



# CCJBH

Council on Criminal Justice and Behavioral Health

# 20 YEARS

*of building bridges  
to prevent incarceration*

## Diversions/Reentry Workgroup

### October 25, 2024

**Brenda Grealish**

Executive Officer, CCJBH  
Office of the Secretary, Jeff Macomber  
California Department of Corrections and  
Rehabilitation (CDCR)

**Jessica Camacho-Hall**

Health Program Specialist II, CCJBH

**Tony Hobson, PhD**  
Behavioral Health Director  
Colusa County

**Mack Jenkins**  
Chief Probation Officer, Retired  
San Diego County

**Judge Stephen Manley**  
Santa Clara County Superior Court Judge



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## **PARTICIPATION**

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## **COMMENTARY**

Participant comments in the Q&A do not reflect the views or policies of the presenters, the Council on Criminal Justice and Behavioral Health, the California Department of Corrections and Rehabilitation or its affiliates or contractors. By using the Q&A, you agree to keep comments relevant to the topic of today's event. While a variety of diverse perspectives and opinions is welcome, disruptive comments are not aligned with the purpose of this meeting, and users creating disruption may be removed without warning.



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- Remote Participants:
  - Use the “raise hand” feature to make a comment.
  - You will be placed in line to comment in the order in which requests are received by the host.
- In-person Participants:
  - Complete a note card with your name and organization and hand it to the registration table.
  - You will be called to the podium during the public comment period.
- Keep public comment to agenda items being discussed.
- Members of the public should be prepared to complete their comments within **2 minutes** or less if a different time allotment is needed and announced by the Executive Officer.

***Email:***

**[CCJBH@cdcr.ca.gov](mailto:CCJBH@cdcr.ca.gov)**



# Agenda

<b>Time</b>	<b>Topic:</b>
3:00 PM	Welcome and Introductions
3:10 PM	Reflection on August 2024 Diversion/Reentry Workgroup
3:25 PM	California Department of Health & Human Services Update on the Implementation of the Community Assistance, Recovery & Empowerment Act (CARE Act)
3:45 PM	Department of Health Care Services' Overview on the CARE ACT Evaluation
4:05 PM	Stanislaus County Behavioral Health Department's CARE Act Implementation



# Agenda (cont'd)

<b>Time</b>	<b>Topic:</b>
4:25 PM	Q&A with Councilmember Advisors
4:45 PM	Public Comment
4:55 PM	Announcements
5:00 PM	Adjourn



# Councilmember Advisors' Reflections



# Questions for Councilmember Reflections

1. What are the key takeaway(s)/reflection(s) from these presentations?
2. Based on these takeaways/reflections, what recommendation(s) would you propose for consideration in the CCJBH Annual Legislative Report (if any)?
3. Should CCJBH continue working on this issue and, if so, how (continued discussion in workgroup meetings, informational research, etc.)?



# California Department of Health & Human Services Update on the Implementation of the CARE ACT

Karen Linkins, PhD, Principal, Desert Vista Consulting





# Community Assistance, Recovery and Empowerment Act (CARE) Overview and Implementation Status

**Karen W. Linkins, PhD**

Principal

Desert Vista Consulting

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# Legislative Intent of CARE

- SB 1338 signed into law by Governor September 2022, with amendments via SB 35 (2023), SB 42 and SB 1400 (2024)
- Eligible population = those with **untreated schizophrenia spectrum and psychotic disorders** who meet specific health and safety criteria
- CARE is intended to be a **new process**, that can be supported and served by **existing programs**

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# CARE is designed to break the cycle

- As a civil court process, CARE is an upstream diversion designed to break the cycle of homelessness, criminalization, and institutionalization
- The success of CARE will be based on whether this process can connect the respondent to the right services and supports including stabilization medications, wrap around behavioral health services, and housing.

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# Community Assistance, Recovery and Empowerment (CARE) Act

- **‘Upstream’ diversion to prevent more restrictive conservatorships or incarceration.**
- **Provide** behavioral health services to **severely ill, vulnerable individuals** while preserving **self-determination** to the greatest extent possible
- **People can stabilize**, begin healing, and **exit homelessness**
- Hold the **behavioral health system accountable** to holistically serve those who often have the most complex care needs

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# CalHHS Roles and Responsibilities

- Lead coordination efforts with and between the Judicial Council and DHCS
- Engage with cross sector partners at city and county level, individually and through collaboratives and convenings
- Coordinate with partners and a diverse set of stakeholders via regular meetings – including county associations (*CSAC and key affiliates like CBHDA, RCRC, CA Association of PA/PC/PG, CWDA, etc.*)
- Support DHCS training, technical assistance and evaluation efforts, as well as implementation of Behavioral Health Bridge Housing program, monitor housing related needs throughout implementation
- Convene CARE Act Working Group and any sub-groups
- Support communications through a website dedicated to the CARE Act, including a listserv and quarterly reports, respond to media, legislature, and other stakeholder inquiries, provide proactive media and community engagement and outreach. See <https://www.chhs.ca.gov/care-act/>

# Implementation Process

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# Implementation Timeline

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

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# CARE Eligibility Criteria

- 18 years and older with a diagnosis of Schizophrenia Spectrum or Other Psychotic Disorders
- The person has symptoms that are severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living (i.e., basic activities related to personal care), and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time
- The person is not stabilized with ongoing voluntary outpatient treatment

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# CARE Eligibility Criteria

- Either the person is unlikely to survive safely/independently in the community (such as maintaining personal safety, hygiene, diet, health, and/or necessary relationships without supervision) and the condition is deteriorating OR services and support are needed to prevent relapse or deterioration,
- Participation in CARE Act is the least restrictive alternative, AND
- The person will likely benefit from participating in a CARE plan or CARE agreement

