State of California
Major Behavioral Health Initiatives & Implementation of the CARE Act

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Presentation to the California Association of Collaborative Courts

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California Health and Human Services Agency

***Person Centered. Equity Focused. Data Driven*.**

California's Behavioral Health Crisis

- **1 in 20** California adults living with a **Serious Mental Illness** (SMI)
  - >50% increase in the past decade *(2008 – 2019)*
- **1 in 13** children in California has a **debilitating mental illness**, higher rates among low-income children and Black or Latino children
  - >50% increase in suicide rates among black youth *(2011 to 2020)*
- **Half** of Californians reported symptoms of anxiety or major depression related to the pandemic *(July 2020)*
- **1 in 10** Californians have a **substance use disorder**
  - 95% increase in drug-related overdose rates *(2014 to 2020)*
  - 109% increase in opioid-related overdoses *(2019 to 2021)*

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State's Infrastructure lacks Capacity to meet the Growing Need

Residential

- Psychiatric inpatient beds **decreased 42%**
  1995-2017 (per capita)
- Greater need for youth placements in Substance Use Disorder residential facilities
- **Limited placements** in system for individuals with **complex conditions/histories** in mental health residential treatment

Workforce

- By 2028, State will have
  - **41% fewer** psychiatrists; and
  - **11% fewer** psychologists, LMFTs, LPCCs, and LCSWs than needed
- Behavioral health practitioners are not representative of those in need
  - **2-10x less likely** to be Latino;
  - **1-2x less likely** to be Asian; and
  - **1-3x less likely** to be African-American than general population.

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Intersection with California's Homelessness Crisis

Affordable housing, related supports (incl. employment) remain a top priority

- **160,000 people** experiencing homelessness in CA
  2020 HUD
  - ~30% of the nation's homeless population
  - 42% increase in homelessness
    2014-2020
- **23%** of California's homeless have a **Serious Mental Illness** (SMI)
  2020 HUD
- **22%** have **chronic substance abuse**
  2020 HUD
- State hospital psychiatric clients that are homeless have **doubled**
  2010-2020 SAMHSA

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Sources: HUD, 2021; SAMHSA, 2020 / SAMHSA, 2010

Intersection with Criminal Justice System

Mental health

- **65% increase** in last decade of those with an active mental health case in California jails

Substance use

- **66%** of Californians in jails or prisons have moderate or high **need for substance use disorder treatment**
- **Overdose is the leading cause of death** for people recently released from incarceration
- California's incarcerated have drug overdose death rate >3x nationwide rate

Racial disparities

- **29% of incarcerated men are Black**, while Black men make up only 5.6% of California's population

