed) in their lifetime. Some individuals may have long intervals of stability, while others have more frequent cycles of episodes.

Long-Term Outcomes

Individuals with bipolar I disorder usually have a lower incidence of anosognosia (lack of awareness of illness) compared to individuals with schizophrenia. Many individuals with bipolar I recognize changes in their mood or reality-testing, especially once the acute episode passes. As a result, they may be more amenable to engaging in voluntary treatment.

Mood-stabilizing medications can often prevent manic episodes from escalating to a more severe state, which reduces the likelihood of psychosis. Once stabilized, a person with bipolar I may not exhibit any psychosis or major functional deficits for extended periods. Many individuals are able to return to a higher level of functioning, including maintaining relationships, employment, and independent living.

The impact of treatment and supportive services on long-term outcomes is very positive. Early and sustained intervention with mood-stabilizing medication greatly reduces the frequency and severity of mood episodes, which lowers the risk of hospitalization, suicide, substance use disorder, and psychosocial decline.

Psychotherapy and community support services can improve medication adherence and coping skills, leading to better functional recovery.

In many cases, bipolar I disorder can be managed to the point that individuals experience rare relapses and in turn can lead a life of overall stability.

Treatment Recommendations

Treatment should be guided by evidence-based practices, as outlined by the American Psychiatric Association (APA). Treatments should be comprehensive and patient-centered, reflecting the person's goals and cultural background.

The APA's practice guidelines for mood disorders emphasize a combination of pharmacotherapy, psychosocial interventions, and lifestyle interventions for optimal outcomes.

Pharmacotherapy

Mood stabilizing medications can reduce manic symptoms, prevent suicide, and provide long-term mood stabilization. The presence of psychotic features often necessitates the use of **antipsychotic medication**. In some cases, an antipsychotic on its own can manage a manic episode, but combination therapy is often indicated for severe episodes. Antipsychotics are usually tapered down after the acute phase, if possible, with the mood stabilizer continued as maintenance.

Psychosocial Interventions

Several **psychosocial treatments** can improve outcomes in bipolar I disorder. Evidence-based modalities for bipolar disorder include:

- **Cognitive-Behavioral Therapy (CBT)** to help individuals identify and manage triggers for mood swings and challenge dysfunctional thoughts.
- **Family Psychoeducation (family-focused therapy)**, which educates family members on mental illness, communication and problem-solving skills, warning signs of relapse, and the necessity of treatment adherence.

Treatment guidelines also encourage support groups and/or peer support, and rehabilitative services when needed (e.g., supported employment or supportive housing).

Lifestyle Interventions

Lifestyle interventions are advised as part of a holistic treatment plan. Maintaining regular sleep-wake cycles is crucial, as sleep deprivation can lead to an episode of mania. Individuals are typically counseled to minimize alcohol or drug use, since substances can destabilize mood or interact with medications. Managing stress through techniques such as mindfulness or regular exercise can also be beneficial. These interventions should follow a person-centered, trauma-informed, and motivational interviewing approach to identify strategies that align with the individual's goals, cultural practices, and life circumstances.

Integration of Services for County Behavioral Health

- Provide ongoing training for behavioral health staff on the unique features of bipolar I with psychotic features, including diagnosis, treatment, and recovery trajectories.
- Update internal eligibility screening tools to include bipolar I with psychotic features.
- Ensure clinical team members and contracted providers have experience treating mood disorders, including therapies and medications specific to treating bipolar I disorder.
- Proactively reach out to clients who may now be eligible for CARE, including those whose cases were previously dismissed because bipolar I was not an eligible diagnosis.
- Ensure teams are equipped to address the symptoms of bipolar I disorder and to tailor services as the CARE participant's needs change.
- Discuss how to integrate the consideration of therapies proven effective for bipolar I disorder into CARE agreement or CARE plans.
- Routinely check-in with the individual regarding maintaining regular sleep-wake cycles and managing substance use and stress levels. Prepare for rapid intervention during manic or depressive episodes, with protocols for suicide risk assessment and management of impulsive behaviors.
- Develop safety plans that address high-risk activities common in mania. Consider including these plans in a psychiatric advance directive (PAD).
- Offer peer support, psychoeducation, and rehabilitative services as needed.