April 18, 2022

The Honorable Thomas Umberg
Chair, Senate Judiciary Committee
1021 O Street, Suite 3240
Sacramento, CA 95814

RE: SB 1338 (Umberg): The Community Assistance, Recovery, and Empowerment Court Program
As Amended on April 7, 2022 – CONCERNS
Set for Hearing on April 26, 2022 – Senate Judiciary Committee

Dear Chair Umberg,

On behalf of California's 58 counties, the California State Association of Counties (CSAC); Urban Counties of California (UCC); Rural County Representatives of California (RCRC); County Behavioral Health Directors Association of California (CBHDA); California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC); and the County Welfare Directors of California (CWDA) write today to express our members' respectful concerns regarding your Senate Bill 1338 as amended on April 7.

The measure as amended reflects Governor Newsom's vison for creating a new civil court process to reach and treat individuals living with untreated schizophrenia spectrum and psychiatric disorders. These new Community Assistance, Recovery, and Empowerment (CARE) Courts would work with public defenders, county behavioral health, and a new class of trained "supporters" to assist individuals with treatment, medication, and housing.

Our Associations understand that the language within SB 1338 represents a work in progress, and we appreciate the ongoing conversations with you and your committee, as well as the Newsom Administration and other stakeholders on the details. We share our collective analysis of the bill today with the understanding that additional collaboration and technical work is required.

As outlined in SB 1338, CARE Courts require significant engagement from counties – especially county behavioral health and county public defenders – from beginning to end. Our members have raised the following questions, both legal and policy, regarding the language in SB 1338:

- Will local governments or non-affiliated providers be allowed to refer an individual to CARE Court, and will petitioners of any category have the right of legal representation?

Continued on next page

- 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?
- How many times might an individual participate in CARE Court over their lifetime?
- 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?
- How will CARE Court be evaluated? Who petitions, how many participants, what are the outcomes and how does CARE Court alleviate or increase impacts on other systems such as public safety, public guardians/conservators and adult protective services?

Counties believe CARE Courts could serve as a new tool to assist those who cannot help themselves as a result of their mental illness. Because of the vulnerability of the target population and the myriad questions raised by our members as well as other stakeholders, we respectfully suggest the exploration of three additional questions by your Committee:

1. Is the civil court system the proper venue for engaging those who initially lack medical decision- making capacity?
2. Are CARE Courts potentially redundant considering the robust Mental Health, Drug, and other specialty courts currently operating in most counties?
3. Could the state implement CARE Courts as an opt-in pilot project? This third suggestion would allow counties, the courts, and the Legislature 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.

Additionally, we must also express our strong opposition to the notion of proposed penalties and court-ordered receivership for counties that fail to meet the court's undefined expectations under SB 1338. 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.

Our Associations are working diligently to identify and estimate county responsibilities and potential costs to assist with a successful implementation regardless of scale. We each also submitted extensive comments to the California Health and Human Services Agency in late March on CARE Courts before SB 1338 was in print; we have attached those documents to provide additional detail related to county concerns.

Counties are committed to working with all stakeholders to implement CARE Courts in a conscientious and sustainable manner to achieve your vision of early intervention and assistance for some of the most vulnerable Californians. We thank you for the opportunity to provide these comments and look forward to continuing working together on SB 1338.

Sincerely,

Jacqueline Wong-Hernandez
Deputy Executive Director for Legislative Affairs
CSAC
Jwong-hernandez@counties.org

Kelly Brooks-Lindsey
Legislative Advocate
UCC
kbl@hbeadvocacy.com

Mary-Ann Warmerdam
Senior Vice President of Governmental Affairs
RCRC
mwarmerdam@rcrcnet.org

Cathy Senderling-McDonald
Executive Director
CWDA
csend@cwda.org

Michelle Cabrera
Executive Director
CBHDA
csend@cwda.org

Scarlet Hughes
Executive Director
CAPAPGPC
shughes@capapgpc.org

cc. Honorable Members, Senate Judiciary Committee
Ana Matosantos, Cabinet Secretary, Office of Governor Newsom
Jessica Devencenzi, Deputy Legislative Secretary, Office of Governor Newsom
Kim McCoy Wade, Senior Advisor on Aging, Disability, and Alzheimer's, Office of Governor Newsom
Jason Elliott, Senior Counselor, Office of Governor Newsom
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Newsom
Tam Ma, Deputy Cabinet Secretary, Office of Governor Newsom
Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Corrin Buchanan, Deputy Secretary for Policy and Strategic Planning, California Health and Human Services Agency
Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
Michelle Baass, Director, Department of Health Care Services
Susan DeMarois, Director, Department of Aging
Martin Hoshino, Administrative Director, Judicial Council
Marjorie Swartz, Policy Consultant, Office of pro Tem Atkins
Allison Whitt Meredith, Counsel, Senate Judiciary Committee
Reyes Diaz, Principal Consultant, Senate Health Committee
County Legislative Coordinators
County Caucus

California State Association of Counties®

OFFICERS

President
Ed Valenzuela
Siskiyou County

1st Vice President
Chuck Washington
Riverside County

2nd Vice President
Bruce Gibson
San Luis Obispo County

Past President
James Gore
Sonoma County

EXECUTIVE DIRECTOR
Graham Knaus

March 26, 2022

Secretary Mark Ghaly, M.D.
California Health and Human Services Agency
1215 O Street Sacramento, CA 95814

RE: **Comments Regarding Governor Newsom's CARE Court Framework**

Dear Secretary Ghaly,

The California State Association of Counties (CSAC) is a membership organization led by the elected county supervisors in each of the state's 58 counties. County Supervisors are elected by and responsible to the same constituents as our honorable state partners and are tasked with administering key health and human services programs on the state's behalf.

Counties are distressed and concerned about the homelessness crisis, which has not abated despite significant state investments and massive local effort. In response, counties seek an "all hands on deck" response with clearly defined roles, responsibilities, and resources among all levels of government to solve the greatest humanitarian problem of our time. Governor Newsom's Community Assistance, Recovery, and Empowerment (CARE) Court proposal is but one spoke of a much larger wheel of services and interventions that are needed to safely shelter vulnerable Californians. The CARE Court concept does align with the work that counties perform every day: reaching and helping people before they are caught in the unforgiving cycle of homelessness, the criminal justice system, and/or severe mental illness.

Notwithstanding the Herculean efforts by all levels of government and many state-level and community stakeholders, California does not yet have an integrated response to homelessness. Rather, the current system to address homelessness is a patchwork of programs and funding that lacks clear responsibilities, accountability and sustainable funding needed for each level of government and our partners to meet the need. Ultimately, profound progress on homelessness is only achievable through development of a comprehensive system from shelter and housing through services and rehabilitation that recognizes the integral role of the state, counties, and cities and aligns it to clear authority, responsibilities, accountability, and funding. Counties are fully prepared to engage in the development of such a system and invite our state and local partners to work through the many difficult issues to get there.

As the state's closest partners, counties appreciate the opportunity to provide input on the CARE Court framework. Counties are committed to working with the Newsom Administration and the Legislature on the technical and funding components required for implementation and ultimately, success. For CARE courts specifically, CSAC offers the following initial recommendations:

Population: Consult with behavioral health experts, including county behavioral health, to clearly and carefully define eligibility for CARE Court services. Statute must be carefully crafted to avoid severe unintended consequences: first, sweeping underserved and oppressed individuals into the court system and possibly conservatorship, or allowing a flood of petitions for individuals

who are not in crisis and who have access to housing and treatment resources, thereby preventing the people who might truly benefit from access to the program.

Presumptions and Process: Significant details on the entire process – from petition to investigation to clinical evaluation to participation, as well as how an individual might leave or "graduate" from CARE court – remain unknown. Designing a process that is fair, just, and successful requires extensive judicial, clinical, and civil rights expertise. Additionally, the factors for noncompliance have deep implications for the overall program and county systems. Counties are especially concerned about creating any legal presumption that might automatically refer and declare a noncompliant participant into a Lanterman-Petris-Short Act conservatorship. Placing a person into an LPS conservatorship unfortunately does not result in more housing and service options for that individual. Also, county public guardians and conservators, who are funded entirely with county general fund, are struggling to keep up with current caseloads of more than 60 clients per worker, double the recommended caseload for this type of intensive casework. Any new presumption to increase the number of new LPS conservatorships would require sustainable funding to implement.

