SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 1338
AUTHOR: Umberg and Eggman
VERSION: April 7, 2022
HEARING DATE: April 27, 2022
CONSULTANT: Reyes Diaz

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

SUMMARY: Establishes the Community Assistance, Recovery, and Empowerment (CARE) Court Act for the purpose of providing a court-ordered CARE plan to individuals who have a severe mental illness and meet other specified criteria that includes behavioral health treatment services, a trained supporter to assist the respondent in navigating the process, and identifies an appropriate housing plan.

Existing law:

1) Implements assisted outpatient treatment (AOT, known as "Laura's Law") statewide, whereby an entity can petition for a court to order a person over the age of 18 with a mental illness to receive AOT if the court finds the individual meets specified criteria, including: a clinical determination that the person is unlikely to survive safely in the community without supervision; the person has a history of noncompliance with treatment for his or her mental illness; the person's condition is substantially deteriorating; and, participation in AOT would be the least restrictive placement necessary to ensure the person's recovery. Permits a county or group of counties that do not wish to implement Laura's Law to opt out of the requirements of AOT services through a specified process. [WIC §5346]

2) Establishes the Lanterman-Petris-Short (LPS) Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in county-designated facilities. [WIC §5000, et seq.]

3) Permits a court, after notice to the defendant, defense counsel, and the prosecution, to hold a hearing to determine whether to take specified actions, including referring a defendant to AOT or conservatorship proceedings, as specified. [PEN §1370.01]

4) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). [HSC §1340, et seq.]

5) Requires the Department of Health Care Services (DHCS) to ensure all covered mental health (MH) and substance use disorder (SUD) benefits are provided through Medi-Cal managed care plans, including a county that has opted into the Drug Medi-Cal Organized Delivery System, as specified. [WIC §14197.1]

This bill:

Court process

1) Permits a court to order an individual who is the subject of a petition (respondent) to participate in CARE Court Act proceedings if the court finds, by clear and convincing evidence, that the facts stated in the petition are true and establish that the requisite criteria set forth in this section are met, including all of the following:

    a) The respondent is 18 years of age or older;
    b) The respondent has a diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders;
    c) The respondent is not clinically stabilized in on-going treatment with the county behavioral health agency; and,
    d) The respondent currently lacks medical decision-making capacity.

2) Permits the following persons to file a petition, signed under the penalty of perjury, as specified, to initiate CARE proceedings:

    a) A person 18 years of age or older with whom the respondent resides;
    b) A spouse, parent, sibling, or adult child of the respondent;
    c) The director of a hospital, or their designee, in which the respondent is hospitalized;
    d) The director of a public or charitable organization, agency, or home, or their designee, currently or previously providing behavioral health services to the respondent or in whose institution the respondent resides;
    e) A qualified behavioral health professional, or their designee, who is, or has been, either supervising the treatment of, or treating the respondent for a mental illness;
    f) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker;
    g) The public guardian or public conservator, or their designee, of the county in which the respondent is present or reasonably believed to be present; and,
    h) The director of a county behavioral health agency, or their designee, of the county in which the respondent is present or reasonably believed to be present.

3) Requires a petition to contain, among other information, either:

    a) An affirmation or affidavit of a qualified behavioral health professional stating that the qualified behavioral health professional or their designee has examined the respondent within three months of the submission of the petition, or has made appropriate attempts, but has not been successful, in eliciting the cooperation of the respondent to submit to an examination, and that the qualified behavioral health professional had determined that, based on an examination or a review of records and collateral interviews, the respondent meets, or is likely to meet, the diagnostic criteria for CARE proceedings; or,
    b) Evidence that the respondent was detained for intensive treatment pursuant to the LPS Act within the previous 90 days.

4) Requires a court, upon receipt by the court of a petition, to set an initial hearing not later than 14 days from the date the petition is filed with the court, and to appoint counsel and a "supporter," as defined, for the respondent within five calendar days of filing.