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# Pathways for Petitions

- County behavioral health, crisis teams, and contracted providers
- Hospitals and LPS Designated facilities
- Public Guardian / Public Conservator offices (for LPS diversions and step downs)
- Jail Mental Health (for pre-release transition planning)
- Misdemeanor and Felony Incompetent to Stand Trial (IST) diversions
- Families
- Homeless services providers and Shelters
- First Responders
- Public Defenders (supporting self-referral)
- Adult protective services
- Tribal courts
- Indian health services program or tribal behavioral health department

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# Accountability in CARE Goes Both Ways

- In addition to being a pathway to engage the individual, CARE supports accountability on the county or other local government partners.
- As party to the CARE agreement or plan, the court ensures the county can provide a robust and responsive set of services and supports to a population with the most complex care needs.

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# Housing, Homelessness, and CARE

- Finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.
- CARE plans will include housing plan that meets the needs of the respondent which could include interim housing, permanent supportive housing, adult residential facilities, or housing with family or friends
- Over the last two years, the state has made historic investments to prevent and end homelessness, totaling over \$15B, including \$1.5B in the Behavioral Health Bridge Housing program which prioritized CARE participants.

# Implementation Update

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# Solutions and Ongoing Challenges

## Effective Solutions

- Deep system coordination
- Educating the community
- Engagement/ locating people
- Workforce leveraging existing staff and expanding role of peers for outreach and engagement
- Housing leveraging multiple funding sources
- Services – ACT and peers are key

## Ongoing Challenges

- Petition and supporting documentation
- Deeply complex conditions – co-occurring SUD and physical health conditions
- Acuity

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# CARE Act Reporting and Assessment

In consultation with relevant stakeholders, DHCS to develop **early implementation report** by December of 2024, with complete **annual reports** in July of subsequent years. Annual reports will include:

- Demographic information
- Outcome measures to assess housing, SUD rates, hospital utilization, law enforcement contacts, and involuntary treatment/conservatorship
- Includes equity assessment

**Independent evaluation** to be conducted 3 years after implementation

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# CARE Clean Up Legislation

- **SB 1400 - Increase transparency through additional data and reporting.** Require counties to document and report on outreach attempts as part of county investigation and respondent outcomes when deemed ineligible, so we know what happened to them. Require DHCS to annually post county-by-county data on their website, to hold counties accountable.
- **SB 42 - CARE connection for LPS.** Provide a pathway for CARE to be used as a step down to transition individuals out of an LPS hold or LPS conservatorship. These individuals are more likely to participate in CARE voluntarily, because they can be stabilized and avoid returning to LPS holds/conservatorships, jail, or worse.

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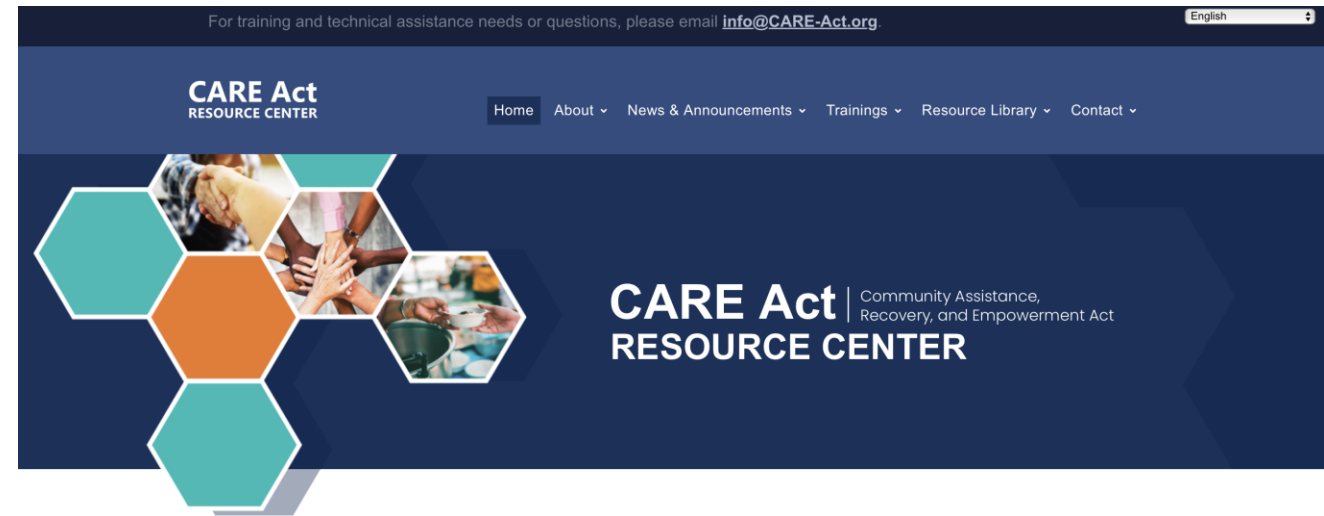
# CARE Act Next Steps

- Cohort 2 launches by December 1, 2024
- CalHHS, DHCS, and Judicial Council continue to work closely with counties, the courts, legal representation, and others through the CARE Act Working Group to support successful implementation.
  - This includes efforts to support data and evaluation, communication tools to support local partner engagement, and supporting the provision of provide integrated, holistic care to CARE respondents.
- Ongoing efforts to support understanding of the CARE Act
  - Efforts include outreach and training through NAMI, California Medical Association, First Responders, and others

# CARE Act Resource Center

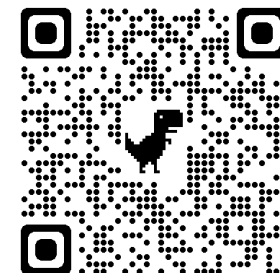
[CARE-Act.org](https://www.care-act.org)

- Information regarding upcoming trainings
- Resource library
- Timeline with implementation milestones and progress
- FAQ
- Technical assistance request form
- Stakeholder feedback form
- Ability to join the listserv



## CARE Act OVERVIEW

Through a new civil court process, the [CARE Act](#) provides community-based behavioral health services and supports to Californians living with untreated schizophrenia spectrum or other psychotic disorders.



