CARE ACT 202: THE CARE AGREEMENT & CARE PLAN

CARE Act Process

This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

Welcome to this training on how we can work together to implement CARE Act services. We appreciate all the great work being done on the county level to help get ready to provide this support. This training provides a high-level overview, and other trainings will be geared more towards the specifics and mechanics.

The goal of these trainings will be to help you feel prepared as you begin to implement the CARE Act. We want to be really responsive to what your needs are, so please share them with us. Upcoming trainings will be listed on the website, CARE-Act.org, and we will be sending out registration links for each training on the listserv.

All information shared during this training is effective and accurate as of May 17, 2023.

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Presenters

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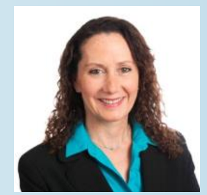

CAROL CLANCY, PSYD, MSW
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[Slide Image Description: This slide includes images of the presenters of this training on a light blue background.]

The presenters include Rachel Johnson-Yates, MA, LMHC, LAC, Deborah Rose, PsyD, Marc Avery, MD, and Carol Clancy, PsyD, MSW from Health Management Associates.

Rachel Johnson-Yates, from Health Management Associates, is a licensed mental health and addiction counselor, public speaker, and educator with a demonstrated track record of developing innovative programs that focus on mental and behavioral health. She has dedicated her career to increasing access to care through approaching her work from an equity-focused and trauma-informed framework. Ms. Johnson-Yates has extensive experience designing, launching, and replicating complex programs to meet the many disparate needs of the clients she serves. She held significant leadership roles in outpatient behavioral health, state government, criminal justice, inpatient psychiatric care, low barrier shelters for veterans, higher education, and residential substance use disorder treatment.

Deborah Rose, from Health Management Associates, is an experienced executive with a demonstrated history of designing and scaling new initiatives in the healthcare industry. She has extensive experience working with managed Medicaid, procurement and grant writing, nonprofit management, integrated care, care coordination, program development,

supported housing and homeless service models, stakeholder engagement, and social determinants of health. Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in nonprofit and community-based agencies. She has strived to improve access to and delivery of person-centered services for adults with intellectual and developmental disabilities, mental illness, and substance use disorders.

Marc Avery, from Health Management Associates, is a board-certified psychiatrist and a recognized national leader in the subject of person-centered, integrated psychiatric care for high-needs and safety-net patients. He is an expert in delivery system transformation and workforce training in the areas of integrated care, population health, collaborative care, telehealth, person centered care, and measurement-based care. Dr. Avery has played key roles in many large-scale health system transformation efforts, including leadership development of a large California Medicaid health plan's health homes (HHP) and enhanced care management (ECM) programs. He has also served as a subject matter expert and strategic planning partner on several regional behavioral health network development projects.

Carol Clancy, from Health Management Associates, is a licensed clinical psychologist with 20 years of leadership experience in correctional health, recovery services, and other public and nonprofit mental health settings, including residential treatment and shelter care. Dr. Clancy's experience includes program design, development, implementation, and oversight of service systems, budgets, and policies. She works across and between service teams to develop and implement behavioral health and substance use disorder (SUD) programs from in-custody through re-entry to assure a seamless continuum of care for mentally ill, justice-involved individuals, and other marginalized and at-risk populations.

Agenda

Review of the CARE Act Flow

- Review the CARE Act process, with an emphasis on inflection points in which the CARE agreement, CARE plan, and graduation plans are created.
- Compare voluntary engagement, CARE plan, and CARE agreement.
- Preview outcomes of the 1-year review to be considered at the outset.

The CARE Agreement & CARE Plan

- Discuss recommended elements of a CARE agreement and CARE plan.
- Share strategies for engagement and coordination.
- Highlight how to individualize to the needs of the client.

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[Slide Image Description: This slide shows the major sections of this training on a light blue background.]

In this training, we are giving a high-level overview of the CARE agreement and CARE plan. This first section will provide an overview of the CARE Act flow, focusing on inflection points related to the CARE agreement, CARE plan, and graduation plans. Then, we will compare the differences and similarities between voluntary engagement, CARE plans, and CARE agreements, and then review outcomes of the 1-year review. The second section will go into detail on what is in the CARE agreement and CARE plan.

Objectives

At the end of the session, participants will have an increased ability to:

- » Identify the key points in the CARE Act process including the CARE agreement, CARE plan, and graduation plan.
- » Describe the differences between voluntary engagement, CARE agreement, and CARE plan.
- » Identify elements of a CARE agreement and CARE plan, including those services that may be prioritized for the CARE client/respondent.
- » Describe at least three strategies for engaging the client/respondent into the CARE planning process.