5) Requires a court, at the initial hearing, to determine if the respondent meets the CARE criteria within 14 days after the petition is filed with the court. Requires the petitioner to be present, or the matter is dismissed.

6) Requires a court, if it finds that the petitioner has submitted prima facie evidence that the respondent meets the CARE criteria, to order the county behavioral health agency to work with the respondent and the respondent's counsel and supporter to determine if the respondent is required to engage in a treatment plan. Requires a case management conference to be set for no later than 14 days after the court makes its finding.

7) Requires a court, at the evaluation review hearing, to review the evaluation and any other evidence from all interested individuals, including, but not limited to, evidence from the petitioner, the county behavioral health agency, the respondent, and the supporter.

8) Permits a court to either approve the plan as presented and make any orders necessary for the implementation of the plan; order the plan modified to better meet the needs of the parties, approve the plan as modified, within the scope of the county behavioral health agency's services, and make any orders necessary for the implementation of the plan; or, reject the plan and order the parties to continue to work on the plan. Requires a court to set a subsequent hearing for no more than 14 days after rejecting the proposed plan.

9) Specifies that court approval of the CARE plan begins the one-year CARE program timeline. Requires a court to schedule a status conference 60 days after the approval of the CARE plan to review the progress of the plan's implementation and every 180 days thereafter. Requires a court to review intermittent lapses or setbacks experienced by the respondent.

10) Requires a court, at the 11th month of the program timeline, to hold a one-year status hearing to determine whether to graduate the respondent from the program with a graduation plan or reappoint the respondent to the program for another term, not to exceed one year, as specified.

11) Prohibits the respondent from being reappointed to the program if they have successfully completed participation in the one-year CARE program. Permits the respondent to request graduation or reappointment to the CARE program. Permits the respondent to request any amount of time, up to and including one additional year, to be reappointed to the CARE program if at completion of the first year the respondent elects to accept voluntary reappointment to the program.

12) Requires a court to officially graduate the respondent and terminate its jurisdiction with a graduation plan if the respondent requests to be graduated from, or times out of, the program, as specified.

13) Permits a court to fine a county up to $1,000 per day for noncompliance with providing a respondent CARE services. Permits a court to appoint a receiver to secure court-ordered care for the respondent at the county's cost, as specified.

14) Permits a court terminate the respondent's participation in the CARE program if, at any time during the proceedings, the court determines the respondent is not participating in CARE proceedings or is failing to comply with their CARE plan, as specified.

15) Requires respondents to have specified rights, such as to receive notice hearings, to be presented by counsel at all stages of a proceeding, to have a supporter, present evidence, and cross-examine witnesses.

Respondent's CARE supporter

16) Requires the California Department of Aging (CDA) to administer the CARE supporter program, which shall make available a trained supporter to the respondent. Requires CDA to train the supporter on supported decision-making with individuals who have behavioral health conditions and on the use of psychiatric advance directives, with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. Defines "supporter" as a trained adult who assists a respondent, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions.

17) Requires a supporter to do all the following, to the best of their ability and to the extent reasonably possible: support the will and preferences of the respondent; respect the values, beliefs, and preferences of the respondent; act honestly, diligently, and in good faith; and, avoid, to the greatest extent possible, and disclose, minimize, and manage, conflicts of interest. Prohibits, unless explicitly authorized, a supporter from make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury; signing documents on behalf of the respondent; or, substituting their own judgment for the decision or preference of the respondent.

18) Requires a supporter to be bound by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. Specifies that a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion, or mistreatment is not limited, as specified.

Respondent's CARE plan

19) Requires a CARE plan to be created by the respondent, their supporter and counsel, and the county behavioral health agency. Requires the plan to include all of the following components:

    a) Behavioral health treatment, which includes medically necessary MH or SUD treatment, or both;
    b) Requires a county to provide all medically necessary specialty MH and SUD treatment services, if the respondent is enrolled in the Medi-Cal program, as specified, to a respondent when included in their court ordered CARE plan. Permits specialty MH and SUD treatment services to be included in the CARE plan if they are determined to be medically necessary by the clinical evaluation;
    c) Encourages counties are to employ medically necessary, evidence-based practices and promising practices supported with community-defined evidence, which may include assertive community treatment, peer support services, and psychoeducation; and,
    d) A housing plan that describes the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement, as specified. Specifies that the provisions in this bill do not allow the court to order housing or require the county to provide housing.