# Department of Health Care Services Overview of the Evaluation for the CARE Act

**Andy Potter**, Program Evaluation Section Chief, DHCS  
**Stephanie Holliday**, Senior Behavioral Scientist, RAND



# CARE Act Independent Evaluation Plan Overview

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COUNCIL ON CRIMINAL JUSTICE AND BEHAVIORAL HEALTH  
DIVERSION AND REENTRY WORKGROUP

OCTOBER 25, 2024



# Today's Agenda

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- Overview of RAND Independent Evaluation
- Components related to Incarceration and Criminal Legal System Involvement
- Next Steps
- Questions



# Goals of RAND's CARE Evaluation

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Document the theory of change for the CARE Act model

Evaluate the program implementation, outcomes, and impact

Document lessons learned related to the CARE Act model and policies

Make recommendations for ongoing implementation of the CARE Act

# Current Status of Evaluation

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✓ Developed Evaluation Plan, which is under final review

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✓ Designed Survey, under review

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✓ Began Data Analysis for Participant Snapshot

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# Evaluation Plan for CARE Act Independent Evaluation

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# Centering Equity at Every Stage

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## Participant selection:

- Ensures underrepresented and marginalized groups can participate
- Accommodates participation in preferred languages

## Stakeholder engagement:

- Focus on inclusivity
- Actively seeks input from a broad range of voices
- Captures varied perspectives and experiences

## Selection of variables and data analysis:

- Prioritizes metrics addressing disparities
- Measures outcomes across different demographic groups

## Holistic analysis:

- Embeds equity into every component of the evaluation
- Sensitive to nuanced needs and impacts on all communities involved

# Evaluation Logic Model

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- Logic model provides an overview of the theory of change as a result of CARE, outlining
  - Evaluation questions
  - CARE Act strategies and activities
  - Associated process and outcome measures (implementation & expected impact)

# CARE Evaluation Logic Model – Draft 5-13-24

Evaluation Questions	Strategies & Activities	Implementation Outcomes	Key Outcomes
<p><b>Implementation:</b></p> <ol style="list-style-type: none"> <li>1. How prepared were counties to implement the CARE Act model?</li> <li>2. How was CARE implemented?</li> <li>3. What factors might be impacting the effectiveness of CARE?</li> </ol>	<p><b>Individual-level</b></p> <ul style="list-style-type: none"> <li>• Participation in CARE process: <ul style="list-style-type: none"> <li>○ Petition/Initiation</li> <li>○ Engagement</li> <li>○ Court process and development of CARE plan</li> <li>○ Service connection</li> <li>○ Service delivery</li> </ul> </li> <li>• Engagement of advocates, including peers, family, and volunteer supporters</li> </ul>	<p><b>Individual-level</b></p> <ul style="list-style-type: none"> <li>• Number and description of individuals on different pathways: <ul style="list-style-type: none"> <li>• Elective clients</li> <li>• Voluntary CARE agreement status</li> <li>• Ordered CARE plan status <ul style="list-style-type: none"> <li>○ Developed</li> <li>○ Accessed</li> <li>○ Shared</li> <li>○ Adhered to</li> </ul> </li> </ul> </li> <li>• Psychiatric Advanced Directive status</li> </ul>	<p><b>Community Assistance, Recovery and Empowerment:</b></p> <p><u>3-legged stool:</u></p> <ul style="list-style-type: none"> <li>↑ Engagement in services</li> <li>↑ Medication stabilization</li> <li>↑ Safe, stable, preferred housing</li> </ul>
<p><b>Community Assistance, Recovery and Empowerment:</b></p> <ol style="list-style-type: none"> <li>4. Did CARE participants increase their engagement in needed services?</li> <li>5. Was access to services equitable?</li> <li>6. Did CARE participants experience increased mental illness recovery and empowerment?</li> <li>7. Were recovery and empowerment outcomes experienced equitably?</li> </ol>	<p><b>System-level</b></p> <ul style="list-style-type: none"> <li>• County workflows to support CARE implementation</li> <li>• System coordination and linkage, including County BH, Public Defenders, Courts, and County Counsel</li> <li>• Data collection and sharing</li> <li>• Accountability levers</li> </ul>	<ul style="list-style-type: none"> <li>↑ Perceived appropriateness of care</li> <li>↑ Perceived quality of care/services</li> <li>↑ Perceived choice in care/services</li> <li>↑ CARE participant satisfaction with process</li> <li>↑ Family/caregiver satisfaction with process</li> <li>↑ Social support (emotional, tangible, informational)</li> <li>↑ Awareness of service options</li> </ul> <p><b>System-level</b></p> <ul style="list-style-type: none"> <li>↑ Coordination between County BH, Public Defenders, Courts, and County Counsel</li> <li>• Barriers and facilitators to implementation</li> <li>• Availability of appropriate services</li> <li>• County accountability (e.g., claims, fines and sanctions)</li> </ul> <ul style="list-style-type: none"> <li>• Equity/disparities in above outcomes</li> </ul>	<ul style="list-style-type: none"> <li>↑ Personal recovery (CHIME framework): <ul style="list-style-type: none"> <li>○ Connectedness,</li> <li>○ Hope,</li> <li>○ Identity,</li> <li>○ Meaning and purpose,</li> <li>○ Empowerment</li> </ul> </li> <li>↑ Achievement of personal CARE goals</li> <li>↑ Meaningful work or community engagement –e.g., employment, volunteering, caring for others or enrollment in education</li> <li>↓ ED use</li> <li>↓ Hospitalizations</li> <li>↓ Arrests and incarceration</li> <li>↓ LPS and probate conservatorships</li> </ul> <ul style="list-style-type: none"> <li>• Equity/disparities in above outcomes</li> </ul>