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[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

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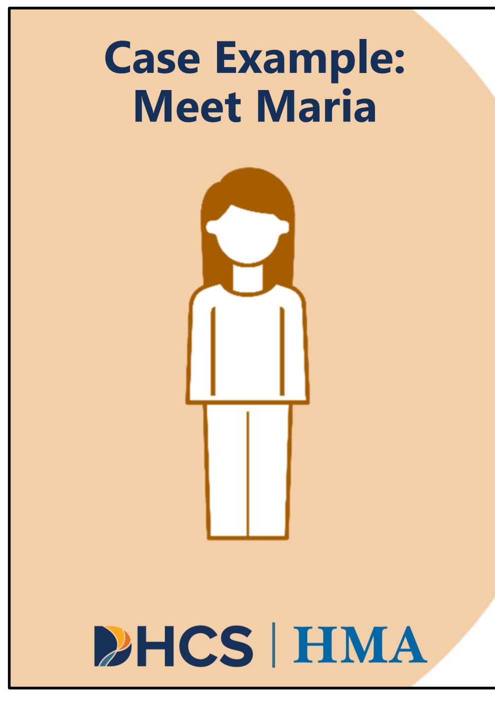
- Describe the differences between voluntary engagement, CARE agreement, and CARE plan.
- Identify elements of a CARE agreement and CARE plan, including those services that may be prioritized for the CARE client/respondent.
- Describe at least three strategies for engaging the client/respondent into the CARE planning process.

We don't anticipate that everyone will know exactly what they need to do by the end of this training, but our overall goal is that you have an increased ability to accomplish these objectives.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In this section, we will review the CARE Act Flow.



What is Maria’s background?

- 40-years-old; Spanish is her first language
- Diagnosed with Schizophrenia at age 24
- History of drug use – primarily heroin/opiates
- Unmanaged diabetes
- Parents are a primary support, but unable to house her
- Often living in abandoned buildings around the city

What is her current situation?

- Intermittently engaged with mental health/SUD services, but not for the last 4 years
- Does not seek care for her diabetes, other than the ER
- Recent instances of being verbally explosive to community members when experiencing psychosis
- 3 arrests in the last year with less than 30 days incarceration each time
- Has been assaulted several times while in shelters

[Slide Image Description: This slide shows an orange silhouette of a person representing Maria with a description of her background and her current functioning.]

The CARE Act is about leveraging a system to help provide support, and we don’t want to lose focus on helping an individual. We are going to look at this process through the lens of a respondent, Maria. Maria is not one person; she’s a conglomeration of people that many of us have worked with before. As we go through the content today, keep in mind Maria’s background and current situation and what her experience would look like in creating a CARE agreement and plan.

- 40-years-old; Spanish is her first language
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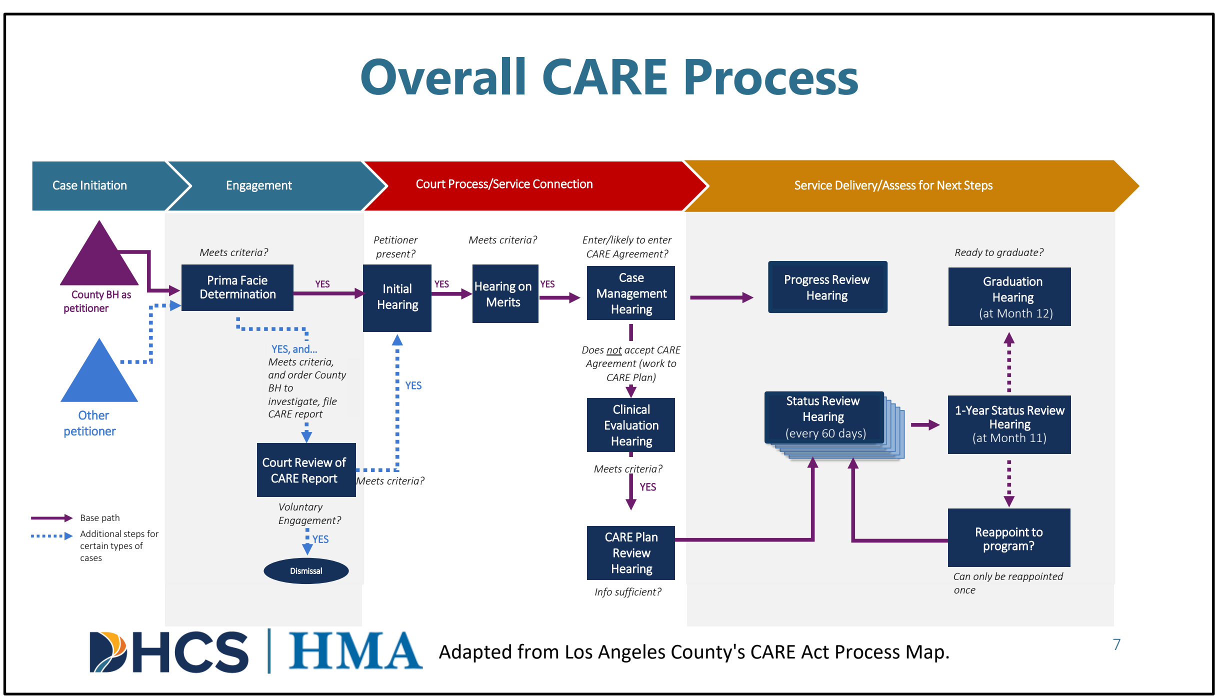