20) Permits the CARE plan, as part of the provision of behavioral health care, to include medically necessary stabilization medications, including antipsychotic medications, including as long-acting injections, as specified. Prohibits court ordered stabilization medications from being forcibly administered, absent a separate order by the court, as specified.

21) Requires the respondent, in the development and on-going maintenance of the plan, to work with their behavioral health care provider and their supporter to address medication concerns and make changes to the treatment plan. Permits medically necessary stabilization medications to be prescribed by the treating licensed behavioral health care provider. Requires medication support services to be offered.

Coverage mandate

22) Requires a health plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses, to cover the cost of developing an evaluation for the respondent's eligibility for CARE Court and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE plan approved by a court, as specified.

23) Prohibits a health plan from requiring prior authorization for services provided pursuant to a CARE plan approved by a court under the CARE Court program. Permits a health plan to conduct a postclaim review to determine appropriate payment of a claim, and permits denial under specified circumstances. Prohibits services provided to an enrollee pursuant to a CARE plan from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. Prohibits an individual or entity from billing the enrollee or subscriber, or seeking reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE plan. Specifies that these provisions do not apply to Medi-Cal managed care contracts, as specified.

Technical assistance and administration

24) Requires, subject to an appropriation:

    a) DHCS to provide technical assistance to county behavioral health agencies to support the implementation of the requirements in this bill, including trainings regarding the CARE model and statute and data collection;
    b) DHCS to administer the Behavioral Health Bridge Housing program to provide funding for clinically enhanced bridge housing settings to serve individuals who are experiencing homelessness and have behavioral health conditions. Requires individuals who are CARE program participants to be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program; and,
    c) The Judicial Council to provide technical assistance to judges to support the implementation of the requirements in this bill, including trainings regarding the CARE model and statutes, working with the supporter, best practices, and evidence-based models of care for people with severe behavioral health conditions.

25) Permits the California Health and Human Services Agency (CHHSA), DHCS, and CDA to implement, interpret, or make specific provisions in this bill, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action. Permits CHHSA, DHCS, and CDA to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, as specified.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the authors, this bill creates the CARE Court program, which is a proposed framework to deliver MH and SUD services to the most severely impaired Californians who too often languish—suffering in homelessness or incarceration—without the treatment they desperately need. The proposed CARE Court program is a response to the urgent need for innovative solutions for individuals who are suffering with untreated schizophrenia spectrum and psychotic disorders, often unhoused in our communities, and who face high risks for repeated hospitalization, incarceration, institutionalization, conservatorship, and premature death. In California and nationally, comprehensive care, medication, and housing have been clinically proven to successfully treat and stabilize individuals with severe mental illness but are too often available only after arrest or in secure facilities. Therefore, this bill will create a program to connect a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The program provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services, including housing.

2) *CARE Court proposal.* In early 2022, Governor Newsom proposed the CARE Court program, as an alternative to amending the LPS Act, to help connect a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent, which includes short-term stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. According to the CHHSA's website, housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent, or in a vehicle. CHHSA states that CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration, based on evidence that demonstrates many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer-acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community. CHHSA further states that CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity, before they enter the criminal justice system or become so impaired that they end up in a LPS conservatorship due to mental illness. CHSSA states that although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions, and the CARE Court proposal aims to connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court is estimated to help thousands of Californians on their journey to sustained wellness. SB 1338

(Umberg and Eggman) and AB 2830 (Bloom) of this Legislative Session implement the CARE Court proposal.