# Evaluation Questions and Data Sources

		Implementation Partner Interviews	CARE Participant Interviews	Petitioner Interviews	CARE Participant Survey	Administrative Data
Process Evaluation	Q1. How prepared were counties to implement the CARE Act model?	X	X	X		X
	Q2. How was CARE implemented?	X	X	X	X	X
	Q3. What factors might be impacting the effectiveness of CARE?	X	X	X	X	X
Outcome Evaluation	Q4. Did CARE participants increase their engagement in needed services?	X	X	X	X	X
	Q5. Did CARE participants experience increased mental illness recovery and empowerment?	X	X	X	X	X

# Qualitative Methods

In-depth interview data collection to address evaluation questions:

Q1: How prepared were counties to implement the CARE Act model?

Q2: How was CARE implemented?

Q3: What factors might be impacting the effectiveness of CARE?

Draw both local and state-level conclusions about implementation

Anticipate selecting 12 counties to participate in qualitative methods from Cohorts 1 and 2

# Qualitative Methods

## Implementation Partner Interviews

- Interviewees to include County and State level including BH Agencies, DHCS, HMA, CalHHS, and Judicial Council
- Interview topics to include staffing and training; implementation process; efforts to ensure equity in access and outcomes; facilitators and challenges to implementation

## CARE Participant Interviews

- Elective clients, voluntary CARE agreements, and CARE plan respondents
- Interview topics to include CARE process initiation; barriers and facilitators to participation; overall satisfaction and suggestions for improvement.

## Petitioner Interviews

- Interview topics to include CARE petition filing process; perceptions of types of quality of services; and questions about equitable access to services and support for the respondent.

# Quantitative Methods

Quantitative data to address evaluation questions:

- Q1: How prepared were counties to implement the CARE Act model?
- Q2: How was CARE implemented?
- Q3: What factors might be impacting the effectiveness of CARE?
- Q4. Did CARE participants increase their engagement in needed services?
- Q5: Did CARE participants experience increased mental illness recovery and empowerment?

# Quantitative Methods

## County data collected with HMA support

- Examples: Total CARE respondents across pathways, Volunteer Supports, Psychiatric Advanced Directives, Engagement in Services, Medication Stabilization, Housing, LPS conservatorships, Arrests and Incarceration, ED use and Hospitalizations

## Supplemental data sources, as available

- Health Care Access and Information (HCAI) data, MediCal claims, state hospital data, incarceration data, etc.
- Examples: Healthcare Utilization, Access to BH treatment, Mortality, Housing

# Respondent Survey

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Survey of CARE participants at two points in time, in all three CARE pathways

- Three formats: web-based, phone interviews, and in-person field interviews
- Topics will include individual-level outcomes including:
  - Perceived choice in/appropriateness of care
  - Perceived quality of care
  - CARE participant satisfaction with the process
  - Awareness of service options
  - Social support
  - Engagement in services
  - Medication stabilization
  - Safe, stable, preferred housing
  - Recovery
    - CHIME (connectedness, hope, identity, meaning and purpose, empowerment)
    - Attainment of personal recovery goals
    - Community engagement

# Components related to Incarceration and Criminal Legal System Involvement

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## Implementation of CARE

- Understanding perceptions of CARE as helping to prevent legal system involvement
- CARE as an opportunity to provide services to clients transitioning out of incarceration or who are incompetent to stand trial

## Outcomes of CARE

- Exploring whether participation associated with reductions in recidivism

# Planned Analyses

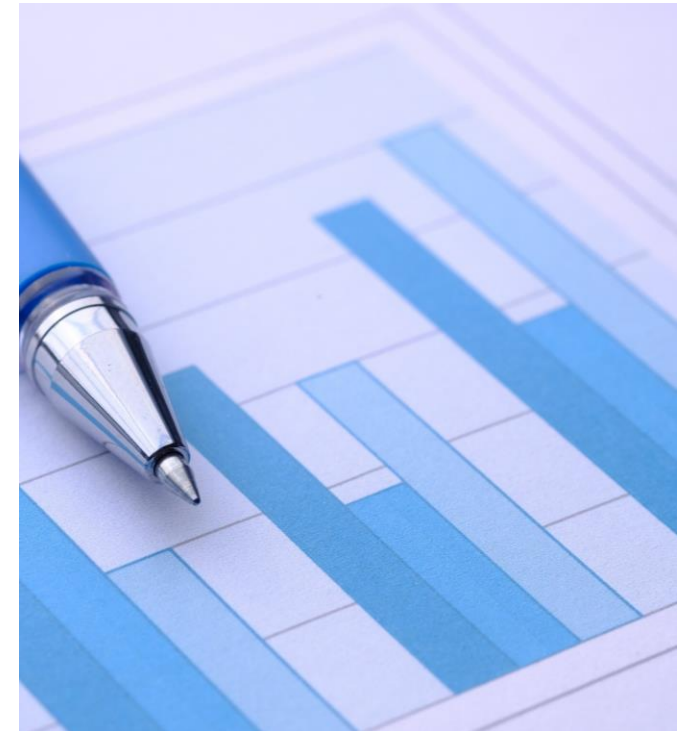
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## Qualitative:

- We will use qualitative information gleaned from interviews to answer the process evaluation questions (i.e., Questions 1, 2, 3).
- Will use thematic analysis to summarize data within and across counties.
- Will apply a consistent framework to synthesize the qualitative data across multiple data sources.