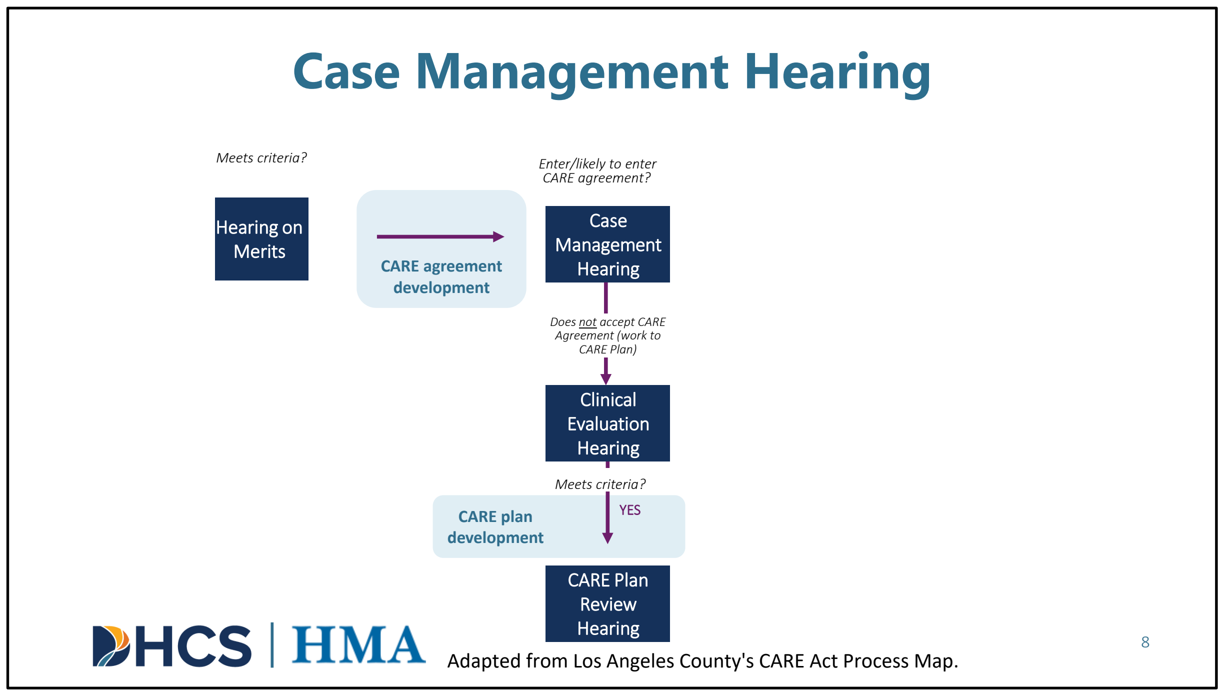
[Slide Image Description: This slide shows a process flow shows an example of pathways through the CARE Act process.]

We wanted to start off by showing the high-level process overview. In today's session, we are going to talk about a few key inflection points involving a CARE agreement and CARE plan, and discuss voluntary engagement. We will also look forward to the graduation plan, so that we can begin the process with the end in mind.

Description of Flow

1. There is a Prima Facie Determination to see if the respondent meets the criteria.
    1. If someone other than the County BH agency is the petitioner, if the respondent is found to meet the criteria, the BH agency will investigate and file a CARE report.
    2. If at this point, the respondent voluntarily engages in services, the case is dismissed.
    3. If they do not voluntarily engage in services and the County BH report finds that the respondent meets the criteria, they will progress to the initial hearing.
2. If the respondent meets the criteria, there will be an initial hearing (with the petitioner present).

3. If the respondent still meets the criteria, then there will be a Case Management Hearing.
    1. If it's determined in this hearing that a CARE agreement is likely to be reached, then there will be at least one progress review hearing (but potentially there could be more).
4. If it's determined at the case management hearing that a CARE agreement is not likely to be reached, then there will be a clinical evaluation and then a hearing to review that clinical evaluation.
5. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
6. There will then be a status review hearing at least every 60 days.
7. At month 11, there will be a 1-year status review hearing to determine next steps.
    1. The respondent will graduate (and have a graduation hearing at month 12).
    2. The respondent will be reappointed to the program, which can only happen once.