Funding: Provide adequate and sustainable funding for all new CARE Court duties and obligations imposed on direct stakeholders, including the court system, public defenders, county behavioral health, public guardians and conservators, local law enforcement, and county social services. More details are required to determine whether new CARE Court duties represent reimbursable mandates, or new or higher levels of service under Proposition 30 – or both. Regardless, ignoring the funding needs of CARE Court partners simply ensures a single outcome for the CARE Court concept: failure.

Sanctions: The CARE Court concept is inherently a legal process, but the proposed plan to give courts the authority to sanction counties that "do not meet their specified responsibilities under the court-ordered Care Plans" is puzzling. Diverting funding from the very workers and programs designed to help individuals in crisis will needlessly exacerbate the problem. It also fails to acknowledge the fact that counties provide behavioral health and access to social services on behalf of the state and may only perform these critical services at the level that matches available funding and authority.

Housing: Housing is the linchpin for any strategy to reduce homelessness. The CARE Court framework includes a "housing plan" and the Governor has proposed $1.5 billion in one-time funding to help vulnerable clients obtain housing. Written plans and one-time funding, while necessary, do not meet the urgent need for long-term solutions and the wraparound and intensive services required to help Californians remain safely housed.

Thank you for the opportunity to provide input on the Governor's CARE Court framework. Given that counties provide services to all Californians – some funded entirely by counties, others in partnership with the state and federal governments as well as community organizations – our members are uniquely positioned to engage on the urgent systematic issue of homelessness. Counties are committed to building upon the state's investments and innovations, such as Project Roomkey and Homekey, the Behavioral Health Continuum Infrastructure Program, and the proposed Behavioral Health Bridge Housing funding to make CARE Courts successful. We also look forward to beginning the larger conversation regarding systematic change and the flexible funding needed to create a housing services continuum that ensures access to safe, healthy, and self-sufficient housing for all Californians.

Thank You,

As signed by

Graham Knaus
Executive Director
California State Association of Counties

cc. Ana Matosantos, Cabinet Secretary, Office of Governor Newsom
Jason Elliott, Senior Counselor, Office of Governor Newsom
Kim McCoy Wade, Senior Advisor, Office of Governor Newsom
Jessica Devencenzi, Deputy Legislative Secretary, Office of Governor Newsom
Richard Figueroa, Deputy Legislative Secretary, Office of Governor Newsom
Tam Ma, Deputy Legislative Secretary, Office of Governor Newsom
Marko Mijic, Undersecretary, California Health and Human Services Agency
Stephanie Welch, Deputy Secretary for Behavioral Health, California Health and Human Services Agency
Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, California Health and Human Services Agency

#

March 25, 2022

Secretary Mark Ghaly, MD
California Health and Human Services Agency
1215 O Street
Sacramento, CA 95814

RE: CARE Court Proposal

Dear Secretary Ghaly:

On behalf of the County Behavioral Health Directors Association (CBHDA) which represents the county behavioral health executives who administer Medi-Cal and safety net services for serious mental health (MH) conditions and substance use disorders (SUDs) in all 58 counties in California, I write to provide the following comments on the Community Assistance, Recovery & Empowerment (CARE) Court proposal introduced by the Administration on March 3rd. This letter outlines a variety of considerations and concerns which we believe are necessary to resolve in order to achieve CARE Courts' ambitious goals.

CARE Court has been discussed as a solution to homelessness, upstream engagement for individuals who do not meet conservatorship criteria, and a prevention measure to stem the growth in individuals with felony charges found incompetent to stand trial (IST). The proposal has been put forward as a proposed framework and paradigm shift to deliver mental health and substance use disorder services to the most severely impaired Californians who suffer the impacts of untreated mental illness, including homelessness and incarceration. County behavioral health agencies would be central to this proposal, as the entity held responsible by the courts for the implementation of CARE Court plans, and as such respectfully request consideration of our concerns and recommendations outlined below.

Funding for County Behavioral Health Services
County behavioral health will require new funding to implement CARE Courts in any meaningful and successful way. CARE Courts would require county behavioral health to incur new expenses and to divert already scarce clinicians and staff to engage with the court in the development of care plans, as well as potential engagement with a new client population. While we understand that the intention is to target a relatively small population of individuals with certain identified conditions, because high expectations have been set for the potential of CARE Courts across multiple interest groups, without clarifying criteria and appropriate controls on referrals, CARE Courts could easily result in a significant redirection of staff and other resources, impacting our ability to fund our core Medi-Cal entitlement and other vital upstream prevention and early intervention strategies.

Given our current workforce shortage, adding a significant new programmatic responsibility without new resources will increase workforce burnout, and undermine the goals of CARE Court to successfully engage individuals into services prior to conservatorship or law enforcement involvement.

Today, county behavioral health staff typically spend hours on standby in Mental Health, Drug, or Homeless Courts or consulting with law enforcement and court partners. This time is rarely Medi-Cal reimbursable. As such, the requirement to staff CARE Court activities is likely a reimbursable mandate. In addition, if CARE Court is considered coercive, questions may arise about whether Mental Health Service Act (MHSA) funding can be used for these expanded services, and counties would need to rely on realignment funds which are already oversubscribed.

While the Administration has cited this year's growth in funding for county behavioral health as evidence of sufficient funding for county behavioral health services, counties' ability to grow funding is based on the temperamental millionaire's tax, and each of our funding streams come with different funding parameters and restrictions. In addition, county behavioral health funding from various sources is not linked to growth in the Medi-Cal population and their needs, or the cost of doing business. It is well documented that the trauma and stress of the pandemic have resulted in increased SUD and mental health needs across the whole population. None of this increased demand for services within the Medi-Cal population is accounted for in how funding is structured. County behavioral health alone cannot predict nor prevent the social determinants of significant behavioral health crisis or need, including the impact of anti-gay and transgender policies in other states, structural racism, the global pandemic, social media, or lack of housing. Adjustments to revenues do not come with inflation that increases the cost of sustaining a specialty network, including workforce salary and benefit costs. More must be done to acknowledge that external factors may increase demand for specialty behavioral health services and to resource our public behavioral health safety net accordingly.

- **Recommendation:** CBHDA requests that, at a minimum, the Administration adequately fund county behavioral health for increased staffing and service costs related to CARE Courts to ensure that CARE Courts do not exacerbate our existing workforce crisis and to support quality care plan development and implementation.

Equity

Currently, the CARE Court construct identifies individuals with either schizophrenia spectrum or psychotic disorders who lack medical decision-making as eligible for CARE Courts. This category is inclusive of individuals with drug-induced psychosis. These eligibility criteria create the need for CARE Courts to be designed with equity considerations at the forefront.

For example, it is well documented that the largely white profession of psychiatry tends to inappropriately misdiagnose Black and Latinx individuals with schizophrenia and other psychotic disorder diagnoses. A 2019 study[1] found that Black individuals are more likely to be diagnosed with a psychotic disorder than white individuals, despite no scientific evidence that they are more likely than other populations to have schizophrenia. Researchers found that this misdiagnosis was due to racial bias and clinicians not appropriately screening for and diagnosing depression and mood disorders. Similarly, despite lower rates of drug use than whites, African Americans are more likely to be incarcerated for drug-related offenses due to racial bias in the policing of drug use.

[1] Michael A. Gara, Shula Minsky, Steven M Silverstein, Theresa Miskimen, Stephen M. Strakowski. A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic. Psychiatric Services, 2019; 70 (2): 130 DOI: 10.1176/appi.ps.201800223

We must raise concerns that by attempting to narrow referrals by limiting this court program to schizophrenia spectrum and psychotic disorders, this proposal may unintentionally increase stigma and discrimination towards individuals with significant behavioral health conditions and expand court and justice involvement for Black Californians, who are more likely to be misdiagnosed and overpoliced. Because CARE Courts set up a court-based structure to compel adherence to a care plan, with a legal presumption for conservatorship, we believe that these equity and disparity considerations must be carefully considered upfront.

- **Recommendation:** At a minimum, the concerns around misdiagnosis argue for careful research and evaluation components which specifically identify the race, ethnicity, sexual orientation and gender identity, and payer status of individuals referred to CARE Courts, and their outcomes. These data should be publicly reported annually, and the state should establish an independent quality and oversight review entity, to include peers and clinicians with expertise in schizoaffective disorders and substance use disorders, to provide recommendations for addressing identified disparities.