3) *Senate Human Services Committee Comment*. This bill was triple referred to the Senate Human Services Committee, but due to the Covid-19 protocols, the referral to the Senate Human Services Committee was rescinded. The Senate Human Services Committee's comment on portions of the provisions of this bill that relate to their jurisdiction can be found below:

There are a variety of ways in which this proposal crosses into the human services arena, but for the purpose of this comment the focus will be on CDA's administration of the CARE Supporter program and how this proposal intersects with California's existing Housing First policies.

CDA's Administration of the CARE Support Program: Currently, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities, such as Residential Care Facilities for the Elderly or Adult Residential Facilities. CDA contracts with a statewide network of Area Agencies on Aging (who directly administer a number of programs providing supportive services, meals, community involvement, and caregiver support to eligible older adults and their families) and agencies that operate Multipurpose Senior Services Program (which operate Adult Day Health Care Centers and Medi-Cal Community Based Adult Services Program providing direct services to eligible seniors in their communities). CDA also houses the Long-Term Care Ombudsman, whose representatives assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences. None of these ongoing programs seem to directly translate to the requirements of the CARE Supporter program.

As provided for by this bill, the CARE Supporter program requires CDA to make a trained supporter available to the respondent. CDA is required to train the supporter on supported decision making with individuals who have behavioral health conditions and on the use of psychiatric advance directives, with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. Through its work on the Master Plan on Aging, and other efforts, CDA has worked with stakeholders and advocates to create plans related to Alzheimer's and other dementias, but it is unclear as to whether they have any other experience working on behavioral health conditions. It has been suggested that the diagnoses targeted through CARE Court, i.e. schizophrenia spectrum or other psychotic disorders, are similar to Alzheimer's and other dementias in that they impair the individual's decision making ability. However, it seems that the similarities between these two populations may stop there. It is very unclear how experience working with the Alzheimer's population would translate to expertise with or ability to know the needs of unhoused individuals who are severely mentally ill. Moving forward, the authors' offices may wish to work with stakeholders to ensure this bill would not incidentally impact the Alzheimer's disease and other dementias community, as well as work to examine whether CDA truly is the right home for the CARE Supporter program.

Housing First: In 2016, the state's efforts to address homelessness shifted to use Housing First core components. Senator Mitchell authored SB 1380 (Chapter 847, Statutes of 2016), which created the Cal ICH (name changed from HCFC by SB 1220, (Rubio, Chapter 398, Statutes of 2021)) to oversee implementation of the Housing First regulations and coordinate

the state's response to homelessness, as well as create partnerships among state agencies and departments, local government agencies, nonprofits, and federal agencies to prevent and end homelessness in California. SB 1380 also aligned the Housing First guidelines for any state program that provides housing and supportive services to people experiencing homelessness. Housing First means the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

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

It seems somewhat unclear how an individual meeting the requirements for participation in CARE Court can truly make progress, in terms of complying with the components of their CARE plan, if they remain unhoused. Additionally, the language of this proposal is currently silent on whether an individual who is housed through the CARE Court program may lose their housing if they fail to comply with their CARE plan, stop taking their psychotropic medications, or experience a relapse. This raises questions in regards to how the program complies with existing Housing First principals, and raises the question of whether it is creating a "Housing Second" model. The authors' offices may wish to consider working with stakeholders to ensure the provisions of the CARE Court align with Housing First, and to seek to address whether components of a CARE plan can be successfully implemented when respondents remain unhoused.

4) *Double referral.* This bill is double referred to the Senate Judiciary Committee. Should it pass out of the Senate Judiciary Committee, it will be referred to this Committee.