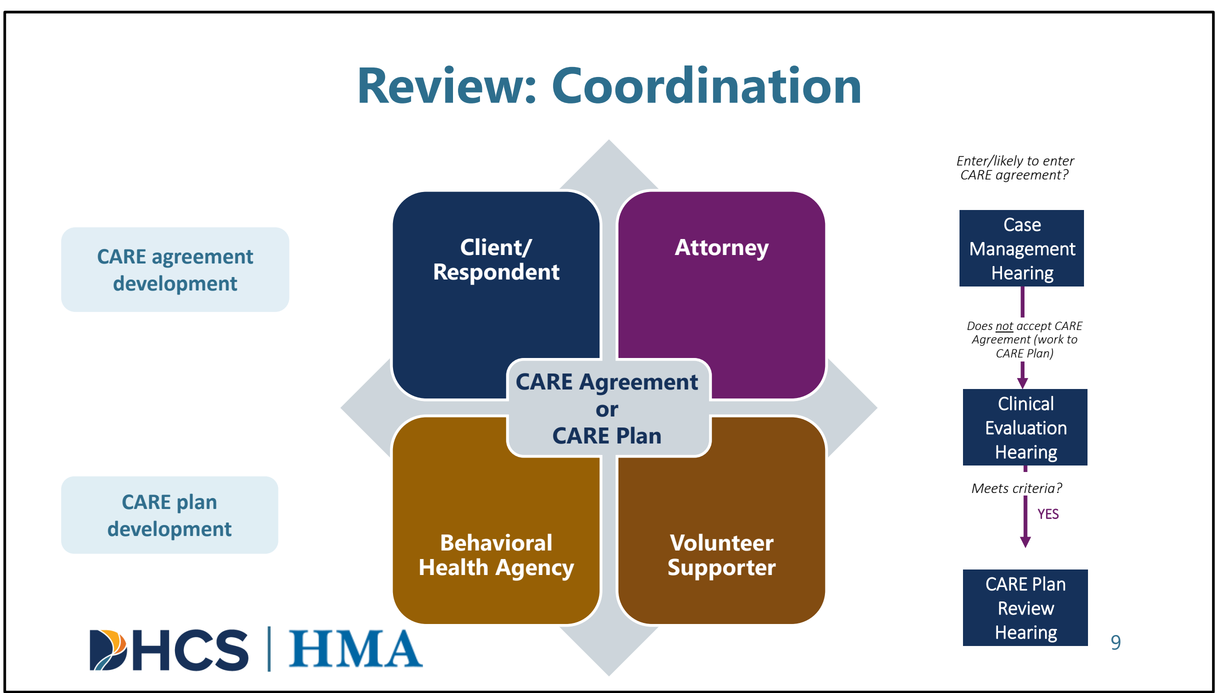


[Slide Image Description: This slide shows a process flow of Maria's journey through the CARE Act, specifically the points at which a CARE agreement or CARE plan is developed.]

CARE agreement: At the Hearing on the Merits, if the court finds Maria to be eligible for CARE proceedings, it orders Maria, her attorney, the behavioral health agency and her identified volunteer supporter (if Maria has identified one) to attempt to develop a CARE agreement (and we will go into the components of that plan later in this training). The CARE agreement will be reviewed in the Case Management Hearing.

- If the CARE agreement was reached, they will work together to formalize it in court.
- If the CARE agreement wasn't reached, the BH Agency will complete a clinical evaluation/report with recommendations.

CARE plan: At the Clinical Evaluation Hearing, the court will determine if Maria is still "eligible" and in need of services. If they are eligible (and not likely to enter into a CARE agreement), the court will order the development of a **CARE Plan** between all interested parties.



[Slide Image Description: This slide shows the four sectors of the CARE Agreement, including the client/respondent, attorney, behavioral health agency, and volunteer supporter are shown. Also, a process flow for Maria's coordination is included.]

Whether it's a CARE agreement or a CARE plan, the client (Maria)**, her attorney**, the **behavioral health agency** and a **volunteer supporter** (if so desired by the client/respondent) will coordinate together.

Voluntary Engagement vs. CARE Agreement vs. CARE Plan

Voluntary Engagement

Once the court finds there has been Prima Facie showing on the petition, a county agency is ordered to assess Maria.

If Maria accepts services voluntarily, the case is dismissed. There is no CARE Agreement or Plan.

CARE Agreement

If Maria does not agree to services but the agency finds her eligible, there will be an attempt to develop a CARE agreement.

This includes services that Maria agrees to follow—and the county agrees to provide—as approved by the court, including any modifications.

CARE Plan

If Maria does not agree to services, a clinical evaluation is ordered. If she is found eligible, a CARE plan is developed.

This includes services that Maria is court ordered to accept, and the county is court ordered to provide.

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[Slide Image Description: This slide shows three blue boxes are that give descriptions of Voluntary Engagement, CARE Agreement, and CARE Plan.]

In the next few slides, we will be going over each of these, but we wanted to show a side-by-side to compare voluntary engagement, a CARE agreement, and a CARE plan.

Voluntary engagement would happen early in the process once there is Prima Facie and a county agency has been ordered to assess the client (Maria). If services are accepted, the case is dismissed, and no CARE agreement or plan are needed.

However, if the client does not initially agree to services, but the behavioral health agency finds the client eligible, there will be an attempt to create a CARE agreement. The client is able to accept or deny services in the agreement, if accepted the CARE agreement is developed and approved by the court.

If the CARE agreement is not voluntarily agreed to by the client, a clinical evaluation is ordered; if the client is still eligible for services, a CARE plan is developed under court order.

Voluntary Engagement

» After court is petitioned

» County BH completes evaluation and submits CARE report

» Based on evaluation, client meets criteria

» Client voluntarily decides to engage in services
  - Court case closed

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[Slide Image Description: This slide shows an orange silhouette of an individual representing Maria and a description of Maria's voluntary engagement process.]

After the court is petitioned and there is prima facie evidence that the client/respondent meets the criteria, the county BH agency will submit a CARE report that determines if they meet eligibility. The county behavioral health will then attempt to engage the client in services. If the client voluntarily accepts, the behavioral health report indicated voluntary engagement is submitted and the case is closed with no further action needed.

CARE Agreement

» "A voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports."
» Voluntary engagement in services *may include* court oversight.
» Outlines services, medications, etc. that the client will utilize to prepare them for program graduation.

For more information, visit the 2022 California Welfare and Institutions Code.

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[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Agreement" with a description of what is included in a CARE agreement.]