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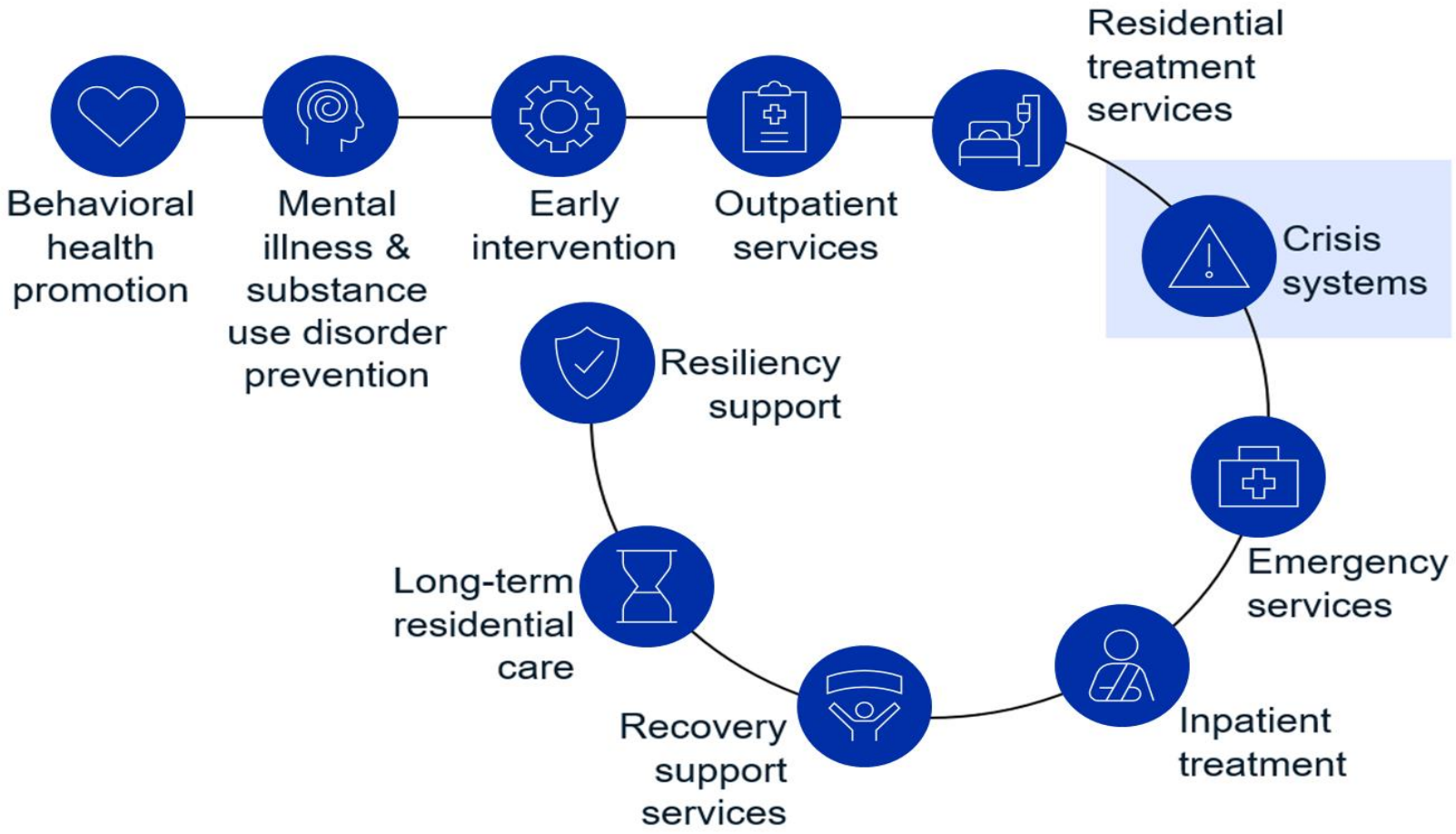
Strategies for Behavioral Health System Transformation

California Health and Human Services Agency (CalHHS) major initiatives and goals

Continuum of Care model



CalHHS Strategic Priorities

Create an Equitable Pandemic Recovery

Build a Healthy California for All

Integrate Health and Human Services

Improve the Lives of the Most Vulnerable

Advance the Well-being of Children & Youth

Build an Age-Friendly State for All

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Goals of CalAIM (California Advancing & Innovating Medi-Cal)

Simplifies, modernizes and improves Medi-Cal behavioral health.

What	How
• Identify and manage comprehensive needs	→ ***whole person care*** *approaches and addressing social drivers*
• Improve quality outcomes, reduce health disparities, and transform the delivery system	→ *value-based initiatives, modernization and* ***payment reform***
• Make Medi-Cal a **more consistent and seamless** system for enrollees to navigate	→ *reducing complexity and increasing flexibility*

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Key Behavioral Health system innovations in CalAIM

System-wide

- **"No wrong door" approach**. Streamline MH and SUD services to address reality that many people need both
- **Enhanced Care Management** for intensive, community-based care coordination for those with SMI
- **Payment reform**: modernize to incentivize outcomes and quality over volume and cost
- More collaborative and regional administration in county specialty MH and SUD services
- New funding for **BH continuum infrastructure**
- Contingency management pilot will offer incentive rewards and payments for positive behavioral changes
- New care model for **foster children and youth**
- Medicaid 1115 waiver for broader use of community-based and inpatient care

Justice-involved

- Enrollment in **Medi-Cal pre-release**
- Community Supports (e.g., housing, food supports) **available upon re-entry**, including residential SUD treatment
- **"Warm handoffs"** to healthcare providers ensuring individuals set up with behavioral health services, medications, etc.

