# CARE COURT: RUMORS, FACTS AND WHAT COUNTIES NEED TO KNOW

# COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT (CARE) COURT PROGRAM – SB 1338 (UMBERG)

- Today's presentation will provide a general overview of CARE Court and how we got here.
- There are big differences between the public/media narrative around CARE Court and the actual provisions of SB 1338.
- This will make it difficult for CARE Court to meet public expectations, potentially increasing pressure on counties.
- The actual provisions were the result of competing policies and political pressures, resulting in some compromises.

# NARRATIVES AROUND CARE COURT

- **Basic sponsor narrative:** Adequate services and funding are available, just mismanaged by counties and not accessed by persons who most need them. Patients need a "push" into services, and counties need courts to act as overseers/case managers.
  - Legislation provides no actual new services or funding, just a different pathway of administration.
  - Does this "push" mean involuntary treatment? This was a central question throughout the legislative process.
- **Counter-narrative:** Pro-patients' rights, against forced treatment.

# THE FINAL BILL

- **Final legislation tries to balance these tensions, without perfect success.**
  - Court may order services, with no serious consequence for patient's non-compliance.
  - No consequence for refusal to take medications as ordered.
- **This leads to conflicting public statements/narratives, indicating both that CARE Court is compulsory and that it's voluntary.**
- **This tension also plays out in other areas, family member participation in proceedings, supporter role, etc.**

## OPEN ISSUES

- **No new funding for services. State appears to recognize need to fund counties' process-related costs (investigations, court hearings, county counsel, public defender, etc.)**
- **Legal services nonprofits may represent CARE respondents – likely common only in urban areas.**
  - Counties with limited legal services nonprofits should prepare for the workload impacting the public defender's office.

# OPEN ISSUES

- **Difficult to accurately estimate caseload – both the number of petitions filed and the percentage that become full-fledged CARE cases are hard to accurately predict.**
  - State estimate of 7,000-12,000 cases is likely low.
  - Further, counties will incur burdens responding to petitions that are dismissed, and never become full-fledged cases.
- **The requirement that petitions be accompanied by an affidavit of a licensed professional person (absent multiple 5250's) will likely constrain filings.**

# THE CARE COURT PETITION PROCESS

- **The CARE Court petition process is complicated and includes legal standards that may be difficult to apply.**
  - Extensive list of potential petitioners.
  - Two separate reviews by the judge, and two court hearings before determination that respondent meets CARE criteria.
  - Courts will need to determine how to apply the statutory standards "prima facie showing that the respondent…may be" CARE eligible, and "county's report…support[s] the petition's prima facie showing."
  - Several clean up items will hopefully be addressed through 2023 legislation or Judicial Council rulemaking, including information sharing, hearsay issues, and notice.
- **This highly elaborate procedure extends through the evaluation/CARE plan development process, and throughout the case.**

# CARE PLAN CONTENTS

## Elements of a CARE Plan can include:

- Behavioral health services, as defined.
- Medically necessary stabilization medications, to the extent not described in the definition of behavioral health services
- Housing resources, as defined.
- Social services funded through Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), CalWORKs, California Food Assistance Program, In-Home Supportive Services program, and CalFresh.
- Services provided pursuant to Part 5 (commencing with WIC Section 17000) of Division 9.
- Prioritizes CARE participants for bridge housing provided by the Behavioral Health Bridge Housing program.

## CARE plan contents (and prioritization) limited to available funding and eligibility.

- Important to educate courts (and public defenders) regarding program rules and limits.

## CARE plan can drag in other local agency service providers

- Cities with state-funding housing programs

# SANCTION PROCESS

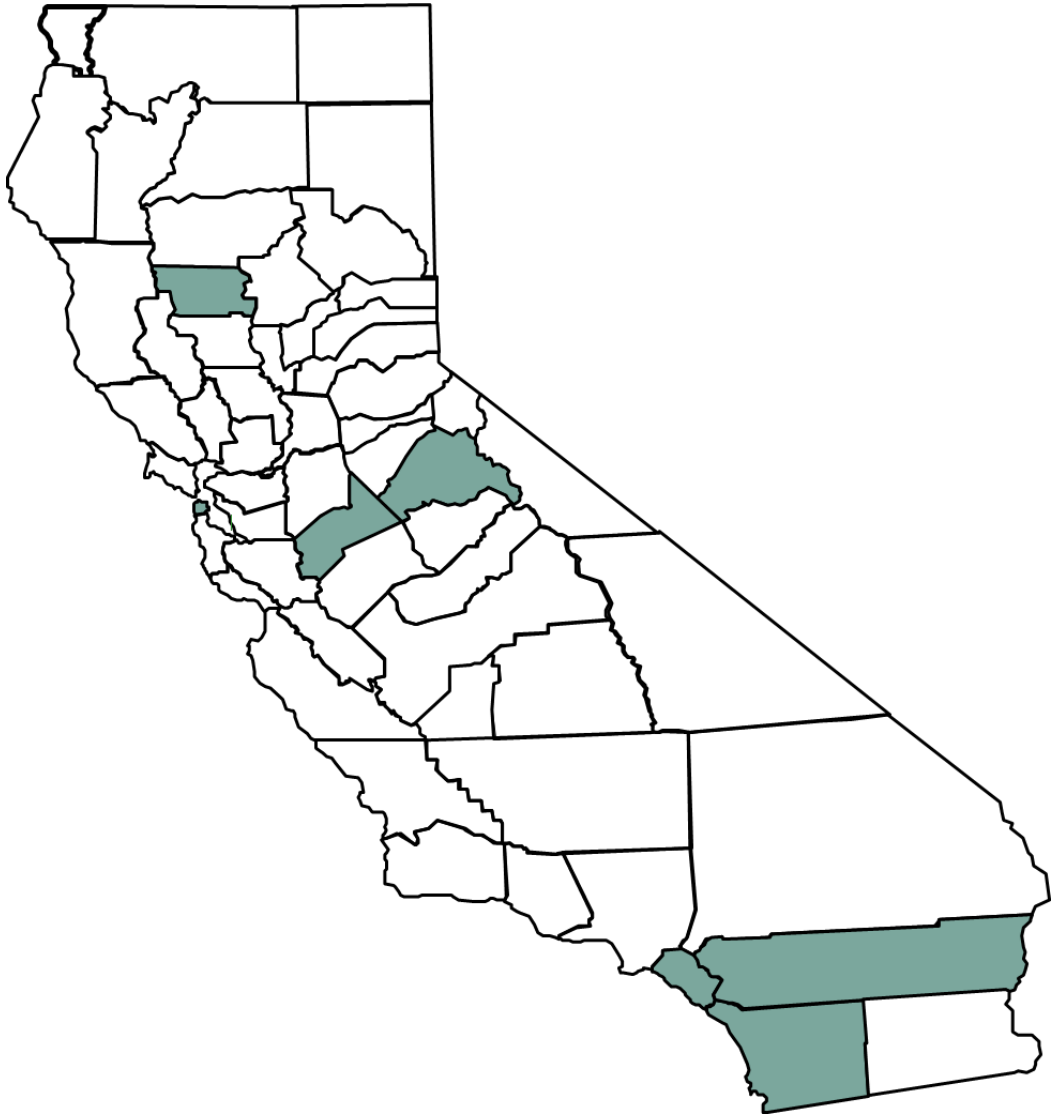
- Sanctions process: Politically unavoidable
- Counties proposed multiple alternative structures.
- Final legislation is intended to move the sanctions determination to a judicial officer not directly involved in the case - and to have the sanctions determination based on the "big picture" totality of the county's conduct across the CARE program.
- Sanctions funds ultimately return to the county with strings. (Some cleanup needed to the legislation.)