The CARE Act statute stipulates that: ""A voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports."

The difference between the CARE agreement and CARE plan is that the CARE agreement may include court oversight, but the CARE Plan always includes court oversight.

For more information, visit the 2022 California Welfare and Institutions Code.

CARE Plan

» "An individualized, appropriate range of community-based services and supports...which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services, as appropriate"

» Happens after
  - Client does not voluntarily engage in services
  - Court-ordered psychiatric evaluation that determines eligibility

» Completed within 14 days of clinical evaluation review hearing, unless extended
  - Participants: respondent/client, volunteer supporter, counsel, & county BH
  - At the CARE plan review hearing, parties present their plans to the court.
    - The county BH agency, the respondent, or both, may present a proposed CARE plan.
    - After consideration of the plans proposed by the parties, the court shall adopt the elements of a CARE plan that support the recovery and stability of the respondent.

For more information, visit the 2022 California Welfare and Institutions Code.

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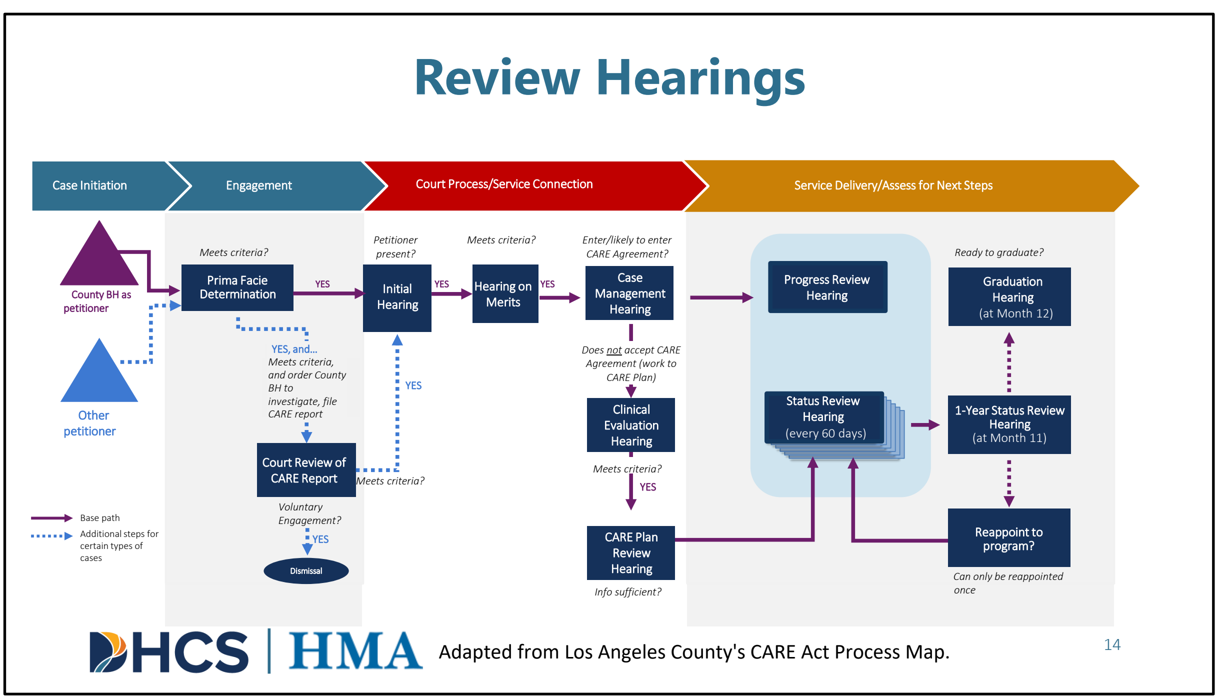
[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Plan" with a description of what is included in a CARE plan.]

The CARE Act stipulates that a CARE plan is ""An individualized, appropriate range of community-based services and supports...which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services, as appropriate."

If the client is not found likely to enter into a CARE agreement, the court will then order a clinical evaluation to assess eligibility (the client may have a volunteer supporter during this process). If the client is found eligible, a CARE plan is created and presented at court during a CARE plan review hearing. During the hearing, the court will decide on which elements will be included in the CARE plan to support recovery for the client.

For more information, visit the 2022 California Welfare and Institutions Code.