## Quantitative:

- Quantitative analyses will address both the process evaluation and the outcome evaluation questions (Questions 1-5).
- Our analyses will try to identify changes attributable to the CARE Act Model.
- The Administrative Data will serve as control measures in our quantitative and qualitative evaluation of the CARE Act's impact.



# Stakeholder Engagement

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Critical component is the engagement of stakeholders.

- Early stages of this evaluation, stakeholder engagement ensured that we have a complete understanding of the CARE Act and the theory of change, and that this is captured adequately within the program logic model.
- Stakeholder feedback has also helped to shape our evaluation methods, such as our plans for sampling counties for the qualitative work, specific implementation partners to recruit for that work, and survey design and administration

Stakeholder engagement will also remain a vital component of our work throughout the course of the evaluation.

- For example, we anticipate sharing interim findings with stakeholders, which will be an opportunity to identify any findings that are potentially unexpected or surprising or generate hypotheses to explain the results.

Details of our stakeholder engagement plan are still in progress, but we will ensure representation from individuals with a range of backgrounds, including state and county departments/agencies, people with lived experience, family members and other potential petitioners, and experts in racial equity.

# Deliverables and Timeline

<b>Deliverable</b>	<b>Due date</b>
<b>Stakeholder engagement</b>	Ongoing
<b>Interim Evaluation Report</b>	September 1, 2026
<b>Final Evaluation Report</b>	September 1, 2028

# Thank You!

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For more information on RAND visit:

<https://www.rand.org>

# Stanislaus County Behavioral Health Department's Implementation of the CARE Act

**Tony Vartan**, Director, Stanislaus County Behavioral Health





# BEHAVIORAL HEALTH AND RECOVERY SERVICES

Director Tony Vartan, MSW, LCSW

## **CARE COURT**

Community Assistance, Recovery, and Empowerment (CARE) Court  
Program Overview

**CCJBH Diversion/Reentry Workgroup**

**October 25, 2024**

# OVERVIEW OF STANISLAUS COUNTY

- Population 561,000 (2023)
- Diverse Demographic Composition (48% Hispanic/Latino, 38% non-Hispanic White, 6% Asian, 2% Black or African American, Smaller % as Multicultural)
- Age Distribution (25% under age of 18, 12% age 65 or older and Median Age of 35)
- In Terms of Employment (Largest sectors: Health Care, Social Assistance, Retail Trade and Agriculture)
- Approximately 40% Enrolled in Medi-Cal (2024)
- Poverty Rate 13.6% (Slightly higher than the National Average of 12.6%)
- Median Household Income \$68,368 (2021)
- Crime Rate 90.27 crimes per 1,000 residents annually (Violent CR 6.42, Property 53.88, Crime Rate of D)

# ABOUT STANISLAUS CO BHRS

- Who We Are
  - Behavioral Health and Recovery Services (BHRS) administers Stanislaus County's Behavioral Health services.
- What We Do
  - BHRS provides integrated mental health services to adults and older adults with a serious mental illness and to children and youth with a serious emotional disturbance. BHRS also provides outpatient and residential substance use disorder treatment and prevention services and serves as Stanislaus County's Public Guardian.
- What We Offer
  - Services are provided in community-based locations throughout the county by over 500 staff in 80 county administered programs and community partnerships. BHRS has a strong emphasis on partnering with consumers and families, on providing culturally competent services and a belief that individuals can and do recover from mental illness and addiction.

# HIGHLIGHT OF FORENSIC BEHAVIORAL HEALTH SERVICES OFFERED THROUGH BHRS

- Court Assessment and Triage Team
  - Soon to be imbedded within the Stanislaus County Public Defender's Office
- Multi-Disciplinary Outreach Team
  - Objective is to utilize their multidisciplinary resources comprised of mental health, criminal justice, physical health, and other services to facilitate, provide, and share responsibility in assessment coordination and treatment services to meet the complex mental, physical, and social needs of the targeted population most appropriately.
  - Comprised of BHRS staff, law enforcement and Public Health
- Jail Based Linkage and Assessment Services
  - Both Mental Health and SUD
- Collaborative Courts
  - Adult Drug Court
  - Mental Health Court
  - Veteran's Treatment Court
  - Diversion
  - CARE COURT

# WHAT IS CARE COURT?



A new ***civil court*** process designed to connect individuals with certain mental health diagnoses over a one-to-two-year process with county behavioral health services under the oversight of a judge



## CARE Court is NOT:

- Criminal court
- For all mental health conditions
- A solution to homelessness

# WHO DOES THIS PROGRAM HELP?



18 years or older



Has diagnosis in disorder class: Schizophrenia Spectrum and Other Psychotic Disorders



Currently experiencing behaviors & symptoms associated with severe mental illness (SMI)



Not clinically stabilized in on-going voluntary treatment



At least one of the following:

- Unlikely to survive safely without supervision and condition is substantially deteriorating
- Needs services & supports to prevent relapse or deterioration, leading to grave disability or harm to others



Participation in a CARE Plan or Agreement is the least restrictive alternative



Likely to benefit from participating in a CARE Plan or Agreement

# WHO IS CARE COURT NOT FOR?

People with conditions other than schizophrenia/psychotic conditions and severe mental illness

Psychosis resulting from:

- Traumatic brain injury
- Autism
- Dementia
- Substance use disorders

Individuals already stabilized in voluntary treatment

Individuals not at risk of relapse or grave disability

# WHO ARE THE PARTIES INVOLVED IN CARE COURT?

## Petitioner

Files a petition to bring a person who they believe to be eligible into CARE Court. Could be a person or organization.