Another equity consideration relates to the disparate resources and misaligned regulations for mental health and substance use disorder (SUD) treatment services, even within Medi-Cal. Inclusion of drug-induced psychosis as criteria for CARE Court could result in individuals with a primary SUD diagnosis coming into CARE Court. This creates problems related to Lanterman-Petris-Short Act criteria, including the new legal presumption created through CARE Court, funding for inpatient resources and access to other treatment requirements that may be mandated but not funded under Medi-Cal. These challenges are especially pronounced when the SUD is primary without an additional mental health diagnosis to support additional mental health services and supports.

- **Recommendation:** Establish a workgroup with CBHDA and other interested stakeholders with expertise in SUDs to make specific recommendations on whether to include individuals with a primary SUD diagnosis as part of CARE Court and any special funding, legal, and other considerations and protections that would be necessary to ensure effective interventions and outcomes for this population.

- **Recommendation:** Expand Drug Medi-Cal Organized Delivery System (ODS) Medi-Cal benefits as a fully funded statewide benefit to include this broader set of SUD services consistently throughout all counties in California as a fully funded Medi-Cal benefit.

Referrals

While we appreciate that the proposal has been designed to target a relatively small population, based on diagnostic criteria and lack of capacity to make medical decisions, we are concerned that referrals into CARE Courts could be higher than anticipated, as cities, family members, and other stakeholders have viewed this as a means to address homelessness and broader systemic challenges with access to behavioral health treatment, particularly for those with commercial insurance.

Non-clinicians could easily overwhelm courts with inappropriate referrals, slowing down courts, and ultimately, the provision of CARE Court services, as referrals are evaluated to determine eligibility. In addition, the rise in new, synthetic methamphetamines and other yet to be discovered substances whose

effects may mimic psychosis are difficult to predict or control for and may increase legitimate referrals over time.

In discussions with CalHHS, there has also been a suggestion that CARE Courts could serve as a diversion from Lanterman-Petris-Short (LPS) conservatorship, although details on how this would function are lacking. CBHDA would appreciate understanding more about this concept.

- **Recommendation:** Given the already significant impacts on court alienists due to competency doubts, CBHDA recommends clearer communication to community stakeholders regarding the goals and target population for CARE Courts. The state's emphasis on CARE Courts as a response to homelessness is harmful in that it reinforces inaccurate assumptions that behavioral health conditions are the primary driver of homelessness in California, and that mental health treatment alone is needed to address our homeless crisis.

- **Recommendation:** In addition, should cities or other referral entities attempt to make mass referrals of individuals experiencing homelessness, CBHDA would request consideration of caps, penalties or fines for inappropriate referrals. For example, given that fewer than 30% of individuals experiencing homelessness have a significant mental health condition, referrals should not exceed 20% of a county's annual point in time homeless count.

- **Recommendation:** Finally, CBHDA requests that the state closely monitor referral rates and sources to evaluate the perceived versus actual need for these services, as well as make funding and programmatic adjustments as needed to adequately resource this initiative.

Clinical Evaluation

Courts would be responsible for assessing eligibility for CARE Courts through a clinical evaluation. CBHDA is concerned with this element of CARE Courts, given the struggles the courts have faced in providing adequate oversight of quality alienist evaluations when competency to stand trial is in doubt. During the IST Solutions Workgroup in the Fall, stakeholders learned that alienists are hired by the courts in haphazard ways with no clinical or quality oversight, leading to consistently unreliable IST determinations. The work group identified that these problems were due to: low alienist pay, a lack of training and clear standards for clinicians (e.g. alienist certification requirements), and the court's lack of quality and clinical oversight ability. For example, alienists often failed to even provide a diagnosis in their IST court reports. CBHDA members are especially concerned that the current 730 court evaluator panels lack the training and ability to appropriately diagnose and recommend services to CARE Court participants.

In addition, since the passage of SB 317 (Stern) Chapter 599, Statutes of 2021, which creates a glidepath to diversion or dropped charges for misdemeanor ISTs, the courts have been overwhelmed by an influx of new doubt declarations for individuals with misdemeanor charges. For example, the County of San Francisco reported that requests for IST evaluation shot up from roughly *ten per year to five to seven per week* for individuals charged with misdemeanors since the law went into effect in January, completely overwhelming the already stretched capacity of court alienists. CBHDA members in other regions of the state confirmed similar sharp increases in misdemeanor IST referrals since the start of the year.

- **Recommendation:** In light of these challenges, CBHDA strongly suggests shifting responsibility for clinical evaluation for criteria to county behavioral health, along with the necessary funding to build the clinical workforce needed to evaluate and assess CARE Court participants. While county behavioral health also faces significant workforce challenges post-pandemic, county behavoral health clinicians will have the expertise to accurately determine eligibility based on clinical need and other eligibility factors, as well as knowledge of the range of services and supports available to participants. If county behavioral health is not provided with the responsibility and funding to perform evaluations, we urge you to consider the development of a wholly new panel of specially trained evaluators with expert knowledge of specialty behavioral health conditions and local resources rather than rely on the current panel of court experts.

- **Recommendation:** In addition, county behavioral health clinicians will be able to both evaluate referrals and conduct the assessment which will eventually inform the development of the behavioral health care plan. This strategy of frontloading assessment as part of the clinical evaluation was an idea that was presented as part of the DSH IST Solutions workgroup and could be revisited to more efficiently use the time of county behavioral health clinicians involved in clinical evaluations for CARE Court purposes.

Supporter

CARE Courts rely on a modified supported decision-making process to provide individuals who meet CARE Court criteria with assistance in understanding, considering, and communicating decisions, as well as providing the participant with the tools to make self-directed choices to the greatest extent possible. Questions remain about who could be eligible to participate as a supporter and the scope of supporter responsibilities, and whether and how a supporter would be provided with training, compensation, or professional standards. The role of certified peers in facilitating recovery is well-documented and should not be lost, regardless of the ultimate design of the supporter. Providing appropriate training and support to supporters to ensure fidelity to the supported decision-making model, will be important. Any professional supporter role should be housed within county behavioral health to ensure participants benefit from certified peer supports with an understanding of the services and supports available to the participant.

- **Recommendation:** Fully fund California's Medi-Cal peer support services as a statewide benefit to ensure that CARE Court participants have adequate access to peer support services, whether as court supporters, or a complementary specialized support for the participant's recovery.

- **Recommendation:** Develop and fund training for supporters, courts, and county behavioral health to ensure fidelity to the supported decision-making model.

- **Recommendation:** Fund supports for family members. Family Psychosocial education and support and family respite have proven to help families with their loved ones along their recovery journey. Not including supports for families is a missed opportunity to strengthen the family supporting a loved one with a chronic condition.

Care Plan Elements
CBHDA understands that the purpose of this model is to attempt to avoid conservatorship and law enforcement involvement through engagement into development of a care plan and an advanced directive with assistance from a supporter along with county behavioral health. The three core elements of the CARE Court care plan are:

1. Behavioral health treatment
2. Medications
3. Housing

Behavioral Health Treatment
CBHDA has numerous questions regarding the scope of behavioral health services that can be ordered by the court as part of this care plan development. First, it is important to understand whether the courts will be able to order behavioral health services that are not a part of that county's Medi-Cal entitlement to CARE Court participants. Because county behavioral health agencies serve as the Medi-Cal plan for specialty mental health and substance use disorder services, our counties are required to provide any medically necessary covered benefits to eligible Medi-Cal beneficiaries. However, due to how Medi-Cal specialty behavioral health services have been developed at the state level, often services and supports which can benefit Medi-Cal beneficiaries may not be covered under Medi-Cal or other insurance, such as outreach and engagement, food, and social services. Residential and inpatient level of treatment may also be excluded from Medi-Cal reimbursement under the Institutes for Mental Disease (IMD) Exclusion based on size of facility. Medi-Cal also includes several key optional benefits, such as Drug Medi-Cal Organized Delivery System (ODS) plan benefits for residential drug treatment and case management and the new peer support specialist benefit. Finally, CARE Court has been presented as a program open to all Californians, regardless of payer status. Any services or supports beyond standard Medi-Cal benefits vary tremendously from county to county due to the role of local communities in guiding funding decisions, and the ability of each county to resource additional services and capacity with grants and categorical funding streams.

- **Recommendations on Care Plan Behavioral Health Services:** Limit courts to standard Medi-Cal benefits and ensure courts are equipped with an understanding of what those are.

- **Recommendation:** Require commercial plans to provide court-ordered services or pay county behavioral health at cost for care plan services.

- **Recommendation:** Fund additional behavioral health services and supports which may not be reimbursable under Medi-Cal but necessary to achieving care plan goals.