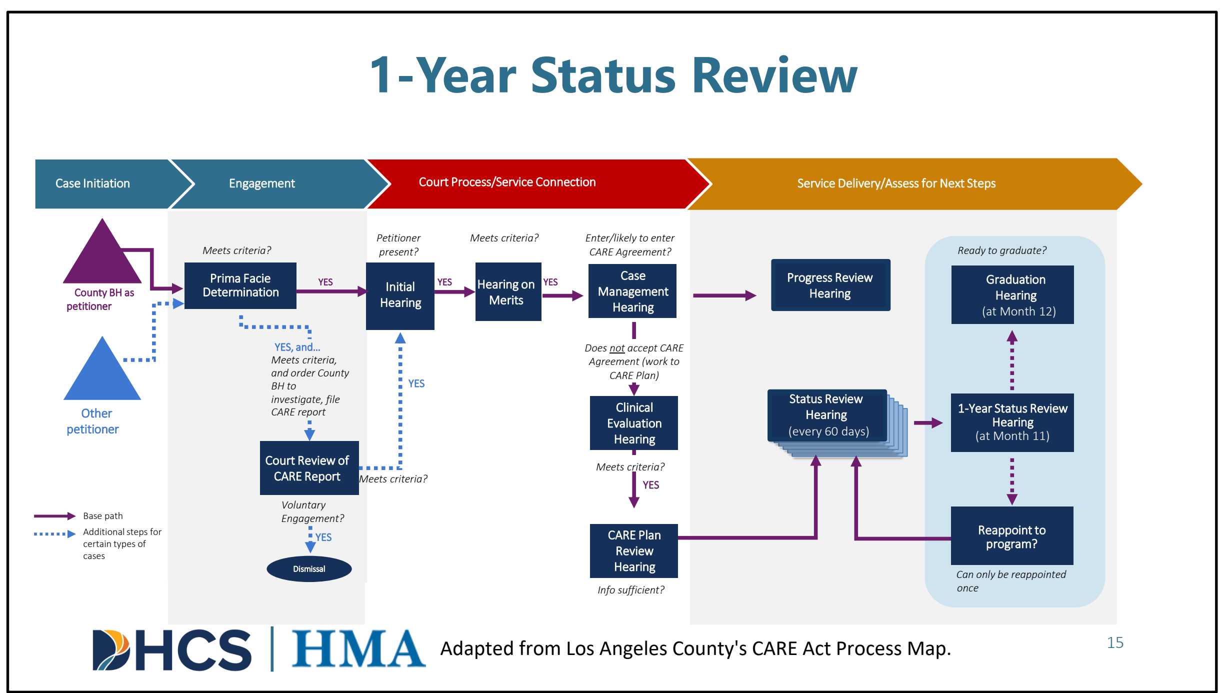


[Slide Image Description: This slide shows a process flow with an example of a pathway through the CARE Act process, and a highlight box is around the review hearing process.]

Another difference between a CARE agreement and a CARE plan is that after a CARE agreement is reached, is what happens next.

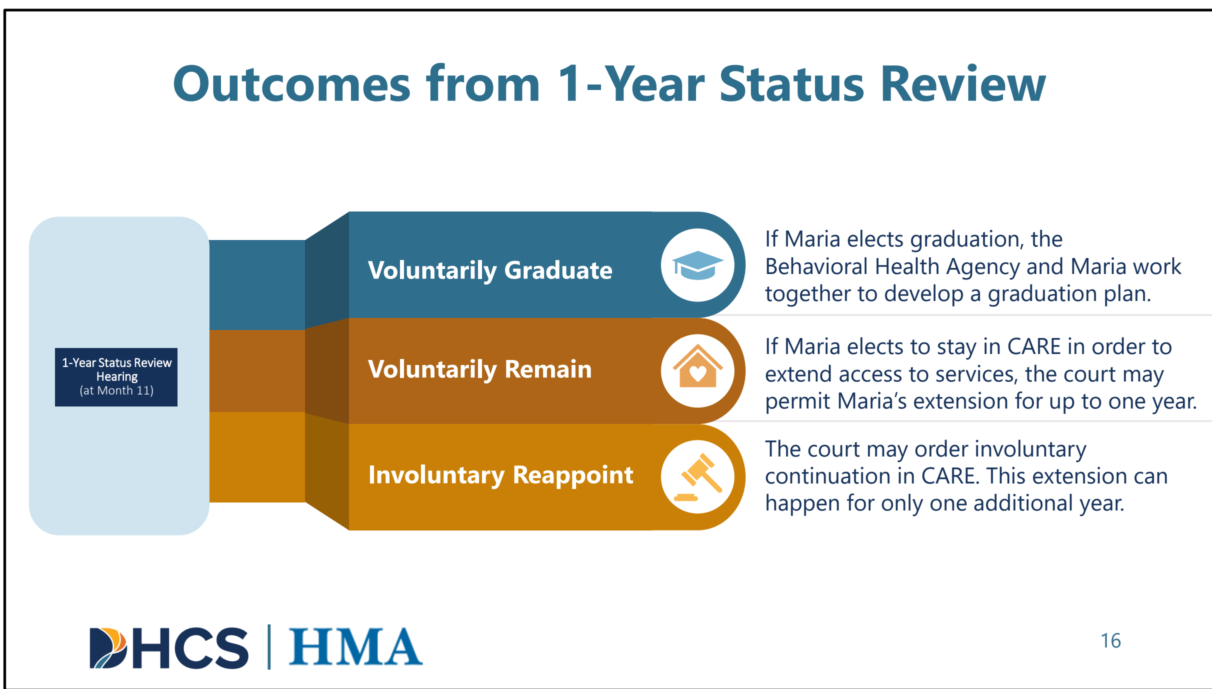
If the client/respondent enters a CARE agreement, there would be one progress review hearings. Counties do have the option to continue to have progress review hearings.

If the client/respondent enters a CARE plan, there is a Status Review Hearing and then the statute requires review hearings at least every 60 days during the duration of the service delivery period.



[Slide Image Description: This slide shows a process flow with an example of a pathway through the CARE Act process, and a highlight box is around the 1-Year Status Review process.]

