CARE Act Overview

What is the CARE Act?

In 2022, Governor Newsom signed SB 1338 establishing the Community Assistance, Recovery, and Empowerment (CARE) Act. The CARE Act creates a new pathway to deliver mental health and substance use disorder services to a subset of Californians with the most complex behavioral health conditions who too often suffer in homelessness or incarceration without treatment. This requires prioritizing those who need help the most, providing a comprehensive CARE plan that honors self-determination to the greatest extent possible, and holds our public systems accountable to delivering services and housing that are key to long term stability and recovery. The CARE Act is designed as an upstream intervention to divert from and prevent more restrictive conservatorships or incarceration.

The CARE Act provides a pathway for individuals to participate in creating their own CARE plan that outlines individual needs. The CARE plan is implemented by local government entities – primarily counties – who are obligated by court order to deliver on the individualized elements of the plan, which include behavioral health services, housing, and support.

The local civil courts have the authority to monitor the implementation of the plan components by local government entities, hear implementation concerns by either the participants or local government partners, and take steps to ensure the plan is fully implemented. Court actions include the potential for sanctions of local government partners who fail to implement CARE plan components. Court monitoring is meant to provide support and encouragement to participants who will often require some assistance to continue with the plan's components and to ensure the services and housing being offered meet the needs of the participant.

Unlike the requirement on local government, individual CARE Act participants are not forcibly compelled to participate. There are no locked doors in the CARE Act. Robust engagement practices support active participation, however, if the individual does not participate in their plan, they may be scheduled for additional court hearings and may eventually be terminated from the CARE proceedings and/or the Court may use existing law to ensure their safety.

How does the CARE Act work?

The CARE Act is a pathway to allow certain people, called “petitioners,” to request civil court-ordered treatment, services, support, and a housing plan for eligible people 18 years of age or older, called “respondents,” who have untreated severe mental illnesses (schizophrenia or another psychotic disorder) and who meet specific health and safety criteria. Petitioners are encouraged to consider alternatives to CARE Act proceedings in advance of filing a petition. "Some respondents may “self-petition” to secure the services they need to gain and maintain stability living in the community."

CARE Act proceedings involve assessments and hearings to determine whether the respondent meets eligibility requirements. A county behavioral health agency must be involved in the process and must actively outreach to the respondent and initially seek to engage the respondent in voluntary services.

If the respondent does not engage in voluntary services and meets the CARE eligibility standards, a CARE agreement or plan may be created and, if approved, ordered by the civil court. The CARE plan or agreement lasts for up to 12 months, with the possibility to extend for an additional 12 months.

Individuals engaged in CARE plans and agreements may be prioritized for a range of services and programs, including supportive housing.

Who is eligible for CARE Act?

All eligibility determinations are case-specific, and respondents must meet all eligibility criteria listed below for a petition to be considered. Homelessness and a diagnosis alone are not sufficient to meet eligibility requirements.

While CARE respondents may be experiencing homelessness or housing insecurity, untreated severe mental illness and the resulting impairment is the primary driver of CARE eligibility.

A respondent must meet the following criteria to be eligible for CARE:

- Be 18 years of age or older.
- Have a severe mental illness with a diagnosis of a schizophrenia spectrum disorder or other psychotic disorder.
- Not be clinically stabilized in on-going voluntary treatment.
- Additionally, at least one of the following must be true:
    - The respondent is unlikely to survive safely in the community without supervision and the respondent’s condition is

substantially deteriorating, OR
    - The respondent needs services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to the respondent or others.
- The respondent's participation in a CARE plan or CARE agreement must:
    - Be the least restrictive alternative necessary to ensure the respondent's recovery and stability, AND
    - Be likely to benefit the respondent.

Who can file a petition?

Eligible petitioners include roommates, family members, clinicians, behavioral health departments, first responders or the respondent themselves.

What rights does a respondent have?

Supporting a self-determined path to recovery and self-sufficiency is core to the CARE pathway. Respondents have the right to be informed of the proceedings, the right to take part in the proceedings, the right to be represented in all stages of the process, the right to replace the court-appointed attorney with an attorney of their choosing, the right to have a supporter of their choosing throughout the process, and other rights.

In the CARE process, each respondent can choose a volunteer supporter. A supporter is an adult chosen by the respondent to assist them to understand, make, and express their decisions throughout navigating the CARE process. The supporter may be a friend, family member, faith leader, mentor, person with lived experience with a mental health and/or substance use disorder, or other support person chosen by the respondent. The role of the supporter is to help the respondent understand, consider, and communicate decisions to ensure the respondent can make self-directed choices to the greatest extent possible.

