Implementation of California's Community Assistance, Recovery, and Empowerment (CARE) Act

A documentation of ongoing implementation at seven Cohort 1 counties

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Executive Summary

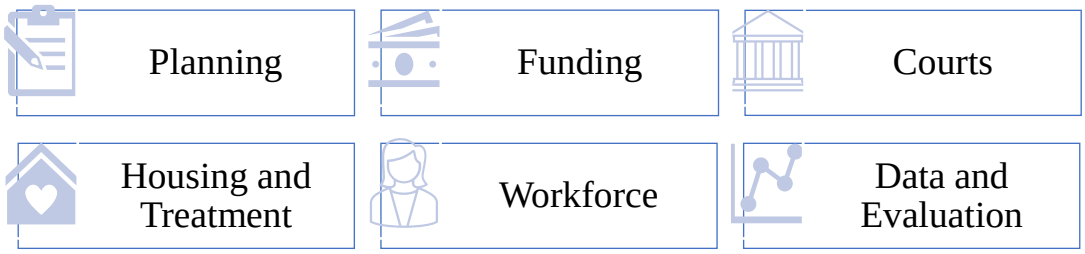
Given much attention by the media and the Governor's talking points in 2022, the CARE Act (SB 1338) was framed as a new solution to address the vexing issue of reaching those with untreated schizophrenia and psychotic spectrum disorders. Statements on the legislation were also inextricably tied to the state's homelessness crisis: CARE was seen as an important new tool to empower non-traditional actors (family members, roommates and providers) to directly initiate a civil court process for an individual (a CARE "respondent") aimed to result in treatment.

However, one important component the CARE Act did *not* include was a compulsory element. Like Laura's Law (Assisted Outpatient Treatment, AOT), the CARE Act does not impose any criminal or civil penalty on those that do not participate. In fact, the only compulsory element was on the County-side: all 58 Counties and Superior Courts are required to implement CARE by the end of 2024.

The Act legislated a two-phased approach to implementation, with seven "Cohort 1" Counties implementing by October 2023 (Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and City and County of San Francisco). Los Angeles is implementing by December 2023, and all other 50 counties in "Cohort 2" must implement by December 2024.

The state agencies leading CARE are the California Health and Human Services Agency (CalHHS), its subsidiary Department of Healthcare Services (DHCS), and the Judicial Council of California (JCC).

This paper documents the planning and considerations by the seven Cohort 1 counties (not inclusive of Los Angeles) and the one-quarter of state residents they represent, as they take on the challenge of implementing CARE on an unprecedented 13-month timeline. Findings in this report are grouped into six broad categories:



Planning

In practice, implementing a new process – even one perceived as transformational – starts with very familiar County planning tools: meetings and flowcharts. Through these, Cohort 1 Counties have been deciding how and if CARE will fit into their existing processes, which also affects the estimated number of CARE petitions. Chiefly, making CARE an explicit Conservatorship diversion tool will likely mean more petitions. Importantly, every county emphasized their estimate for the number of CARE petitions was still just an estimate: this is still the biggest planning unknown.

Another important element that will determine the potential "size" of a County's CARE program is managing the public's expectations. CARE's media coverage has been extensive, but not all of it is accurate. CARE is still billed as forced treatment, solely for those experiencing homelessness, and for any mental illnesses – none of which is wholly accurate. To shift this narrative, counties plan to leverage their partnerships with local Cities, NAMI chapters, and CBOs to get more accurate messaging out.

Finally, CARE implementation may look different in the 32 counties that have implemented Laura's Law, than the 26 that have not. Counties with Assisted Outpatient Treatment (AOT) can leverage existing staff and processes on a broader scale for CARE. For those without, County Behavioral Health may be new to the responsibility of carrying the "burden of truth" in a courtroom, and so those counties are leveraging training from Public Guardian/Conservator which are more versed in court processes.

Funding

Last year's state budget dedicated $63 million to Counties and Courts for CARE planning and implementation. However, the Administration underscored in spring 2022 that recent major homelessness and Behavioral Health investments – including the $1.5 billion Behavioral Health Bridge Housing (BHBH) program – should largely support those in CARE.