If a CARE plan was entered into, at Month 11, there will be a 1-Year Status Review Hearing, with the goal of determining the next step. We will review what those options are, including graduation or reappointment.



[Slide Image Description: This slide shows a three boxes that depict what could happens if Maria chooses to voluntarily graduate or voluntarily remain, or if the court orders involuntary reappointment.]

This is an overview of what happens at the 1-Year Status Review.

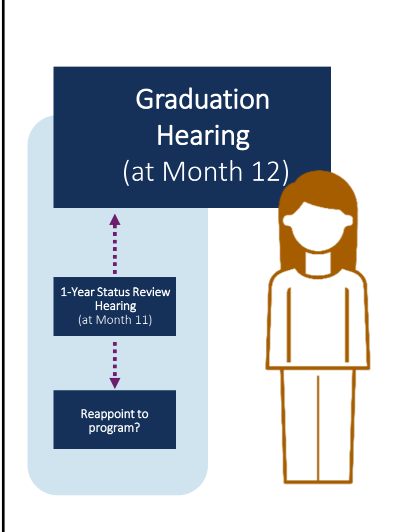
There are three potential outcomes from the 1-Year Status Review:

1. Maria elects graduation
   - This means that Maria is doing well, and she will work together with county behavioral health to develop a graduation plan, including the services she will continue to engage in.
2. Maria voluntarily elects to stay in CARE proceedings.
   - The court may permit Maria's extension for up to one year. (Reasons Maria may want to extend – better access to services, accountability/structure is helpful for her.)
     - "(B) If the respondent elects to remain in the CARE process, respondent may request any amount of time, up to and including one additional year. The court may permit the ongoing voluntary participation of the respondent if the court finds both of the following:
       - (i) The respondent did not successfully complete the CARE plan.

- (ii) The respondent would benefit from continuation of the CARE plan.

3. The court orders involuntary continuation in CARE proceedings.
    - The court could determine it would benefit Maria to stay with the CARE plan.
    - This extension may happen only for one year.

Graduation



- County BH agency and the client jointly create a graduation plan
  - same elements as a CARE plan
- Present plan in a hearing
- Voluntary agreement to transition out of court jurisdiction
  - May include a psychiatric advance directive
    - A voluntarily executed legal document that documents a person with capacity's preferences for mental health treatment
    - Protects autonomy and ability to self direct care by documenting treatment preferences in advance of a crisis
- The plan does not place additional requirements on the local government entities and is not enforceable by the court

For more information, visit the 2022 California Welfare and Institutions Code.

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[Slide Image Description: This slide shows an orange silhouette of a person representing Maria and a description of the graduation process for Maria.]

If the respondent elects to be graduated from the program, the court shall order the county behavioral health agency and the respondent to work jointly on a graduation plan, which **includes the same elements as a CARE plan** to support the respondent in accessing community-based services and supports.

The court shall schedule a hearing in the 12th months after adoption of the CARE plan for presentation of the graduation plan. Upon completion of the hearing, the respondent shall be officially graduated from the program.

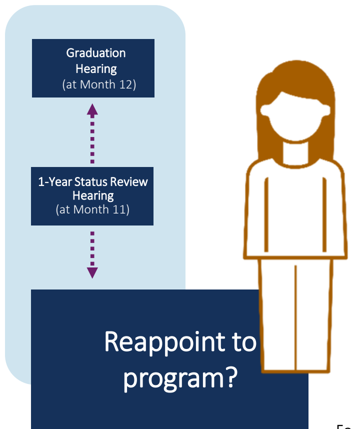
The plan may include a "psychiatric advance directive," which is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions. It allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis. An advance directive does not place more responsibility on the government entity as it is not enforceable by the court.

Definitions from 2022 California Welfare and Institutions Code:

Graduation Plan: “Graduation plan” means a voluntary agreement entered into by the parties at the end of the CARE program that includes a strategy to support a successful transition out of court jurisdiction and that may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports. The graduation plan shall not place additional requirements on the local government entities and is not enforceable by the court.”

For more information on graduation plans and psychiatric advance directive, visit the 2022 California Welfare and Institutions Code.

Reappointment



- The respondent may request an extension for up to one additional year, if they didn't complete the CARE plan and they would benefit from continuation.
- The respondent may be involuntarily reappointed to the program for one year only if the court finds, by clear and convincing evidence, that all of the following conditions apply:
  - The respondent did not successfully complete the CARE process.
  - All services and supports required through the CARE process were provided to the respondent.
  - The respondent would benefit from continuation in the CARE process.
  - The respondent currently meets the requirements in Section 5972.

For more information, visit the 2022 California Welfare and Institutions Code - 5977.3.