5) *Related legislation.* SB 1416 (Eggman) expands the definition of "gravely disabled" to include the inability of an individual to provide for their basic personal needs for medical care for the purpose of involuntarily detaining the individual for evaluation and treatment of a mental health condition, as specified. *SB 1416 passed this Committee by a vote of 9-0 on April 20, 2022.*

SB 1337 (McGuire) requires health plans and insurers to provide coverage of coordinated specialty care for the treatment of first-episode psychosis according to detailed specifications and billing requirements. Requires DMHC, Department of Insurance, and DHCS to create a working group that meets once per month for one year to establish guidelines, and 60 days

after the guidelines are established, regulations to be adopted. *SB 1337 is scheduled to be heard in this Committee on April 27, 2022.*

AB 2830 (Bloom) is identical to this bill. *AB 2830 is pending in the Assembly.*

6) *Support.* NAMI-CA believes that all people should have the right to make their own decisions about medical treatment but states that there are individuals with serious mental illnesses, such as schizophrenia and bipolar disorder, who at times, due to their illness, lack insight or good judgment about their need for medical treatment. In cases like this, a higher level of care may be necessary, but must be the last resort. NAMI-CA members have been calling for reform for their loved ones for years. NAMI-CA believes that the availability of effective, comprehensive, community-based systems of care for persons suffering from serious mental illnesses will diminish the need for involuntary commitment and/or court-ordered treatment. NAMI-CA argues that before we reach the stage of last resort, we must fully fund, build, and staff our community-based system so all who need care can access it long before they reach a crisis level. NAMI-CA is heartened to see that accountability is one of the pillars of the CARE Court framework and believes we must hold the system accountable at all delivery points. The California Hospital Association states that this bill holds great promise of creating new pathways to treatment and housing for the many individuals hospitals see each day who, under the status quo, may otherwise continue to cycle needlessly through periods of crisis, homelessness, failing health, and hospitalization. Hospitals are hopeful that impending behavioral health capital infrastructure and workforce investments will expeditiously create the missing levels of care our communities so desperately need for individuals living with a serious mental illness.

7) *Opposition.* A coalition of opponents, the majority of the listed opposition comprised of advocates that advance and protect the civil rights of Californians living with disabilities, experiencing homelessness, and involved in the criminal legal system, argues that the CARE Court framework is unacceptable for a number of reasons:

- It does not guarantee housing as a solution to address homelessness;
- Evidence shows that adequately resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment;
- It will perpetuate institutional racism and worsen health disparities;
- There are flaws in this bill's reliance on a person's lack of capacity to make medical decisions;
- Use of the terms "supportive decision-making" and "supporter" reflects a misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court; and,
- Critical terms and concepts are not defined in this bill or elsewhere in California law.

The coalition in opposition further states that CARE Court is a system of coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives. CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction, and is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness. While the coalition in opposition agrees that state resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, CARE Court is the wrong framework.

The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services. The coalition in opposition argues that California law is very clear about the process to determine whether a person lacks capacity to make medical decisions, which includes the right to a court hearing, that must be followed, and this bill does not require any of these steps. Instead, it allows unacceptable shortcuts.

The Drug Policy Alliance (DPA), not part of the coalition described above, argues similar points regarding institutional racism and needed investments for housing and community-based services. DPA also states that though this bill does not name substance use as a criterion for qualification for CARE Court, both Governor Newsom's statements and information about the plan released by CHHSA notably do. Regardless, despite not articulating people using drugs as a target population for CARE Court, people on the streets dealing with addiction will almost certainly be swept into these proceedings. This inevitability is due in large part to the broad category of people who can petition to force an individual into CARE Court proceedings, as well as the incredibly low threshold for triggering an initial hearing on the petition. The current process outlined in the CARE Court proposal will lead to people who have no expertise in healthcare attempting to make complex medical determinations, which they will undoubtedly get wrong at least some, if not most, of the time. Therefore, DPA believes that instead of the person who has been forced into CARE Court getting treated with true care, dignity, and properly tailored support, they will undergo the stressful experience of undergoing a confusing and intimidating court process. CARE Court sends a message to vulnerable people dealing with myriad struggles that they are wrong, because things don't end up in court when they are right. DPA states California can and must do better.