Nonetheless, counties will receive additional funding. The Governor's FY 2023-2024 May Revise Budget included $128.9 million for CARE implementation for the upcoming year, eventually scaling up to $290.6 million ongoing. In order to best leverage every funding opportunity, Cohort 1 counties are deepening their inter-County coordination on grant applications and doing their best to dial back on cost and data reporting required of overtaxed fiscal and administrative staff (wherever possible).

Courts

While the CARE Act's very involvement of courts was at the heart of arguments against it, Cohort 1 counties have welcomed the opportunity to increase collaboration between county departments and courts, and develop strategies to improve outcomes for participants in all collaborative courts.

This includes avoiding holding "court proceedings" in a court at all. Counties are exploring holding proceedings in more inviting settings: remotely (accompanied by a Social Worker); in a neutral room where the Judge can sit at the same table as a respondent; or even in treatment centers themselves.

Court self-help centers will also serve a critical role in CARE. These are likely to be the first-stop for family members seeking to file a petition, and possibly for respondents who've received one. Centers will need to be able to answer questions about process and eligibility, help with form completion, and – new for them – possibly manage unstable individuals, and provide direct County Behavioral Health referrals.

Public Defenders and Qualified Legal Service Providers are preparing for the new challenges that CARE presents. Chiefly, the tight timelines to build trust; outstanding questions around the meaning of "**likely to result** in grave disability"; how to best incorporate family members and Supporters; and whether a case manager embedded on the counsel team would help CARE respondents more readily agree to treatment.

Housing and Treatment

Cohort 1 counties are preparing a mix of new resources and fortifying existing ones for CARE respondents. Orange County is launching a new intensive treatment program (Full-Service Partnership) for individuals with schizophrenia and psychotic spectrum disorders, funded by the Mental Health Services Act. Riverside County is exploring a master-lease of an apartment complex near their courthouse: hoping to achieve better access to respondents and quickly demonstrate "carrots" of participating. Stanislaus County is utilizing their state funding to supplement Board-and-Cares.

Treating co-occurring needs will be critical. Those with CARE-qualifying diagnoses have significantly higher rates of substance use disorders (especially methamphetamine use) and physical health needs. Facilities that specialize in co-occurring treatment are in short supply.

Quality of treatment is also a key factor. Behavioral Health staff in populous counties with many services will need to consolidate information for Judicial officers and Counsel, in a way that makes clear both what is available, and what can realistically be expected for a respondent when they arrive.

Workforce

California was in a Behavioral Health workforce crisis well before the passage of CARE. Last year, more than 90 percent of counties reported difficulty recruiting LMFT, LCSWs, and Psychiatrists.

Cohort 1 counties have focused on the "long-game", such as efforts to expand the pipeline from graduate schools. Stanislaus has spearheaded a 3-county partnership with Stanislaus State University to double master in social work (MSW) slots – the only MSW program in the San Joaquin Valley. Strategies to then recruit those graduates include paid stipends, contracting clinical supervision (so as to not overburden existing staff), and streamlining hiring timelines by bringing Human Resources directly to hiring fairs for on-the-spot interviews and fingerprinting.

Finally, a less-focused aspect of the workforce crisis is the backbone administrative and fiscal staff. New state funding has been contingent on ever-more reporting and data requirements. High vacancies in important Behavioral Health administrative positions jeopardizes a county's ability to expand services.

Data and Evaluation

The data collection component of CARE is mandated in Senate Bill 1338 statute. The state is pursuing creative strategies to launch a workable data system on CARE's ambitious timeline. However, Counties are also simultaneously working through defining CARE success at the local level, and success to some county planning efforts could be staying out of the process entirely by early acceptance of voluntary treatment, or simply getting into the County Behavioral Health system. The state hopes to align its data collection and evaluation efforts with how counties are approaching defining success in CARE and leverage existing data collection processes wherever possible.

Further, the data a county feeds to the state will be largely influenced by how its CARE system is set up within existing County processes. Will CARE petitions mostly originate from non-County parties? Or will they come as a potential diversion from a Conservatorship process? As one County staff noted, "Every system is set up to get the results it gets." Even if data collection is standardized through the state's system, the forces generating that data on a county-by-county basis could be set up very differently.