Sources: CalAIM Behavioral Health and Justice-Involved initiatives

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Update Drug Medi-Cal Organized Delivery System Benefits based on lessons learned

DMC Benefits	DMC-ODS Benefits
Outpatient treatment	Early intervention (for beneficiaries under 21)
	Outpatient/Intensive outpatient
Intensive outpatient	Residential/inpatient services
	Withdrawal management
Residential SUD services for perinatal women only (16 beds or fewer)	Narcotic treatment program
	MAT
Naltrexone treatment (oral for opioid dependence or with TAR for other)	Recovery services
	Care coordination services
Narcotic treatment programs (methadone only)	Clinician consultation services
	Partial hospitalization (optional)
Detoxification in a hospital	Peer support services (optional)
	Contingency management (optional)

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New Investments in Behavioral Health

Approved in last two State budgets FY 2021-22 and FY 2022-23

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Children and Youth

$4.4b for Children and Youth Behavioral Health Initiative

Enhance, expand and redesign the systems that support behavioral health for children and youth.

- **$100m** for a Public Education and Change campaign

  Co-designed for and by youth in order to raise behavioral health literacy and reduce stigma among youth, caregivers, and their communities.

$139.2m for Addressing Complex Care Needs for Foster Youth

Assist counties with serving foster youth with complex needs and behavioral health conditions.

$175m for Urgent Needs and Emergent Issues in Children's Behavioral Health

Provide wellness and resilience-building supports for children, youth, and parents, support the School-Based Peer Mental Health Demonstration project, and other initiatives

$40m for Children and Youth Suicide Prevention Grants and Outreach Campaign

At-Risk Populations

$106m for Older Adult Recovery and Resiliency

Increase service levels of existing programs based on local need including: Senior Nutrition, Senior Legal Aid, Home Modifications and Fall Prevention, Behavioral Health Line, Senior Digital Connections, Family Caregiver Support, Senior Employment Opportunities, Elder Abuse Prevention, and Aging and Disability Resource Connection.

$50m for Veteran Health Initiative

Prevention, early intervention, and direct services to effectively combat the risk factors associated with suicidal idealization, thereby reducing the number of veterans that die by suicide through a mental health support network, an outreach and education campaign, and a veteran suicide surveillance and review program.

Expanding Infrastructure

$2.2b for Behavioral Health Continuum Infrastructure Program

Competitive grants to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources.

$1.5b for Behavioral Health Bridge Housing

Immediate housing and treatment of people with serious behavioral health conditions that are experiencing or at eminent risk of homelessness.

$1.4b for Medi-Cal Community-Based Mobile Crisis Intervention Services

Add qualifying community-based mobile crisis intervention services no sooner than January 1, 2023 as a Medi-Cal covered benefit through the Medi-Cal behavioral health delivery system.

$38m for 9-8-8 Augmentation and CA Peer-Run Warm Line

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Justice-Impacted

$535.5m for Felony Incompetent to Stand Trial Waitlist Solutions

Solutions focusing on Early Stabilization and Community Care Coordination and Expanding Diversion and Community-Based Restoration Capacity for IST population. Will establish 5,000 beds over four years.

$501.6m to Increase Sub-Acute Bed Capacity

Including Institutions for Mental Disease, Mental Health Rehabilitation Centers, Skilled Nursing Facilities, or any other treatment options, including Community Based Restoration programs.

$148.8 Expansion of Community-Based Restoration

$38.3m Forensic Conditional Release Program (CONREP) Mobile Forensic Assertive Community Treatment (FACT) Team

$126m for Integrated Substance Use Disorder Treatment (ISUDT) Program Expansion and Enhancements

$100m to Los Angeles County Justice-Involved Population Services and Supports

Grant program to support and expand access to treatment for individuals with behavioral health disorders, of which $50 million is to be targeted to individuals charged with a misdemeanor and found incompetent to stand trial.