## Respondent

The individual who is the subject of the CARE Court petition.

## Court/Judge

Responsible for receipt of petitions, and oversight of the CARE Court process.

## County Behavioral Health Agency

Responsible for engaging the respondent, mental health services and supports.

## Public Defenders/Legal Aid Attorneys

Responsible for representing the respondent in proceedings.

## County Counsel

The county's lawyers.

# WHO CAN PETITION?

## "FAMILY/HOME"

- Person with whom respondent resides
- Spouse, parent, sibling, child, grandparent or other individual in place of a parent
- Respondent (i.e., self-petition)



## "COMMUNITY"

- First responder (e.g., peace officer, firefighter, paramedic, mobile crisis response, homeless outreach worker)
- Director of a hospital, or designee, in which respondent is hospitalized (including for 5150s, 5250s)
- Licensed behavioral health professional, or designee treating respondent for mental illness
- Director of a public/charitable organization providing behavioral health services or whose institution respondent resides



## "COUNTY"

- County behavioral health director, or designee (e.g., BHRS CARE Court team)
- Public guardian, or designee
- Director of adult protective services, or designee



## "TRIBAL JURISDICTION"

- Director of a California Indian health services program, California tribal behavioral health department, or designee
- Judge of a tribal court located in CA, or designee



# HOW TO FILE A PETITION

CONFIDENTIAL CARE-100

PETITION TO COMMENCE CARE ACT PROCEEDINGS

1. Petitioner's name  
a. Is your address in care and control of the state?  
 Yes  
 No  
b. Is your name on the respondent's records, such as a driving license, or government of respondent?  
 Yes  
 No  
c. Are you who stands in the place of a parent?  
 Yes  
 No  
d. The identity of a resident in which respondent is registered?  
 Yes  
 No  
e. The identity of a person or persons respondent is registered in?  
 Yes  
 No  
f. A criminal record of respondent?  
 Yes  
 No  
g. A criminal record of respondent?  
 Yes  
 No  
h. A criminal record of respondent?  
 Yes  
 No  
i. A criminal record of respondent?  
 Yes  
 No  
j. A criminal record of respondent?  
 Yes  
 No  
k. A criminal record of respondent?  
 Yes  
 No  
l. A criminal record of respondent?  
 Yes  
 No  
m. A criminal record of respondent?  
 Yes  
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 Yes  
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 Yes  
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 Yes  
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u. A criminal record of respondent?  
 Yes  
 No  
v. A criminal record of respondent?  
 Yes  
 No  
w. A criminal record of respondent?  
 Yes  
 No  
x. A criminal record of respondent?  
 Yes  
 No  
y. A criminal record of respondent?  
 Yes  
 No  
z. A criminal record of respondent?  
 Yes  
 No

- Complete petition (CARE-100) – *remember to fill out all requested information*
- Additionally, provide the required documentation:
  - Completed ***Mental Health Declaration*** (CARE-101) from licensed behavioral health provider  
- OR -
  - Evidence the respondent was detained for a minimum of two periods of intensive treatment (**aka, WIC 5250 holds**), the most recent one within the previous 60 days

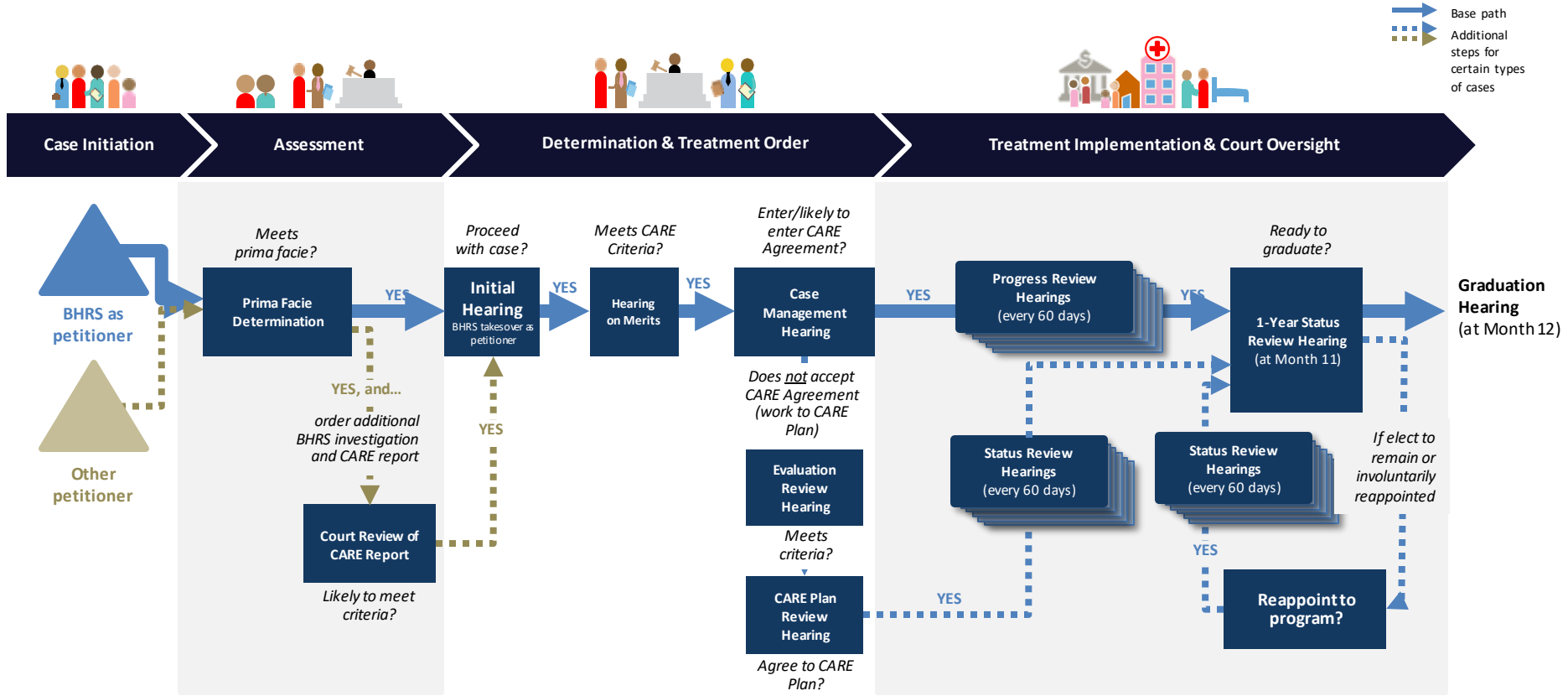
Each County will develop its own filing process.