- **Recommendation:** As already noted in our comments, CBHDA would also request consideration of expanding Medi-Cal optional benefits such as the peer support specialist benefit and Drug Medi-Cal Organized Delivery System (ODS) to ensure more consistency on quality, impactful optional benefits such as these on a statewide basis.

Mental Health Advance Directives
The CARE Court Framework also includes the adoption of a mental health advance directive. Starting in 2021, five counties (Fresno, Mariposa, Monterey, Orange, and Shasta) secured an MHSA Innovation

grant to develop a standardized Psychiatric Advance Directive (PAD) template, training resources and a "toolkit" (all in multiple languages), PADs accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures. Additional counties are expected to join in this collaborative; however, PADs are not commonly used tools nationally or in state. CBHDA members are highly supportive of the development of PADs as a standardized tool to engage clients prior to a crisis, however, it will take additional time, training across various clinical settings, including hospitals and other providers, and resources to make them a truly effective tool to support individuals at risk of experiencing a psychotic break.

Recommendation: Develop a work group to explore the legal, infrastructure and operational changes that will be needed to be addressed in order to bring use of PADs to scale. Again, access to PADs should not be contingent upon involvement in CARE Courts, but we welcome the opportunity for further dialogue and engagement on how to advance the use of PADs in California.

Medication

With respect to the medication component, while psychiatric medications can be instrumental in stabilization and and treatment of psychiatric disorders, this category also has limitations. First, CBHDA members question whether the court could direct physicians to prescribe medications in light of physician autonomy in clinical decision making?

- **Recommendation on Medications:** Restrict the ability of the courts to override the clinical recommendations of treating physicians.

Housing Plan

The CARE Court care plan would also include a plan for housing participants. Often, housing barriers for individuals with significant behavioral health needs are as much on the housing provider side as they are with our clients. CBHDA surveyed counties in early 2022 regarding efforts to house individuals already voluntarily participating in services through Full Service Partnerships (FSPs). Of the more than 12,000 individuals who entered FSPs unhoused in the past year, county behavioral health has been successful in housing roughly half. However, the other half remained *unhoused and in treatment*. Typical reasons our FSP clients remained unhoused included: no housing available in the community, inability to meet credit checks, and other rental criteria, participants were not welcome due to behaviors related to their conditions, e.g., inability to live with roommates.

CBHDA is deeply appreciative of the Administration's proposal to invest $1.5 billion in Bridge Housing targeting county behavioral health clients, yet we are concerned that the current design of CARE Courts would fall short of adequately addressing the long-term housing needs of participants. Many CARE Court participants are likely to require 24/7 staffed housing options over many years in order to succeed in remaining stably housed. In addition, some unhoused CARE Court participants will likely require a higher level of support than intensive case management available under Medi-Cal and their need for subsidized housing and housing supports will continue beyond the timeframe for the proposed Bridge Housing proposal as these are chronic conditions.

Furthermore, CBHDA must note here that development of a housing plan, without additional help from the courts to compel cities and local housing authorities, or Medi-Cal managed care plans to dedicate housing resources will significantly stymie CARE Courts' effectiveness.

CBHDA would have liked to see additional accountability and tools to compel housing authorities to prioritize the needs of our clients as well. Finally, we would object to restricting proposed Bridge Housing funds to CARE Court participants as counties are hopeful that those resources can be used to address the immediate needs of our clients actively engaged in services while unhoused. CBHDA is concerned that requiring county behavioral health to develop a housing plan within existing resources will result in outcomes similar to what we see with our FSP participants today.

- **Recommendations on Housing Plan:** Give courts the authority to seek and order housing from local housing authorities for CARE Court participants.

- **Recommendation:** Align the court's authority over housing authorities with that afforded to them for oversight of behavioral health services.

- **Recommendation:** Ensure access to Medi-Cal managed care plan housing Community Supports benefits for CARE Court participants.

- **Recommendation:** Expand the state's investment of $1.5 billion in Bridge Housing for county behavioral health clients to include more long-term, sustainable housing options, such as permanent supportive housing vouchers, maintenance costs, board and care patches, and other housing services and supports as ongoing funding.

<u>Other Health Plans</u>
CBHDA is also unclear about why other services and supports are not identified as necessary to the goals and outcomes of CARE Court. For example, Medi-Cal managed care plans (MCPs) have responsibility for the Medi-Cal non-specialty mental health, enhanced care management, community supports, transportation, and physical health benefits. For the CARE Court target population, their unmet physical health needs are more likely to contribute to early mortality than their mental health conditions. Commercially insured beneficiaries, likewise, have existing health plans who are likely already responsible for the delivery of a range of health and behavioral health services. Again, CBHDA fails to see how the MCP and commercial plans' responsibilities to attend to those needs can be viewed as separate.

- **Recommendation on Broader Medi-Cal Benefits and Services:** CBHDA would request that CARE Courts be designed with this disparity and parity of services in mind to expand the care plan to include accountability for Medi-Cal MCP services to be delivered, whether it is a non-specialty mental health service for a person with a SUD, or physical health services and the all-important transportation benefit or others.

- **Recommendation on Commercial Plans:** Ensure that commercial plans are held accountable for covered physical and behavioral health services for their beneficiaries, and require commercial plans to reimburse county behavioral health at cost for additional services provided through the county behavioral health agency under CARE Court.

Other Connected Systems and Services

In addition to a broader range of Medi-Cal services, some of our more challenging clients have co-occurring developmental disabilities or other conditions that cannot be addressed through county behavioral health services, such as individuals with long-term care needs, and intellectual and developmental disabilities.

- **Recommendation on Broader Connected Systems and Services:** A work group may be necessary to better analyze and understand the various systems that may be required to assist with helping the target populations to succeed in CARE Courts, whether Regional Centers, aging, long-term care or other services.

Court Ordered Services

County behavioral health agencies have extensive experience with court-ordered behavioral health services across multiple specialty courts throughout the state, and have experience with court attempts to weigh in on treatment modalities and care plan specifics, particularly with respect to medications.

- **Recommendation:** Ensure appropriate and effective care plans and ensure the integrity of clinical decision-making by prohibiting courts from ordering specific treatment services or modalities, including medications.

Sanctions

CARE Court proposes to sanction and even appoint a court agent to direct county behavioral health resources for failing to provide court-ordered services.

Although county behavioral health plans are required to offer and provide Medi-Cal specialty mental health and substance use disorder services, any services that are funded and available beyond Medi-Cal may not be available in every county. Even with guaranteed reimbursement, failure to provide a service that is not offered under the standard Medi-Cal benefits package will present unique challenges, particularly if contract providers are not readily available in that jurisdiction, or counties must prioritize Medi-Cal entitlements. Under CARE Court, a county without the resources needed to comply with the court ordered plan would be further financially penalized, diverting funding from the county's core Medi-Cal entitlement responsibilities and subjecting them to further fiscal sanctions from other regulators, such as DHCS. Furthermore, the degree of COVID-19's impact on new demand and eligibility for county behavioral health services, along with related workforce shortages, may legitimately constrain counties' ability to meet the court's expectations. Questions remain about the nature of the sanctions which could be ordered and their purpose.

- **Recommendation:** Remove the proposed sanction from the CARE Court framework as it would in no way contribute to the creation of programs or services that do not exist today.

- **Recommendation:** Should sanctions remain a component of care courts, they should be expanded to include other responsible entities, such as those responsible for housing, MCPs, commercial insurance payers, and others.

New Legal Presumption
CBHDA is concerned that this proposal would bypass the professional judgement of Public Guardians/Conservators and county behavioral health clinicians by creating a new presumption for LPS Conservatorship for anyone who is found by the court to have failed to comply with the Care Plan developed in this new court process. Trained professionals should have the ability to advise the court on the individual's progress and whether conservatorship is appropriate or necessary as the experience of involuntary treatment can further traumatize and harm individuals, particularly when it is not necessary or helpful in their recovery and engagement into services.

- **Recommendation:** Revise CARE Court to remove the automatic presumption that failure to comply with the CARE Court care plan is indicative of the need for conservatorship. Instead, allow public guardians and behavioral health to make a recommendation related to the value of a potential conservatorship.

Implementation Timeline
Implementation should be delayed to ensure county behavioral health and courts have the time to build up services and staffing to support CARE Courts, including the additional infrastructure under the Behavioral Health Continuum Infrastructure Program and Community Care Expansion program which launched this year.