A More Equitable System

$63.1m for California Reducing Disparities Project

Supports pilot projects operated by community-based organizations, which provide culturally responsive mental health and behavioral health services to historically underserved communities.

$140m for Equity and Practice Transformation Provider Payments

Payments to Medi-Cal managed care plans or providers to advance equity, reduce COVID-19-driven care disparities, improve quality measures in children's preventive, maternity, and behavioral health care, and provide grants and technical assistance to allow small physician practices to upgrade their clinical infrastructure that allow the adoption of value-based and other payment models that improve health care quality while reducing costs.

Workforce

More than $1.4B investment to **hire**, **train**, and **advance** a **diverse behavioral health workforce**, including:

- **$391.1M** to increase behavioral health specialists (e.g., psychiatrists, social workers), including:
  - **$50M** to create training positions for addiction/psychiatric residents, psychiatric mental health nurse practitioners, psychology interns/fellows, and psychiatric nurses.
  - **$55.1M** from the Opioid Settlement Fund to fund Substance Use Disorder workforce training
  - **$60M** to expand MSW slots in public universities and colleges
  - **$52M** for University/College grants and training programs to increase number of licensed behavioral health professionals
  - **Golden State Social Opportunities Program: $10M** for scholarships to support youth with lived experiences as foster and homeless youth pursue careers in social work

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California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration

- **As part of CalAIM,** CA committed to pursuing a Section 1115 Demonstration to support adults with SMI and children and youth with SED.
- **CMS' 2018 guidance -** permits states to use 1115 demonstrations to receive federal financial participation (FFP) for short-term care provided to Medicaid members living with SMI/SED in qualifying institutions for mental disease (IMDs), provided states establish a robust continuum of community-based care and enhance oversight of inpatient and residential treatment settings.*
- DHCS has released an external concept paper detailing the proposed approach, you can review all materials at: https://www.dhcs.ca.gov/CalAIM/Pages/CalBH-CBC.aspx
- Target Populations – Children and Youth, Individuals Experiencing or at Risk of Homelessness, and Justice-Impacted Individuals

Per CMS guidance, this **Section 1115 opportunity is limited to short-term stays in psychiatric hospitals and mental health residential treatment settings, defined as stays that are no longer than 60 days, with a requirement for a statewide average length of stay of 30 days.*

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CalBH-CBC Approach

Amplify State's Investments in BH Continuum

- **Strengthen the statewide continuum of community-based services**and evidence-based practices available through Medi-Cal, leveraging concurrent funding initiatives, including clarifying coverage requirements for evidence-based practices for children and youth.
- **Support statewide practice transformations** and improvements in the county-administered •behavioral health system to better enable counties and providers to strengthen the continuum of community-based services; to improve the quality of care delivered in residential and inpatient settings; and to strengthen transitions from these settings to the community.
- **Improve statewide county accountability** for meeting service improvement requirements •and implementing new benefits through incentives, robust technical assistance, and oversight.
- •**Establish a county option to enhance community-based services** through coverage of evidence-based practices that reduce the need for institutional care and improve outcomes.
- **Establish a county option to receive FFP for services provided during short-term stays in •IMDs,** contingent on counties meeting robust accountability requirements; ensuring that care is provided in an institutional setting only when medically necessary and in a clinically appropriate manner; offering a full array of enhanced community-based services; and reinvesting new Medi-Cal funding into community-based care.

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CalBH-CBC Approach

The Demonstration may include the following initiatives. Many may be statewide while others may be implemented as part of a county option to offer an enhanced continuum of care and receive FFP for short term stays in IMDs.