In Stanislaus County the petitions can be filed in-person at the Stanislaus County Courthouse at the 1100 I St entrance.

E-filing is available

The Self-Help Center will be available to provide assistance to petitioners.

# CARE Court



# WHAT IS IN A CARE AGREEMENT/PLAN?



**Behavioral Health Services**



**Medications**



**Housing Resources**



**Social Services & Supports**

# CARE PLAN: MEDICATION ORDERS

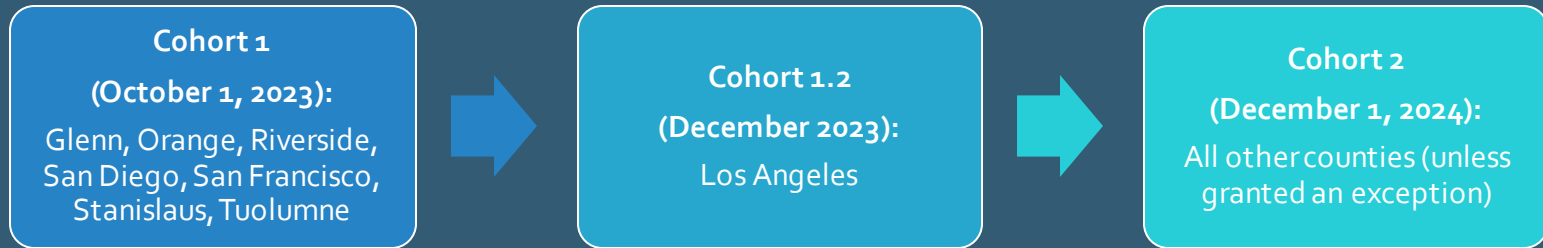
**Stabilization medications:**  
antipsychotic medications to reduce symptoms of hallucinations, delusions, and disorganized thinking.

Can be court ordered;

Cannot be forcibly administered;  
AND,

The respondent **cannot be** penalized for failure to comply with medication order.

# WHEN AND WHERE WILL CARE COURT BE AVAILABLE?



# CARE ACT DESIGN AND IMPLEMENTATION STRATEGIES

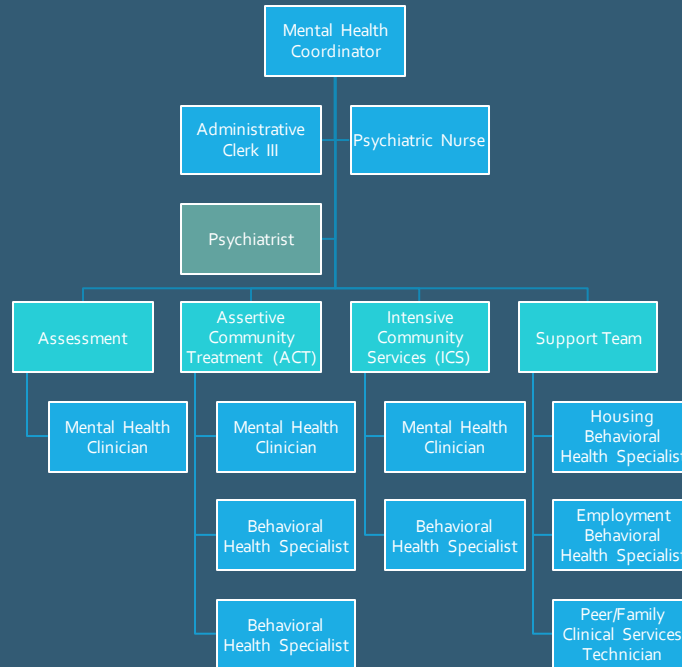
- Utilized a “Meet Early, Meet Often” approach
  - Nearly a year in advance of program implementation, Stanislaus County partners began convening meetings with various stakeholders and partners
    - Quarterly meetings with all Cohort 1 counties and State representatives
    - Monthly local level Executive Oversight Committee meetings
    - Bi-Weekly Workgroups
- Asset Mapping to Determine Gaps and Opportunities
  - Housing Inventory
    - Increasing the full continuum of housing/placements options
  - Treatment Team Capacity
    - Team composition based on several data sources