- **Recommendation:** Delay implementation of CARE Courts until at a minimum 2025 to allow for complementary housing, infrastructure, workforce and other investments to accrue.

CARE Court Outcomes & Evaluation
CARE Courts should be evaluated to understand outcomes, any unintended consequences, and to center the voice of the individuals who move through this new court process. Several examples have been provided here, however, given the potential for CARE Courts to usher in a new form of coerced care for individuals with specifically identified psychotic disorders, a rigorous evaluation component is merited, along with a sunset.

- **Recommendation:** Require a rigorous longitudinal evaluation of CARE Court to analyze outcomes and provide recommendations for programmatic challenges, barriers and areas of potential improvement or modification.

- **Recommendation:** Include a sunset to allow for the Legislature and other stakeholders to evaluate and consider changes.

- **Recommendation:** Require data collection on the number of individuals referred for conservatorship as a result of unsuccessful CARE Court participation.

Today, county behavioral health agencies and the clients we serve will be most significantly impacted by the CARE Courts proposal. Because of the central role of county behavioral health, CBHDA appreciates the consideration of our membership's input on this iteration of the proposal and moving forward. We agree that more can be done to address the needs of individuals with significant behavioral health needs and in particular individuals experiencing homelessness. However, CBHDA disagrees with

the notion that solving for these issues is a matter of prioritization of existing resources and court oversight. We believe that the only way for substantial progress to be made in engaging individuals upstream of involuntary treatment and justice involvement will require partnership between the state and county behavioral health agencies and look forward to our continued engagement as key stakeholders in the development of CARE Courts.

Sincerely,

Michelle Doty Cabrera
Executive Director

Cc: Marko Mijic, Undersecretary, CalHHS
Stephanie Welch, Deputy Secretary, CalHHS
Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, CalHHS
Kim McCoy Wade, Senior Advisor, Office of Governor Newsom
Jessica Devencenszi, Deputy Legislative Secretary, Office of Governor Newsom
Tam Ma, Office of Governor Newsom
Richard Figueroa, Office of Governor Newsom
Michelle Baass, Director, DHCS
Jacey Cooper, Medicaid Director, DHCS
Dr. Kelly Pfeifer, DHCS

CWDA
Advancing Human Services
for the Welfare of *All* Californians

925 L Street, Suite 350
Sacramento, CA 95814
p: 916.443.1749 | f: 916.443.3202
cwda.org

March 25, 2022

Dr. Mark Ghaly
Secretary, California Health & Human Services Agency
1215 O Street
Sacramento, CA 95814

Re: CARE Court Comments

Dear Secretary Ghaly:

On behalf of the 58 county human services agencies we represent, the County Welfare Directors of California (CWDA) writes to provide comments and considerations for the Governor's Community Assistance, Recovery and Empowerment (CARE) Court proposal. We appreciate the multi-jurisdictional approach of the CARE Court framework. In the social services and housing programs that county human services agencies operate, we know the value of a wholistic and systemic approach to meeting the needs of vulnerable children, families, and adults. We also know that clarity in the roles, responsibilities, and expectations of all jurisdictions will be essential to successful implementation of the CARE Court program as envisioned. To that end, CWDA raises the following questions and considerations for the Administration as the Care Court proposal continues to be further developed.

- The recent conversations and published materials on the proposal so far indicate that court-ordered Care Plan is to include social services, but there has been no description of those services. What are the specific social services that are envisioned to be required as part of the Care Plan? If any of those social services either do not currently exist or are not provided by counties, can the court compel counties to offer them to individuals participating CARE Court?

- What specific role is envisioned for county human services agencies in developing or implementing the Care Plan? Does the responsibility for providing the social services ordered in the plan fall to county human services agencies? At a minimum, it will be important that the entities responsible for developing the Care Plan, including the courts, the Supporter, and other county agencies, be aware of the services and supports offered by county human services agencies and coordinate with their human services partners. The roles and responsibilities of county human services agencies should be clearly defined, particularly if those agencies are expected to provide services that are included in the Care Plan enforced by the courts. Any additional coordination or case management that is required of county human services agencies under the CARE Courts will also need to be funded as those are not functions counties currently perform.

- Would individuals, by virtue of their participation in the CARE Court, be considered eligible for various programs run by human services agencies, or would they be referred to those programs and need to meet the program's eligibility criteria to receive any services offered by those programs? If county human services agencies will be expected to provide services through our programs to individuals with a Care Plan who are not otherwise eligible for the specific program, who pays for that?

- What is the nexus between an individual refusing services through the CARE Court or failing to comply with their Care Plan and the definition of self-neglect for purposes of determining eligibility for Adult Protective Services (APS)? If there are additional referrals and caseload in the APS program driven by the CARE Court, who pays for that? There may be Proposition 30 implications for impacts on the APS program.

- Should an individual "fail" their Care Plan, is there still a role for human services agencies? Are services provided for the duration of an individual's participation in the CARE Court intended to end if an individual does not comply with their Care Plan?

- Can judges penalize counties for not meeting specific elements of the Care Plan? Can counties be penalized for not providing services ordered in the Care Plan that do not exist or are not provided by counties? Can counties be penalized if there is insufficient capacity to provide services because there are not enough community providers or other issues beyond the county human service agency's control? What form will the penalties/sanctions take?

We realize that the CARE Court proposal is in the early stages of development and there may not be answers yet to many of these questions. CWDA looks forward to working with the Administration and other county agencies in developing the details to achieve the vision and ensure the successful implementation the CARE Court model. Thank you for the opportunity to provide this feedback.

Sincerely,

Cathy Senderling-McDonald | Executive Director

cc: Stephanie Welch, CalHHS
Corrin Buchanan, CalHHS
Kim McCoy Wade, Office of the Governor
Jessica Devencenzi, Office of the Governor

March 28, 2022

The Honorable Gavin Newsom
Governor, State of California
State Capitol Building
Sacramento, CA 95814

RE: Care Court: Statement of the California Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC)

Dear Governor Newsom:

On behalf of the California State Association of Public Administrators, Public Guardians, and Public Conservators (CA PAPGPC) we would like to applaud your proposal to provide services to the State's most vulnerable citizens, those experiencing homelessness with significant mental health illnesses. The membership of CA PAPGPC is made up of all 58 counties whose PAPGPC programs serve as a safety net for the most vulnerable older and dependent adult Californians and their estates. Public Guardian/Conservator programs are appointed by superior courts to serve adults in every California county who are unable to act in their own best interests as a result of serious mental illness, cognitive impairment, or death. Public Guardians (PGs) primarily assist individuals with dementia, traumatic brain injuries, or other cognitive impairments that affect their ability to make decisions. Public Guardians make decisions for individuals' medical care, placements, housing, and financial matters. Public Conservators (PCs) become the legal decision maker for individuals with serious mental illnesses, such as schizophrenia, bipolar disorder, or depression, that affect their ability to provide for their own basic needs. They make decisions for individuals' psychiatric treatment, medical care, placements, housing, and financial matters

We are fully committed to working with your Administration as the details of the Care Court program are developed. Our members do have questions about the provisions of the program and respectfully seek clarification on the following issues:

Increased Referrals to Conservatorship: Care Court is being discussed as an alternative to conservatorship for those individuals who are eligible for services through the program. The goal of the client's participation in Care Court is to avoid Conservatorship, avoid locked placements and to provide "stabilizing medication" (verses crisis medication), housing and voluntary mental health treatment to help the client live well in the community. Care Court focuses on people with schizophrenia or other psychotic disorders who lack medical decision-making capacity before they become so impaired that they end up in conservatorship.

We believe Care Court creates a new pathway for individuals to enter into the mental health system and consequently will result in increased referrals of individuals determined to need conservatorship because they are either ineligible for Care Court services, may choose not to participate, or may not be able to fully participate in the care. As these individuals are clearly unable to care for themselves, and by virtue

of not being able to participate fully in Care Court, it is expected that "all other alternative" care will be considered to be exhausted, setting up the criteria for conservatorship by the courts. This increased case load comes with no additional funding or identified resources that are being discussed for Care Court participants.

County PCs and PGs already are severely under resourced. To our knowledge, County PG and PCs are the only social service program that does not receive any state funding for individuals currently being considered or are under conservatorship. To address this current lack of funding, CA PAPGPC has submitted a budget proposal for $200 million to cover current caseload needs, but that funding would be insufficient to meet the new Care Court population. Although there is dedicated Care Court funding it is not clear if the resources provided to individuals through Care Court, for example housing, would follow these individuals to conservatorship or if these resources will become the responsibility of the County.