- ***Strengthen Statewide Continuum of Community-Based Services*** – cross sector incentive pool, activity stipends, initial child welfare/ specialty mental health assessment
- ***Support Statewide Practice Transformations*** – centers of excellence, incentive programs, tools for connecting AMI/SED to appropriate care, promote improved quality and standardization in residential and inpatient care
- ***Improve Statewide County Accountability for Medi-Cal Services*** – transparent monitoring, key performance expectations and accountability standards, streamlined performance review process
- **Next Steps – DHCS is reviewing stakeholder comments and preparing for submission**

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Community Assistance, Recovery and Empowerment (CARE) Act

Senate Bill 1338

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Background and Legislation's intent

- SB 1338 signed into law by Governor September 2022
- Eligible population = those with **untreated schizophrenia spectrum and psychotic disorders**
  - Estimated 7,000-12,000 in California
- CARE is intended to be a **new process**, that can be supported and served by **existing programs**
- Intended as a compassionate, **upstream diversion** to prevent more restrictive conservatorships or incarceration

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The CARE process involves…

The respondent, as well as:

- Petitioner
- County Behavioral Health Department
- Civil court
- Legal Aid or Public Defender
- Voluntary Supporter, if desired
- Comprehensive CARE Plan

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Differences from LPS Conservatorship and Laura's Law

- Does not include custodial or long-term involuntary medication
- CARE petition may be filed by a variety of people known to participant (family, clinicians/ physicians, first responders)
- Incarceration, hospitalizations are not required to be eligible
- Supporter role to assist client in identifying, voicing, and centering the individual's decisions, including a Psychiatric Advanced Directive
- Requires local government accountability

CARE Eligibility

Chapter 2, Section 5972. All of the following must be met:

a) 18 years or older

b) Experiencing severe mental illness **and** has a diagnosis in the schizophrenia spectrum and other psychotic disorder class

c) Not clinically stabilized in on-going voluntary treatment

d) Meets one of the following:

   1) Person is unlikely to survive safely and the person's condition is substantially deteriorating.
   2) Person is 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 self or others

e) CARE would be the least restrictive alternative to ensure recovery and stability

f) It is likely that the person will benefit from participation in CARE

Why Courts?

- Criminal courts are often in the crosshairs of the lives of those suffering from severe, decompensated mental illness
  - By going upstream with a civil court process, CARE aims to serve individuals **before criminal court or conservatorship**
- CARE is a **vehicle for collaboration and coordination**, not compliance
  - County outreach and engagement begins before court engagement
- The court can deepen its engagement and oversight if:
  - The government entities can't implement an appropriate, person-centered plan; or
  - Client cannot participate

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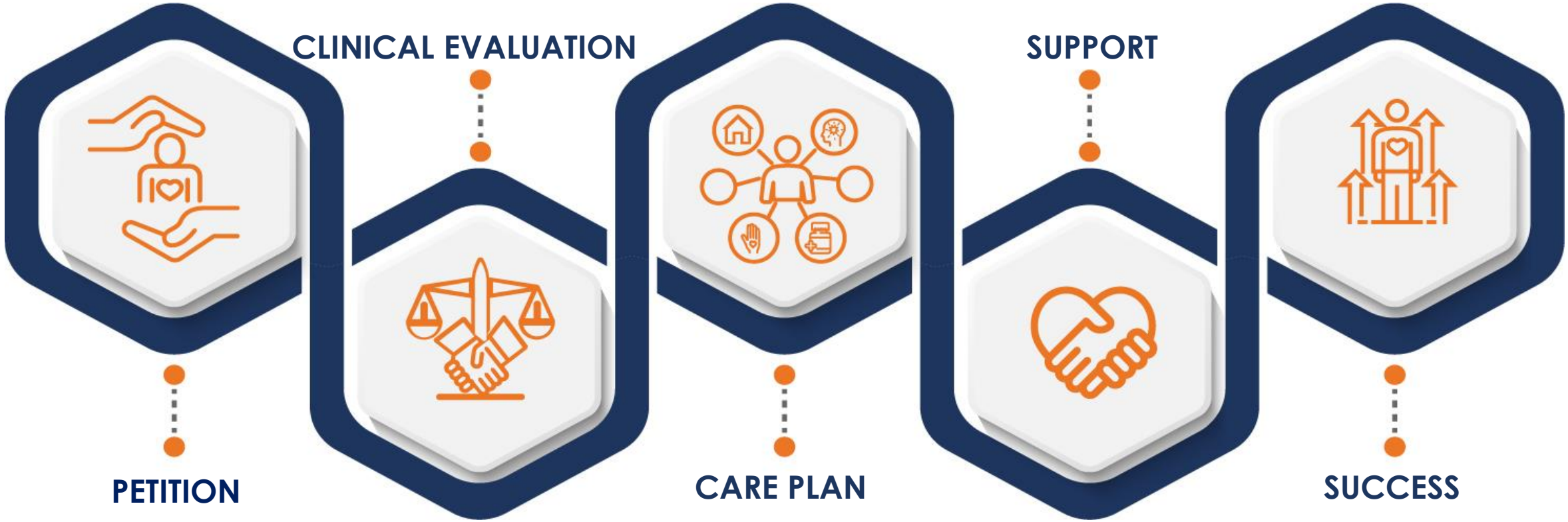
CARE Process