8) *Letters of concerns.* A coalition of county representatives (California Association of Public Administrators, Public Guardians, and Public Conservators; California State Association of Counties; County Behavioral Health Directors Association; County Welfare Directors of California; Rural County Representatives of California; and Urban Counties of California) expresses their concerns with the understanding that additional collaboration and technical work is required. This coalition states that CARE Courts require significant engagement from counties—especially county behavioral health and county public defenders—from beginning to end, and members have raised some questions regarding the language in this bill, such as:

- How will the proposed statutory CARE Court timelines be integrated so that they are consistent and achievable?
- How will the processes related to petitioning, settlement, development of a CARE Court treatment plan, and graduation or failure from the program be refined?
- Will the required levels of evidence be standardized throughout the process?
- Will continuity of services be ensured upon graduation?
- Will additional details regarding the provision of housing by all levels of government, including counties, cities, and continuums of care be included?
- How will the state estimate and provide resources for the integral role of counties in CARE Courts, including state mandated services and any new responsibilities subject to Proposition 30?
- Is the civil court system the proper venue for engaging those who initially lack medical decision- making capacity?

- Are CARE Courts potentially redundant considering the robust mental health, drug, and other specialty courts currently operating in most counties?
- Could the state implement CARE Courts as an opt-in pilot project to test and improve the process, gauge the resources required for scalable success, and gather data to determine if the outcomes align with the policy intent?

The county coalition also expresses strong opposition to the proposed penalties and court-ordered receivership for counties that fail to meet the court's undefined expectations in this bill. The ability of county behavioral health to respond to increased demand for clinicians to engage in CARE Court, or for services that go beyond existing Medi-Cal entitlement services, will depend entirely on the state's willingness to fund these new activities. Allowing the court to order services beyond counties' existing contracted obligations under Medi-Cal and other regulatory and statutory requirements could result in fines, penalties, and corrective action across multiple existing regulatory frameworks and sets a dangerous precedent for a publicly funded safety net system acting as an arm of the state. Also, penalizing the very system that is attempting to provide the services is counterproductive at best. Counties are committed to working with all stakeholders to implement CARE Courts in a conscientious and sustainable manner to achieve Governor Newsom's vision of early intervention and assistance for some of the most vulnerable Californians.

The California Psychological Association (CPA), not part of the county coalition described above, expresses concerns about language in this bill that provides for psychologists to involve themselves at multiple points, including the ability to serve as a petitioner, provide court attestation to initiate proceedings, or provide the clinical assessment of the respondent. However, unlike statute within the LPS Act, there is no safe harbor provision for any professional operating within the program. The risk exposure to these professionals demands the need for statutory immunity from criminal and civil liability, both for involvement and lack of involvement with the CARE Court program. CPA also sees potential difficulties in creating an overly burdensome process with aggressive timelines for providers working in Medi-Cal and county behavioral health facilities, arguing that CARE Courts would further strain California's precarious public behavioral health delivery system, unless there are significant investments into workforce development and financial support for licensed behavioral health professionals within Medi-Cal, including psychologists.

A second coalition with concerns (California Alliance of Child and Family Services, California Association of Alcohol and Drug Addiction Program Executives, California Association of Social Rehabilitation Agencies, and California Council of Community Behavioral Health Agencies) largely echoes the concerns expressed by the county coalition and additionally is concerned that CARE Court does not include some critical protections and safeguards outlined in AOT, which authorizes a court to order an individual with a mental illness in counties that have not opted-out onto court-ordered services. AOT eligibility criteria is more specific than CARE Court and critically requires that an individual has been offered an opportunity to participate in a treatment plan, and the person continues to fail to engage in treatment, and that participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability. This coalition further states that while CARE Court is not intended to be a silver bullet solution to homelessness, likely a significant portion of the individuals in CARE Court will be experiencing homelessness or housing insecurity. The coalition states it is also important to note that research from Dr. Margot Kushel of UC San Francisco indicates that half of all

individuals experiencing homelessness today are over the age of 50 with half of this population having their first experience of homelessness after they turned 50 years old. There is a significant percentage of this population who have geriatric conditions beyond their biological age, and the coalition questions if the CARE plan designed within the CARE Court model includes adequate access to primary care and physical health care services.