Undefined Terms: The plan includes provisions for "evaluators", "supporters", petitions, and referrals, among others. These terms are being created and described in the upcoming detailed proposal, but at this time remain undefined. In current conservatorship law, referrals of patients come from a physician/psychiatrist who have examined an individual and refer them to the public conservator. A petition is created and filed with the courts to formalize the conservator relationship. As these terms have specific and legal meaning in the current system, those terms must be consistent to avoid confusion.

Additionally, the plan envisions "evaluators" and "supporters" without additional information on who those individuals will be, who will coordinate, supervise, and train these individuals. It has been suggested that PG/PCs might be the best entity to provide training for supporters on Supported Decision-Making. However, PG /PCs do not have the requisite expertise in Supported Decision-Making as a whole to provide the needed training or oversight.

Liability Protection: It is not clear what liability evaluators and supporters will incur as a result of their work in Care Court. The proposal is not clear on who will be responsible for ensuring the full scope of services to be provided to these individuals. Additionally, will counties be liable for those decisions made on their behalf? This must be addressed in the final proposal.

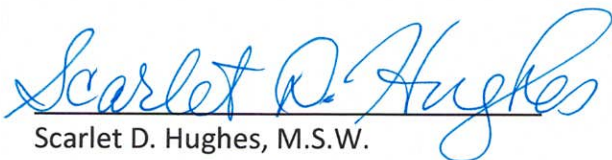
Process: Significant details on the entire process from the investigation process, the clinical evaluation to participation, as well as how the county will address individuals who leave CARE court, remain unknown. It is not fully clear how the individuals who are eligible for Care court services will be identified for the process, how they will enter the process and, if they do not complete care, how will they be removed from the system. It is not clear how individuals who may be equally ill and deserving of services will be handled outside this system. The factors for noncompliance have significant impact on program and county systems.

As previously stated, the CAPAPGPC membership serves those individuals who are unable to act in their own best interests as a result of a mental disorder, or cognitive impairment, and who have no other

person who is willing or able to act on their behalf. We are currently working internally to provide any thoughts on how to address the issues raised by the Care Court proposal. We appreciate the outreach to the Association by the Administration and are willing to provide any expertise we may offer to the debate.

Thank you very much for the opportunity to provide our thoughts on Care Court. Please contact me at shughes@capapgpc.org or call me at (916) 382-4757 should you have any questions.

Sincerely,



Scarlet D. Hughes, M.S.W.
CA Assn. PA/PG/PC, Executive Director

March 25, 2022

Dr. Mark Ghaly, MD
Secretary, California Health and Human Services Agency
1215 O Street
Sacramento, CA 95814

RE: CARE Court Comments

Dear Secretary Ghaly:

On behalf of the Rural County Representatives of California (RCRC), we write to provide comments and recommendations on the Governor's Community Assistance, Recovery and Empowerment (CARE) Court proposal. RCRC is an association of thirty-nine rural California counties, and the RCRC Board of Directors is comprised of elected supervisors from each of those member counties.

Rural counties appreciate the commitment by the Administration to explore new pathways to encourage individuals with serious mental illness to receive treatment. While CARE Court could play an important role in helping individuals with specific mental health conditions (schizophrenia and psychosis), we regret this proposal will not solve the homelessness crisis in rural communities. However, the Governor's CARE Court framework does provide an opportunity to work collaboratively on solutions to better serve individuals with mental health conditions. Increasing access to healthcare services in rural California, particularly for those in need of mental health treatment, is a top priority within RCRC's 2022-2025 Strategic Plan. A key strategy within our goal of equitable access, centers around partnering with "organizations and service providers to enhance health access and behavioral health services in underserved rural areas, including outreach efforts to identify unmet needs in rural healthcare services." In an effort to partner with the State to find solutions that work for all Californians, whether they live in rural, suburban, or urban counties, we provide the following comments, questions, and recommendations on the CARE Court proposal.

Fiscal Impacts

As presented, the CARE Court framework outlines new responsibilities that require additional resources at the county level. Those additional responsibilities and resources span multiple functions, including county behavioral health, public defender, housing, and public guardian. Rural counties have limited personnel and fiscal resources to infuse into

this new program. Counties will likely need to redirect resources, creating a new gap in our system and impacting existing services. While we understand the importance of caring for our most vulnerable populations, expanding or creating new programs without providing counties with additional resources jeopardizes our ability to continue providing current services. With the additional mandated workload for counties outlined in CARE Court, we believe it is essential for the State to provide guaranteed ongoing funding for this workload, in line with constitutional protections for state reimbursable mandates and Proposition 30 (2012) impacted programs. In rural California there is just not enough "flex" in our resources to re-direct from other program areas.

Behavioral Health Infrastructure

In addition to our concerns regarding fiscal impacts, we believe significant gaps exist in behavioral health infrastructure throughout rural counties. Rural communities often lack access to health care and behavioral health care services, including acute care facilities and fewer or in some cases no community-based organizations that partner with counties to provide services. Financing restrictions on the primary sources of funding for the county behavioral health safety net have limited the ability of county behavioral health agencies to invest in building out the full continuum of community-based treatment services across California. RCRC is appreciative of the Governor's investment in the 2021-22 Budget to build out the behavioral health continuum. However, this funding is in the early stages of deployment, and we are still years away from seeing the results of this investment. We are also concerned that the funding is primarily through competitive grants, which disadvantage rural communities. Rural counties lack sufficient technical staff to pursue state funding and often lack the capital required for match requirements. In addition, a greater investment in pre-development support for rural projects is required to get sites shovel-ready. Without a rural set-aside or plan to ensure behavioral health infrastructure funds are deployed equitably throughout the State, we fear rural communities will not have the funds to improve the behavioral health continuum of care required to implement Care Court successfully.

Housing Challenges

The Care Court proposal would also require a housing component that would be difficult to fulfill based on the current housing gaps within rural counties. It remains incredibly difficult to site, fund, and build supportive housing and affordable housing projects in rural communities, many of which are located in the WUI's or forested areas, already under threat of wildfire. We are concerned about how sanctions will be assessed regarding identification and placement into appropriate housing, particularly with limited availability for supportive housing in rural counties. For example, utilizing the No Place Like Home program has been challenging because rural communities do not have the economy of scale to entice developers and builders to come to our counties. Unlike infill housing in urban settings, rural communities often lack the pre-development infrastructure like sewer, utilities, and roads needed to incentive a builder to develop in rural areas. In

the case of Project Homekey many rural communities have limited to no qualifying building types for funding. In addition to the challenges in building supportive housing, hiring qualified individuals to provide wrap-around services essential to an individual's success is extremely difficult with our current workforce shortages.

Workforce Shortages

Addressing behavioral health workforce shortages is foundational to expanding services and managing the workforce crisis facing many of our communities. Many county behavioral health agencies and providers that counties contract with for behavioral health services, are grappling with high vacancy rates. In some rural regions, counties struggle to even find providers in their area for services. Many of our communities are designated as behavioral health workforce shortage areas and medically underserved areas. If rural communities do not have the adequate providers or county mental health workers to provide expanded services, this program is being set up for failure in rural regions and disappointing those most in need of these services. While the Governor recognizes the behavioral health workforce needs by proposing funding in the 2022-23 Budget, these investments will not solve the shortage problems overnight. To ensure workforce investment dollars reach all parts of California, we request the Administration consider setting aside funding specifically for recruitment, retention, and pipeline development in rural communities. Without targeted workforce investments in rural counties, we remain concerned that we will not have adequate staffing to take on Care Court implementation.

Conservatorship

Care Court participants who do not successfully complete Care Plans may be referred to conservatorship, thereby creating additional workloads for county Public Administrators-Public Guardians-Public Conservators, which are primarily funded through county general fund. If Care Court increases conservatorship and the workload of the Public Administrators-Public Guardians-Public Conservators, additional resources should be directed to counties to increase capacity. More broadly, the Care Court proposal depends upon accountability – and therefore meaningful consequences – for all parties. Conservatorship is not, and will not be, an appropriate and effective response for everyone with mental health or substance use disorders. Further, that prospect exists under current law for persons who do not successfully complete less restrictive forms of treatment, and has often been ineffective to motivate the hardest to serve individuals. Without other accountability measures and potential consequences for Care Court participants, it may be impossible for counties to ensure that the newly mandated level of service is actually delivered to those most in need.