What is a CARE agreement or a CARE plan?

A CARE agreement and a CARE plan are written documents that specify services designed to support the recovery and stability of the respondent. These services can include: behavioral health care; counseling; specialized psychotherapies, programs and treatments; stabilization medications; a housing plan; an opportunity to complete a psychiatric advanced directive; and other supports and services provided directly and

indirectly through a local government entity.

A CARE agreement is a voluntary agreement entered into by the respondent and the county behavioral health agency after a civil court has found that the respondent is eligible for the CARE process. If a CARE agreement is not reached, the court will order the creation of a CARE plan, which will include an individualized range of community-based services and supports.

If a CARE plan is ordered by the court, there will be periodic status review hearings during which progress and challenges are discussed. Adjustments to the services and supports in the CARE plan can be made to support the respondent's success.

If included in the CARE plan or agreement, stabilization medications would be prescribed by the treating licensed behavioral health care provider, and medication management supports will be offered by the care team. The treating behavioral health care provider will work with the respondent to address medication concerns and make changes to the treatment plan as necessary. Stabilization medications may not be forcibly administered.

How is the CARE Act funded?

In California, county behavioral health departments are responsible for delivering Medi-Cal Specialty Mental Health Services, publicly funded substance use disorder treatment, and community mental health services. Most respondents in CARE will be Medi-Cal beneficiaries or eligible for Medi-Cal. For a respondent who has commercial insurance, CARE requires that a health plan reimburse the county for eligible behavioral health care costs.

Existing funding sources that may be used for CARE plan services and supports include nearly $10 billion annually for behavioral health care and $1.5 billion in funding through the Behavioral Health Bridge Housing program, as well as various housing and clinical residential placements available to cities and counties including over $14 billion in state funding to address homelessness made available over the last two years.

In addition, the state will provide CARE funding for technical assistance, data and evaluation, legal representation for the respondent, as well as funding to support court and county administration.

What housing is available to a respondent in CARE?

Housing is an important component to CARE, since finding stability and staying connected to treatment is next to impossible while living outdoors, in a tent or a vehicle. Respondents served by CARE will need a diverse range of housing, including clinically enhanced interim or bridge housing, licensed adult and senior care facilities, supportive housing, or housing with family and friends. The court may issue orders necessary to support the respondent in accessing housing, including prioritization for these services and supports.

What is the implementation process for CARE?

The CARE Act is being implemented in cohorts, with the first cohort of eight counties launching in 2023 (Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, San Francisco, and Los Angeles) and the remaining counties launching by December 2024.

As of March 2024, over 300 petitions have been filed and many individuals have engaged voluntarily or have entered into a CARE agreement or plan. Many more individuals, above and beyond those for whom a petition has been filed, are now being served by counties on the presumption that these high-need individuals may eventually end up in the CARE process. So instead of waiting, counties serve them now.

Counties report an array of partnerships that have been developed or strengthened at the county level, including local NAMI affiliates, first responders, hospitals, public defenders, and court Self-Help Centers.

The California Health and Human Services Agency, the Department of Health Care Services, and the Judicial Council continue to work closely with counties, the courts, legal representation, and others through site visits, in-depth technical assistance, and a 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 integrated, holistic care to respondents.

Why did California create the CARE Act?

For far too long, advocates for those with complex behavioral health challenges asserted that if only there were requirements on local governments to develop client-driven solutions for treatment, housing and

supports, more people would receive care earlier and avoid the likely, and often deadly, outcome of chronic houselessness, incarceration, or futile cycling through restrictive institutions.

The CARE Act pathway functions as a structure for local governments, and counties specifically, to intentionally engage individuals who may need additional support to consistently access services over a sustained period. CARE prioritizes participants for the services and supports they need. No longer will California walk by or over this population.

The CARE Act builds on California's significant recent efforts to increase access to mental health care for all, whether insured through Medi-Cal or private insurance; providing treatment and housing to those in crisis and with serious mental illnesses; supporting and serving children and young adults; and building our health care workforce. California has invested more than $10 billion in state resources to strengthen the continuum of community-based care options for Californians living with the most significant mental health and substance use needs including but not limited to the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration proposal, the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis and 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

Where can I learn more?

To learn more, please visit the CalHHS CARE Act website.