CARE Flowchart



CARE Petition

Who may file:

- Lives with CARE participant
- Family member
- Hospital director
- Behavioral health provider
- First responder
- County Public guardian, public conservator, Behavioral health Agency, Adult protective services
- The respondent
- *Note many of these entities can have a designee as the petitioner*

Petitions must include one of the following:

a) Affidavit of a licensed behavioral health professional; **or**

b) Evidence that respondent was detained for at least two 5250's, the most recent one within the previous 60 days

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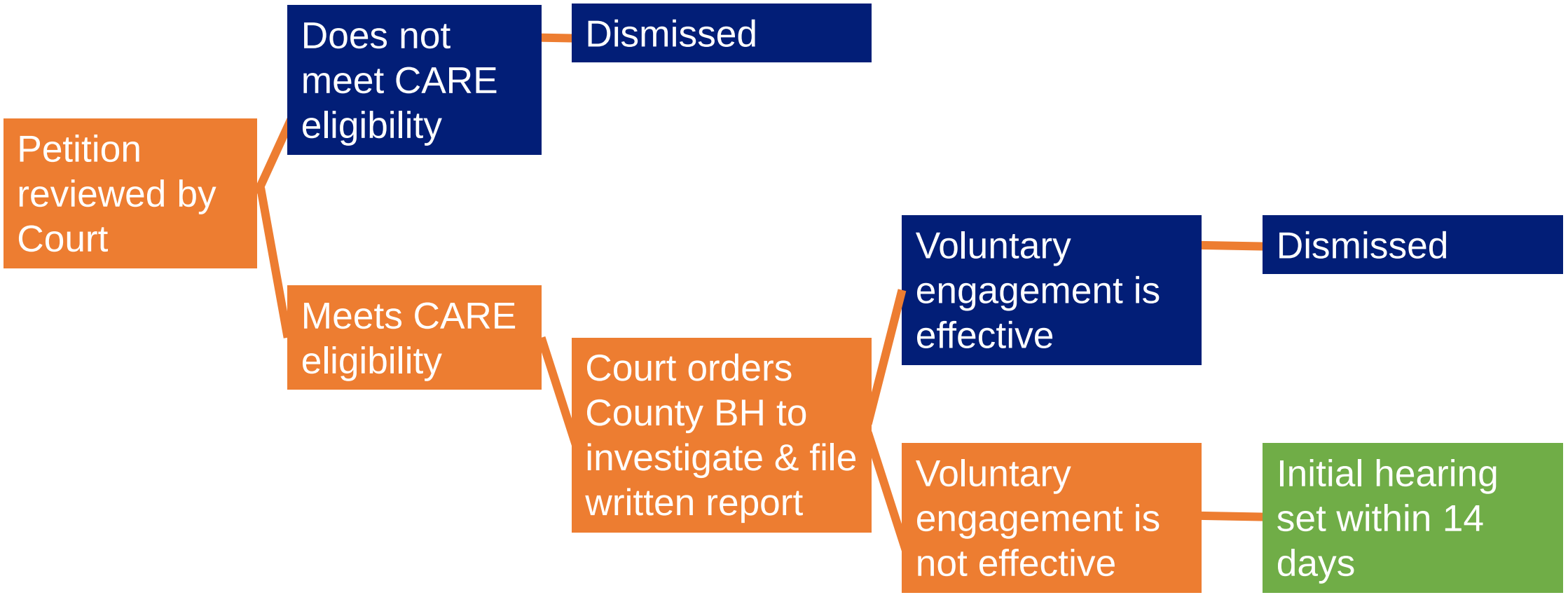
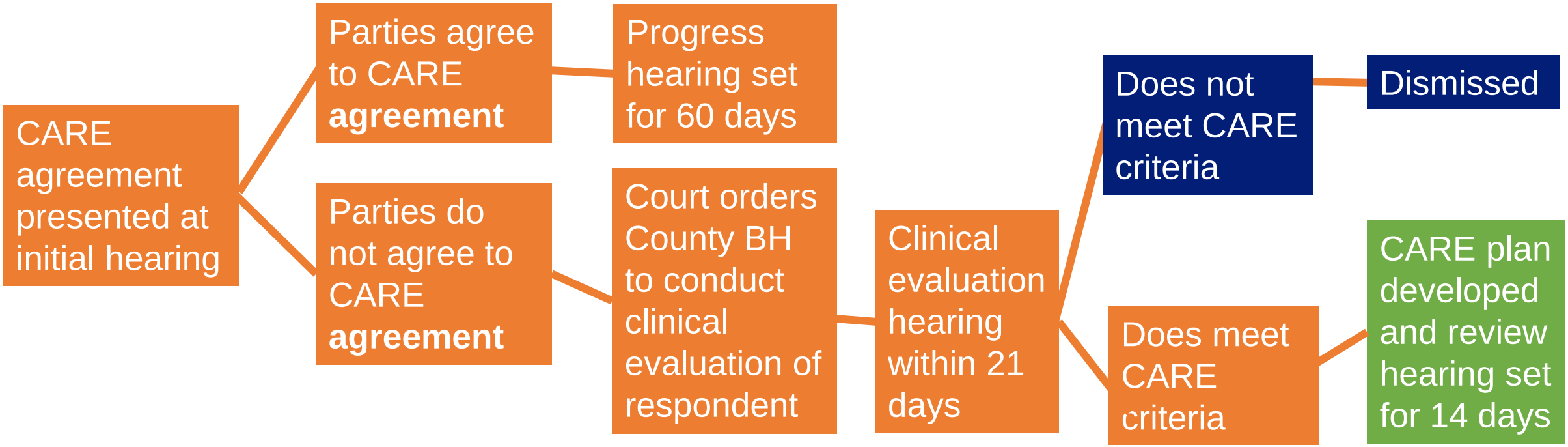
CARE Petition → Initial Court hearing