Sanctions

That the proposal allows the Court to impose sanctions on counties for failing to provide mental health services to CARE Court participants, raises significant concerns. Counties should not be penalized for issues outside of their control. Counties should not incur fiscal penalties if they comply with Medi-Cal network adequacy requirements. It is also essential to ensure that counties are not compelled to expend resources otherwise available to provide care, litigating continual sanctions motions from individuals or groups dissatisfied with discretionary policy decisions, or the results in individual cases. Sanctions, if any, should be reserved for deliberate and chronic deficiencies, and should be imposed only after meaningful engagement with the responsible state agencies. Specifically, there should be no private right of action for sanctions or other relief under this proposal, and no ability for private individuals or groups to ask the Court to impose sanctions "on its own motion." Any penalties should require state-level enforcement action in Court, and should require appropriate findings, such as deliberate indifference - not strict liability for any arguable service deficiency.

Questions

We appreciate the Administration's focus on a creative way to provide enhanced mental health services for individuals with serious mental illness with the Care Court proposal. The framework is the starting point in the discussion and raises several questions on what Care Court implementation will entail. We look forward to more information on the following questions in the coming weeks.

- The State has identified Care Court would potentially serve 7,000-10,000 individuals. Does the State have data on what counties these identified individuals reside? We are particularly interested in the estimates for rural county participation.
- Has the State considered regional approaches for rural areas that do not have the economy of scale to stand up Care Court?
- Will the State provide long-term funding to support new county responsibilities and services?
- Are judges being given the ability to penalize counties for not meeting elements of the care plan? What form can the sanctions/penalties take?
- Can the judge compel a county to provide services that are not available today?
- Does the judge have to approve the CARE plan developed by county behavioral health agencies? If so, do the courts have the appropriate staff required to evaluate the CARE plans?
- If Care Court results in increased referrals to conservatorship, will the State provide additional resources to Public Administrators-Public Guardians-Public Conservators?
- Who is going to evaluate whether CARE Court works?
- Who will evaluate the impact of CARE Court on other systems, such as the impact on public conservators and adult protective services?

Recommendations

To foster collaboration and partnership between the Administration and rural counties, we have outlined recommendations below to assist in refining the proposal to consider the unique needs of rural communities while providing the most vulnerable populations the services they need.

A January 1, 2023, timeline for courts and mental health services to prepare for the creation of CARE Court is an aggressive timeline for all 58 counties, due to the capacity deficiencies and funding issues noted above. RCRC recommends the State first start with a pilot CARE Court in several jurisdictions statewide, focusing on areas with the highest concentration of the 7,000-10,000 potentially eligible individuals identified by the State. A pilot program will provide vital information to understand the usage level for CARE Court, the workforce investments required, the level of long-term funded needed, impacts to conservatorship workload, and data on Care Court outcomes to analyze if the model is successful. While we appreciate the investments in behavioral health infrastructure and workforce development, it takes time to build capacity. Creating a pilot program will allow the Administration more time to develop a phase-in implementation plan to facilitate capacity building at the local level. RCRC recommends as part of the pilot program, the Administration convenes a rural working group to evaluate regional CARE Court approaches that take into account economy of scale issues within rural communities.

RCRC is concerned with capacity issues with lack of acute care facilities, supportive housing, and workforce shortages. RCRC is currently developing strategies to gather and provide data that describes, and documents rural behavioral health care needs and workforce capacity issues so rural counties can respond to state-level funding initiatives with concrete information about where funding is needed and where investments should be focused. RCRC recommends the Administration consider dedicated funding to rural counties to build out the continuum of care and ensure all of California benefits from these investments. In light of the potential impacts to public defenders and public guardians within this proposal, the Administration may want to consider expanding the current Care Economy Workforce proposal to target these positions.

RCRC requests the Administration provide adequate permanent funding to support the increased level of services and new responsibility outlined in the Care Court proposal. Redirecting local funding from other vital programs will negatively affect the other behavioral health clients whom counties serve.

Thank you for the opportunity to provide the Administration with comments that reflect the unique needs of rural counties. RCRC looks forward to working collaboratively with the Administration in finding innovative ways to deliver mental health services within the rural landscape to those in need. We welcome the opportunity to meet and discuss

further our comments, questions, and recommendations. Please feel free to reach out to Sarah Dukett, Policy Advocate, at sdukett@rcrcnet.org with any questions you may have.

Sincerely,

SARAH DUKETT
Policy Advocate

cc: Stephanie Welch, Assistant Secretary, California Health and Human Services Agency
Kim McCoy Wade, Office of the Governor
Jessica Devencenzi, Deputy Legislative Secretary
Jason Elliott, Senior Advisor, Office of the Governor

URBAN COUNTIES
OF CALIFORNIA

Supervisor Buddy Mendes, Chair
Fresno County

Supervisor Keith Carson, Vice-Chair
Alameda County

March 25, 2022

Mark Ghaly, MD
Secretary, California Health & Human Services Agency
1215 O Street
Sacramento, CA 95814

Re: Urban County Comments on the CARE Court Proposal

Dear Secretary Ghaly:

On behalf of the Urban Counties of California, a 14-member coalition of the state's most populous counties, I write to provide comments and recommendations on the Governor's Community Assistance, Recovery and Empowerment (CARE) Court proposal. Urban counties appreciate the CARE Court's cross-jurisdictional approach to providing new ways to encourage individuals with serious mental illness to receive treatment. We see the effects of untreated mental illness in our communities across California. While CARE Court could play an important role in helping individuals with very specific mental health needs access treatment, we must be clear that it will not fundamentally solve our homelessness crisis. However, the Governor's CARE Court framework offers an innovative approach to rethink systems providing services to certain individuals with specified mental health conditions (schizophrenia and psychosis).

In the spirit of collaboration and partnership and in an effort to be constructive, urban counties share the following questions, comments and recommendations.

Overall Construct, Protections, and State-Local Fiscal Relationship

While there are many details to be finalized, it is clear that counties will require new resources to successfully fulfill our role in the CARE Court framework. Counties understand the need to prioritize the most vulnerable in our communities, but we cannot simply redirect resources or focus without creating a new gap in our systems. Therefore, under almost any feasible construct, CARE Court will mandate additional workload for counties. Additionally, counties believe it is not just reasonable for the state to fund this workload, but rather required under the constitutional protections for state reimbursable mandates and Proposition 30 (2012) impacted programs.

Behavioral Health Issues

Equal Access. Medi-Cal ensures equal access for all enrollees – no individual or diagnosis is prioritized over others. Is CARE Court expected to prioritize services for Medi-Cal eligible individuals in this Court over individuals who enroll in Medi-Cal specialty mental health services through other doors? If so, does this create equal access issues? Are state or federal statutory changes necessary to prioritize CARE Court participants?

Eligibility. Not all individuals who are referred to CARE Court and accept services will be eligible for Medi-Cal. Will the service component be means tested? If the individual is not eligible for Medi-Cal (perhaps has private insurance), are counties compelled to serve them? Who pays for services for individuals in CARE Court who are not Medi-Cal eligible?

> *Recommendation*: Individuals should be enrolled in Medi-Cal, if otherwise eligible, as part of the CARE Court process. If an individual in CARE Court has private insurance, state law should clarify that the individual's health plan is responsible for arranging for and paying for treatment services. The health plan should have a role in ensuring the court-ordered treatment plan is provided. Alternatively, if the state is proposing that counties deliver services to individuals not eligible for Medi-Cal, the state should provide funding to reimburse counties for providing services to a new population.

Assessment. The proposal does not appear to require any documentation of qualifying condition prior to someone petitioning Care Court. Does everyone referred to Care Court get the full assessment, or is there some review of the petition to determine that there is sufficient basis to proceed to the assessment? If the petition is reviewed, what entity will conduct the review?

Behavioral Health Treatment Plan. Requiring counties to develop treatment plans for CARE Court is a new role and responsibility. In addition to developing treatment plans, presumably the plan will require preparing regular reports to the CARE Court on treatment progress – which is new workload.

> *Recommendation:* The State should provide funding to county behavioral health for the new role in developing CARE Court treatment plans and reporting to the CARE Court.

Length of Treatment. Because of the acuity level and complex health and social needs of the individuals with severe mental illness, it likely that the 12 to 24 month timeframe of CARE Court is not sufficient for individuals to graduate and continue to succeed without ongoing services and supports. Many individuals that CARE Court is designed to serve will likely need lifelong services and supports. It is not clear that the length of CARE Court matches the treatment needs of these individuals. What happens to individuals who, at the end of 24 months, continue to need treatment and supports?