# CARE ACT DESIGN AND IMPLEMENTATION STRATEGIES

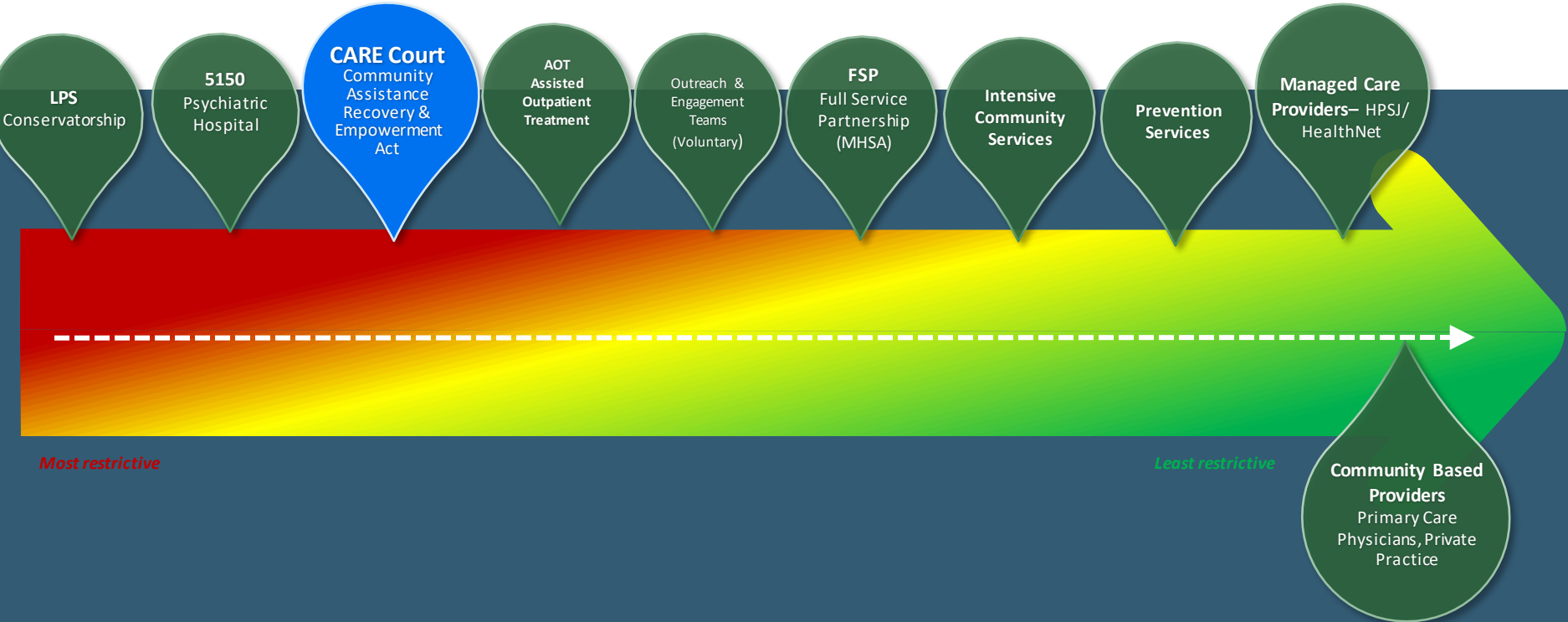
- Projections for numbers of individuals served were based on
  - local psychiatric hospitalization data
  - Assisted Outpatient Treatment (AOT) referrals
  - Conservatee data
  - local misdemeanor Incompetent to Stand Trial numbers

# CARE COURT IN STANISLAUS COUNTY

## CARE Court BHST



# STANISLAUS COUNTY'S CONTINUUM OF CARE



# STANISLAUS COUNTY CARE ACT DATA



86 Unique Individuals  
Served



57 Petitions Received



24 CARE Agreements  
1 CARE Plan

# LESSONS LEARNED AND RECOMMENDATIONS FOR COHORT 2

- What's Been Working
  - Community Engagement and Education
    - Series of town hall meetings to educate community members
    - Social media presence
    - Ongoing partnerships with community stakeholders
    - Trainings to law enforcement, first responders, hospital partners and other agencies
      - Created workflows to assist with submission of petitions as needed
  - Early Intervention and Engagement
    - Early intervention has been key. Identifying and supporting individuals into the appropriate treatment option prior to their situations escalating has proven successful.
  - Collaborative Approach
    - Strengthening collaboration between the courts, BHRS, and other community providers has helped streamline access to care.
  - Using CARE ACT as another "tool in the toolbox"
    - We have successfully engaged individuals into Behavioral Health services that did not meet the CARE Act criteria.

# LESSONS LEARNED AND RECOMMENDATIONS FOR COHORT 2

- Resource Allocation
  - Ensuring adequate staffing, especially mental health clinicians, remains a challenge
- Intersection of CARE Court and Criminal Courts
  - The intersection of criminal proceedings and this new civil process can be challenging

# Additional County Mental Health Resources

Our Behavioral Health and Recovery Services team is available 24/7 at our Access, Crisis and Support Line at **(888) 376-6246**

[Behavioral Health and Recovery Services - Stanislaus County \(stancounty.com\)](https://www.stancounty.com/behavioral-health-and-recovery-services)

[Stanislaus County Superior Court Website](https://www.stancounty.com/superior-court)

[Care Court - Behavioral Health and Recovery Services - Stanislaus County \(stancounty.com\)](https://www.stancounty.com/care-court)



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Chandra Campbell  
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# Q&A With Councilmember Advisors



# Public Comment



# Upcoming Events

## [Full Council Meeting](#)

Friday, December 6, 2024, from 2:00-4:30 PM

Juvenile Justice Workgroup Meeting: TBD

Diversion/ Reentry Workgroup Meeting: TBD

Please visit our website at <https://www.cdcr.ca.gov/ccjbh/>

Email us at [CCJBH@cdcr.ca.gov](mailto:CCJBH@cdcr.ca.gov)

If you would like to be added to CCJBH's listserv, click [HERE](#).

**THANK YOU!**