9) *Policy concerns.* The CARE Court proposal largely is modeled after the AOT court process with some timelines and processes that go beyond what is required in AOT, particularly:

   a) Allowing a petition to include an affirmation or affidavit from a qualified behavioral health professional that an examination on the respondent was conducted within the previous three months;
   b) Allowing one 14-day intensive treatment episode within the last 90 days to be used as evidence that a respondent should be considered for CARE Court; and,
   c) Permitting a court to modify a CARE plan to better meet the needs of the parties.

   Additionally, background information for the CARE Court proposal recognizes that a respondent will have lapses and setbacks over the period of the CARE plan, and this bill requires a court to review those intermittent lapses and setbacks. However, there is no provision that specifies a respondent would not be penalized.

   Concerning the health care service plan contract provision, this bill is not clear that it would apply to only covered services offered by a plan, or if it's an expansion, nor does it specify that a health care service plan can require services to be provided by in-network providers.

10) *Amendments.* To address the concerns mentioned above, the authors may wish to consider the following amendments:

   a) Require a petition to include an affirmation or affidavit from a qualified behavioral health professional that an examination was conducted on the respondent within the previous 14 days of submission of the petition;
   b) Require three previous intensive treatment episodes within the last 90 days with the most recent episode having occurred within the previous 14 days as evidence that a respondent should be considered for CARE Court;
   c) Specify that a court is permitted to modify a CARE plan to better meet the needs of the respondent pursuant to the CARE plan; and,
   d) Specify that a respondent's lapses and setbacks alone should not preclude them from participating in any treatment services or make them ineligible for housing options that have been ordered in the CARE plan.
   e) Specify that the health care service plan is required to provide covered services, and that the health care service plan can require services to be provided by an in-network provider if one is available and qualified to provide the services.

SUPPORT AND OPPOSITION:

Support: Bay Area Council
Building Owners and Operators Association
California Hospital Association
Civic Center and Mid-Market Community Benefit Districts
Golden Gate Restaurant Association
Hotel Council of San Francisco

NAMI-CA
San Francisco Chamber of Commerce
San Francisco Partnership
San Francisco Travel Association
Union Square Alliance

Oppose: American Civil Liberties Union California Action
Anti-Police Terror Project
Bay Area Legal Aid
Bazelon Center
Cal Voices
California Advocates for Nursing Home Reform
California Association of Mental Health Peer-Run Organizations
California Care First Coalition
Caravan4Justice
Corporation for Supportive Housing
Decarcerate Sacramento
Disability Rights Advocates
Disability Rights California
Disability Rights Education and Defense Fund
Disability Rights Legal Center
Drug Policy Alliance
Funders Together to End Homelessness
Housing California
Housing is a Human Right Orange County
Human Rights Watch
Justice in Aging
JusticeLA
Justice2Jobs Coalition
La Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Love and Justice in the Streets
Mental Health Advocacy Services
Mental Health America of California
Mental Health First
National Health Law Project
National Homelessness Law Center
New Life Ministries of Tulare County
People's Budget of Orange County
Project Amiga
Psychologists for Social Responsibility
Public Interest Law Project
Racial and Ethnic Mental Health Disparities Coalition
Rosen Bien Galvan & Grunfeld LLP
Sacramento Homeless Organizing Committee
Sacramento LGBT Community Center
Sacramento Regional Coalition to End Homelessness
San Bernardino Free Them All
San Francisco Pretrial Diversion Project

San Francisco Public Defender's Office
Starting Over, Inc.
Street Watch LA
The Coelho Center for Disability Law, Policy, and Innovation
The Justice Teams Network
The SmithWaters Group
Western Center on Law and Poverty
Western Regional Advocacy Project
One individual

-- END --