Workforce. Addressing behavioral health workforce shortages is foundational to expanding services, as the pandemic turned behavioral health workforce shortages into a crisis. Some county behavioral health agencies have vacancies of 30-40% or more. The providers that counties contract with for behavioral health services are also struggling with high vacancy rates. Almost half the counties in California are designated as behavioral health workforce shortage areas, with the Central Valley and Inland Empire experiencing severe shortages. Staff are leaving for more pay, less complex work, and less stress. Counties are increasing provider contracts so that providers can offer higher salaries but despite these efforts, agencies continue to struggle with vacancies. Urban counties remain concerned that behavioral health system reforms will fall short without significant workforce investments, and workforce investments now will not resolve shortages overnight.

Recommendations:
- Expand educational slots for behavioral health professionals, such as licensed marriage and family therapists, licensed clinical social workers, psychologists, psychiatrists, addiction medicine physicians.
- Expand internships in public behavioral health system.
- Provide funding to support tuition assistance, loan repayment, and internships.

- Develop a more diverse pipeline by partnering with high schools and community colleges in underserved communities.
- Consider piloting CARE Court in select counties, or phasing implementation, based on an evaluation of system readiness.

Facilities. It remains incredibly difficult to site behavioral health treatment facilities. While urban counties appreciate the CEQA exemptions provided for the Behavioral Health Continuum Infrastructure Program in the 2021-22 state budget, siting continues to be very difficult – with some of our city partners unwilling to site facilities in their jurisdictions or placing unrealistic barriers to site such facilities.

> *Recommendation*: Provide incentives in state law for cities and counties to site behavioral health treatment facilities.

Conservatorships

To establish an LPS conservatorship under existing law, the Court must find, without a reasonable doubt, that the mentally ill person is gravely disabled. Gravely disabled means that, because of a mental disorder, the person cannot take care of his/her basic, personal needs for food, clothing, or shelter.

- What is the nexus between refusing services through CARE Court and grave disability definition for LPS conservatorships?
- If the CARE Court is upstream, are individuals going to otherwise meet the definition for conservatorships?
- Is the Administration proposing to change the factors considered for a conservatorship?
- For example, does the refusal to accept CARE Court services create a presumption or contribute to a finding of grave disability?
- Does granting the court the authority to use refusal of CARE Court services as a factor in establishing a conservatorship create equity issues? (Individuals may have transportation and other issues associated with poverty that limit his/her ability to get to court.)
- Can the court in a conservatorship/guardianship proceeding refer someone to CARE Court in lieu of the conservatorship or guardianship?
- If CARE Court or new statutory presumptions increase LPS conservatorships, Department of State Hospitals (DSH) and locals do not have capacity for their placement.

> *Recommendation*: Provide additional resources to Public Administrators-Public Guardians-Public Conservators to address anticipated impacts of additional workload related to referrals from CARE Court. Clarify the CARE Court link to conservatorships and carefully evaluate with impacted stakeholders any resource or capacity needs at the state and local level. If it is determined CARE Court may increase LPS conservatorships in the near-term, expand state capacity to accommodate the increase.

Sanctions

The proposal to allow the court to impose sanctions on counties for failing to provide mental health services to CARE Court raises several questions, including:

- Are judges being given the ability to penalize counties for not meeting elements of the care plan?
- What form can the sanctions/penalties take?

- To the extent that the failure of a plan is the result of the absence of affordable housing, can the judge sanction cities for failure to site housing?
- Assuming county sanctions are assessed based on individual level failure to deliver ordered treatment plans, how will city housing sanctions be assessed at the same individual level?
- Who is responsible for the actual identification of, and placement into, appropriate housing?
- What if circumstances occur outside a county's control (example: a fire destroys a service provider's building resulting in the loss of service capacity for a period of time)?
- If a CARE Court participant is not Medi-Cal eligible and instead has private insurance, do court orders and sanctions apply to individual health plans?
- Under current law, DHCS has the authority to impose sanctions on county mental health plans that fail to meet network adequacy requirements (e.g., time and distance standards). Why aren't the sanctions that DHCS can impose for not meeting network adequacy requirements sufficient for ensuring services are delivered?
- What are the legal ramifications of creating a precedent where providers and health plans can be held accountable to specific services being delivered to a specific individual – potentially above and beyond existing time and distance standards?

  Recommendations: Counties should not be penalized for issues outside of their control (loss of providers, closure of facilities, natural disasters). Counties should not incur fiscal penalties if they are in compliance with Medi-Cal network adequacy requirements. If CARE Court must rely on new sanctions to improve homelessness among this population, all levels of government must face new sanctions, including potentially Continuums of Care.

Court Issues

Role of Judges. Urban counties have several questions about the role of the judge in CARE Court, including:

- Can the judge compel a county to provide services that are not available today?
- Can the judge compel counties to work across county lines to provide services?
- Can a judge order the county to provide services for which there is not state funding or a pre-existing county mandate? If yes, who bears the cost of those new programs or services?
- Can the judge order services not available under the Medi-Cal program for Medi-Cal recipients? If so, how will those services be funded?
- Does the judge have to approve the care plan developed by county behavioral health agencies?

  Recommendation: Provide a statutory framework for what can and cannot be included in a CARE Court treatment plan. Clarify in state law that the CARE Court judge cannot order services and treatment for Medi-Cal beneficiaries that is not covered by Medi-Cal specialty mental health plans.

Public Defender. The proposal creates additional caseload for public defenders that does not exist today. Public defenders already have large caseloads.

> *Recommendation:* Provide resources for public defenders to adequately represent the new CARE Court caseload.

Petitions. Under current court procedures, there is a filing fee to file a conservatorship petition in civil court. Will there be a fee to file a petition in CARE Court? If so, how much will the filing fee be? Would a

no-fee structure encourage over-referring? If public agencies file petitions in CARE Court, will they be required to pay filing fees?

Operational Issues.

- Is there sufficient physical space in court facilities for additional hearings?
- Who is responsible for performing and paying for the initial assessment for entrance into the CARE Court?
- Is there sufficient workforce capacity to meet the anticipated need for assessments? Could the need for additional, similar workforce impact the ability of criminal courts to process IST cases?

  Recommendation: In conjunction with courts and counties, assess the physical space needs for the additional hearings.

Justice-Involved Populations. While intended to be upstream, will individuals on probation or parole who otherwise fit the criteria for CARE Court be eligible for the program?

Start-Up

Timeline. Is there sufficient time between now and January 1, 2023, for courts and mental health services to prepare for the creation of CARE Court?

> *Recommendation*: Phase-in implementation to allow additional time for counties and courts to prepare. Alternatively, pilot CARE Court in several jurisdictions prior to statewide implementation.

"Supporter" Role. Who will fulfill the supporter role? Are these state funded/employed positions, local funded/employed positions, or contracts with community-based organizations? How will supporters interface with courts, probation, or law enforcement in referrals from criminal court? How will the supporter or care plan interface with pretrial programs?

Other Issues

Homelessness Funding. Big cities, Continuums of Care, and counties all receive direct, flexible homelessness funding through the HHAP program, with counties receiving the smallest share of funds. Will cities or Continuums of Care be compelled to prioritize any local flexible homelessness funds for CARE Court coordination, outreach, services, or housing?

Human Services Impacts. It is unclear whether the proposal will authorize the court to order services on the human services side (examples include cash aid/General Assistance, employment services, adult protective services, or rental subsidies). Additional information is needed to understand what impacts CARE Court will have on county human services agencies.

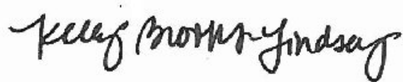
Evaluation. Who is going to evaluate whether CARE Court works? Who will evaluate the impact of CARE Court on other systems, like on public conservators and adult protective services?

> *Recommendation:* The proposal should include an evaluation component that examines outcomes for CARE Court participants, as well as impacts on other public systems.

Conclusion

Thank you again for the opportunity to provide the Administration with comments intended to improve the CARE Court proposal. The Urban Counties of California look forward to working in partnership with the Newsom Administration in finding innovative ways to deliver mental health services to those in need.

Sincerely,



Kelly Brooks-Lindsey
Legislative Advocate

cc: Stephanie Welch, Assistant Secretary, CalHHS
Kim McCoy Wade, Senior Advisor on Aging, Disability, and Alzheimer's, Office of the Governor
Jessica Devencenzi, Deputy Legislative Secretary, Office of the Governor