Initial Court hearing → CARE Plan



What is in a CARE Plan

- Developed with the respondent, counsel, county behavioral health and a Supporter (if desired by respondent)
- **Housing** is a critical component of the plan
  - May range from clinically enhanced interim/bridge housing, licensed adult and senior care settings, supportive housing, or housing with family and friends
- **Court may issue any orders necessary** to support the respondent in accessing appropriate services and supports in the CARE plan, including prioritization
- CARE Plan is **up to 1 year**, with interim status review hearings set by court

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Graduating from a CARE Plan

Court sets 1-year status hearing in month 11 of CARE plan. Court will determine with respondent will:

a) Graduate with a voluntary graduation plan

   Court will review the plan to support a successful transition out of court jurisdiction and may include a psychiatric advance directive

b) Be reappointed to CARE plan for another term (max. 1 year)

   Respondent may also voluntarily request reappointment

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Ensuring local government participation in CARE

- A court can fine a county or other local government entity if it is not complying with CARE
- Fines will be deposited into the CARE Act Accountability Fund and will be distributed back to the local government entity to:
  - “Serve individuals who have schizophrenia spectrum or other psychotic disorders and who are experiencing, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship.”

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Ensuring a respondent's participation in CARE

If participant is not participating in CARE proceedings, the respondent's participation in CARE is terminated

- Court may utilize existing law to ensure safety, and may provide notice to the county behavioral health agency and the Public Conservator/Guardian if warranted
- If conservatorship proceedings occur within 6 months, failed completion of a CARE plan may be a fact considered

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Implementation of CARE

Funding, timeline and guidance

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Implementation timeline

- **October 2023**: Cohort 1 counties
  - Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and San Francisco
  - LA is accelerating implementation to December 2023
- **December 2024**: All 58 counties
  - Unless county granted additional time by DHCS

Funding

- **$64.7m** to counties in current year in start up and implementation funds
  - The Administration continues to work with Judicial Council and counties to estimate costs associated with this new court process, including administrative costs.

  Recent facility, residential, and housing investments most likely to serve CARE respondents
  - **$1.5b** in Behavioral Health Bridge housing
  - **$2.2b** for Behavioral Health Continuum Infrastructure Program

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Technical Assistance

DHCS will provide training and technical assistance to county behavioral health agencies, counsel and supporters

Judicial Council will provide training and technical assistance to Judges

- CARE process
- Agreement and plan services and supports
- Supported decision-making and the supporter role
- Trauma-informed care and elimination of bias
- Psychiatric advance directives
- Family psychoeducation/family role
- Evidence-based models of care for people with severe behavioral health conditions
- Data collection

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DHCS will develop an annual CARE Act report

- Development of report will consult relevant stakeholders
- **Demographic information** on populations
- **Outcome measures** to assess effectiveness
  - Improvement in housing status, including gaining and maintaining housing,
  - Reductions in emergency department visits and inpatient hospitalizations,
  - Reductions in law enforcement encounters and incarceration,
  - Reductions in involuntary treatment and conservatorship, and
  - Reductions in substance use
- Will also include a **health equity assessment** to inform disparity reduction efforts

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An independent evaluation will be conducted after 3 years

- Will identify racial, ethnic, and other demographic disparities, and include causal inference or descriptive analyses on impact of the CARE Act on **disparity reduction efforts**
- Preliminary report to the Legislature is due 3 years after the implementation date of the CARE Act, final report due in 5 years

Addressing racial bias

- **Racial inequities** in clinical diagnosis, homelessness, and justice system impact are well documented
  - These realities must be acknowledged and addressed in CARE's design
- CARE includes standardized tools for assessment and evaluation for ameliorating the features that drive racial bias
- **Implicit bias training** for individuals participating in CARE processes to improve awareness of these drivers of inequity and their own role in perpetuating them
- Communities and stakeholders to be engaged not just in formative part of CARE, but regularly as the program develops over the next few years

Key State Agencies Involved in CARE

CalHHS

- Lead coordination efforts
- Engage with cross sector partners and stakeholders at city and county level, and associations
- Support DHCS training, technical assistance and evaluation efforts
- Implementation of Behavioral Health Bridge Housing program
- Support communications, respond to media, legislature, and other stakeholder inquiries, provide media

DHCS

- Develop training & technical Assistance for counties, counsel and volunteer supporters, including contractor management and RFI
- Supporting data collection, reporting, and independent evaluation
- Administer implementation and start up funding

Judicial Council

- Interagency planning and communication
- Initial CARE Act Procedural Memo distributed to all courts
- Court Communication Hub: information sharing within and across courts; collaboration platform
- Meetings with court teams
- Statewide Court rules & forms (Probate and Mental Health Advisory Committee)
- Court data collection procedural plan
- Legal representation
- Budget administration
- Targeted court training and technical assistance needs; webinars
- Self-Help legal information, assistance, and tools for parties

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CARE Working Group

- Establishment of Working Group legislated in SB 1338
- **26 members** include representation from counties, providers, peers, Legal Aid, Disability Rights, Homelessness, hospitals, and other stakeholders
- Purpose is to provide coordination and on-going engagement with, and support collaboration among stakeholders to **support the successful implementation of the CARE Act**
- 4 meetings per year. First meeting was February 14, 2023

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More information on CARE

chhs.ca.gov/CARE-act/

Email us at CAREAct@chhs.ca.gov join the CARE listserv to receive updates and information on future stakeholder events

Thank you

Questions?

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