# IMMUNITY PROVISIONS

"A county, or an employee or agent of a county, shall not be held civilly or criminally liable for any action by a respondent in the CARE process, except when the act or omission of a county, or the employee or agent of a county, constitutes gross negligence, recklessness, or willful misconduct."

# GENERAL OBSERVATIONS

- **CARE Court will work best in counties where there is high trust amongst the care providers/agencies but will be difficult to implement without that.**
  - This was one of the self-selection criteria urged for Cohort 1 counties.
- **Other counties should begin inter-agency discussions to build this trust and plan for implementation without delay.**



Cohort 1 counties

# GENERAL OBSERVATIONS CONTINUED

- Because CARE Act simply layers new processes upon existing services, it will often be preferable to proactively divert potential CARE respondents into existing service pathways.
- Those willing and able to cooperate will likely move into voluntary services. (The CARE Act specifically encourages this.)
- Those who are unlikely to cooperate will likely be unsuccessful in CARE Court and may need higher levels of treatment.
- Supporter role is not entirely clear, but not the responsibility of the county.

# ON THE HORIZON

- **Phase-in implementation**
  - Cohort 1 – October 1, 2023 – 7 counties
  - Cohort 2 – December 1, 2024 – remaining counties
  - DHCS will issue guidelines allowing counties to apply for additional time to implement the CARE Act. Implementation shall occur no later than December 1, 2025.
- **Local Planning**
  - Cohort 2 – should begin meeting internally regarding planning and utilize allocated planning funding.
  - DHCS will have technical assistance available to county behavioral health agencies and counsel.
- **Clean-up Legislation**
- **Long-term Funding**

# CARE COURT FUNDING AND BUDGET UPDATE

# CARE COURT START-UP FUNDING FOR COUNTIES

- **$57 million total in one-time funding for CARE Act planning activities**
- **$26 million allocated to 7 first-cohort counties:**
  - Orange, Riverside, San Diego: $5.7M each
  - San Francisco, Stanislaus: $3.4M each
  - Glenn, Tuolumne: $1.1M each
- **$31 million allocated to all 58 counties for planning purposes via allocation formula:**
  - 50% based on each county's proportional share of the statewide population
  - 50% based on each county's proportional share of the estimated statewide homeless population
  - Minimum of $250,000 per county

Appropriated to the Department of Health Care Services (DHCS) in AB 179 (Budget Bill Jr.)

Allocated to counties by DHCS in consultation with CSAC, UCC, and RCRC.

Counties received allocations in November 2022.

DHCS issued guidance on general uses of startup funding via BHIN 22-059 – allowable uses are broad and closely follow provisional language included in AB 179.

## GENERAL USES OF CARE ACT STARTUP FUNDING
## DHCS GUIDANCE VIA BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN) 22-059

**Policy:**

"Of the $57 million, $31 million is available for each county and the City and County of San Francisco to support planning and preparation activities, including, but not limited to, hiring, training, and development of policies and procedures, and to support information technology infrastructure costs, including, but not limited to, changes needed to electronic medical record systems, changes to collect needed reporting data, and case tracking and new billing processes to bill commercial plans, and excluding capital expenses.

Of the $57 million, $26 million is available to support Cohort I county planning and preparation to implement the CARE Act."

# ONGOING FUNDING COMMITMENT
## SB 1338 (UMBERG/EGGMAN)

- SB 1338 includes a statutory commitment (WIC section 5970.5(d)) that the CARE Act will become operative only upon the Department of Health Care Services (DHCS) consultation with county stakeholders and the development of a CARE Act allocation to provide state financial assistance to counties to implement the CARE Act process.

- DHCS recently reached out on behalf of the Administration to CSAC and county partners to initiate the process of discussing the ongoing costs to counties of the CARE Act.

# QUESTIONS?

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