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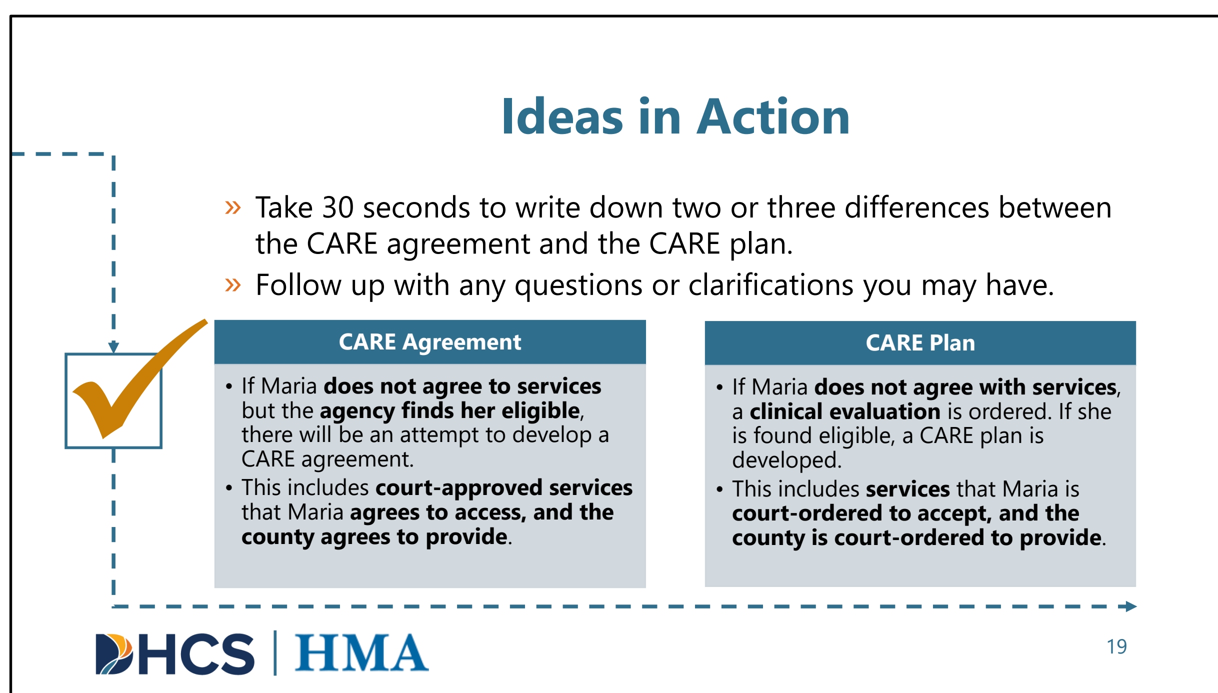
[Slide Image Description: This slide shows an orange silhouette of a person representing Maria and a description of the reappointment process for Maria.]

The respondent may request a one-year reappointment or the respondent may be involuntarily reappointed to the program only if the court finds, by clear and convincing evidence, that all of the following conditions apply:

- The respondent did not successfully complete the CARE process.
- All services and supports required through the CARE process were provided to the respondent.
- The respondent would benefit from continuation in the CARE process.
- The respondent currently meets the eligibility requirements in Section 5972.

A respondent may only be reappointed to the CARE process once, for up to one additional year.

For more information, visit the 2022 California Welfare and Institutions Code - 5977.3.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Consider similarities and differences between a CARE agreement and a CARE plan. If you have any follow-up questions or clarifications, please visit the website at CARE-Act.org or email info@CARE-Act.org.

CARE Agreement:

- If Maria **does not agree to services** but the **agency finds her eligible**, there will be an attempt to develop a CARE agreement.
- This includes **court-approved services** that Maria **agrees to access, and the county agrees to provide**.

CARE Plan:

- If Maria **does not agree with services**, a **clinical evaluation** is ordered. If she is found eligible, a CARE plan is developed.
- This includes **services** that Maria is **court-ordered to accept, and the county is court-ordered to provide**.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In this section, we will discuss the CARE agreement and CARE plan in more detail.

[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Plan" and four boxes list the services that may come from a CARE plan.]

The CARE plan will include client/respondent info and it will also outline services to be received, which may include only the following:

- Behavioral health services (both mental health and substance use disorder services)
- Medically necessary stabilization medications
- Funded housing resources
- Funded social services
- Services provided pursuant to Part 5 (commencing with Section 17000) of Division 9 (County Aide and Relief to Indigents)

Note the following about services in the CARE plan:

- Both the client/respondent and behavioral health agency will be expected to comply with the expectations in the CARE plan. It is not simply a list of demands that the client/respondent has to follow; it is services that s/he has a right to receive.
- The judge can order prioritization of services (e.g., housing) and supports.
    - Statute Language: "After consideration of the plans proposed by the parties, the court shall adopt the elements of a CARE plan that support the recovery and stability of the respondent. The court may issue any orders necessary to support

the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding pursuant to Section 5982. These orders shall constitute the CARE plan."

- Services are subject to available funding and federal/state laws.
- County behavioral health may provide additional services beyond what is in the CARE plan.
- Other Medi-Cal services, such as Enhanced Care Management or Community Support (In lieu of care services), may be suggested (not ordered) by the courts.

For more information, visit the 2022 California Welfare and Institutions Code.

Behavioral Health Services

» May include Full Service Partnership (FSP), assertive community treatment (ACT), or other outreach/intensive case management team

» Services may include:
- Case management
- Mental health & SUD treatment
- Medication management
- Employment services
- Peer Support Specialist
- Community Health Worker
- Housing services resources/services
- Other medical services/support

DHCS | HMA

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[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Plan" with a description of what behavioral health services could be provided.]

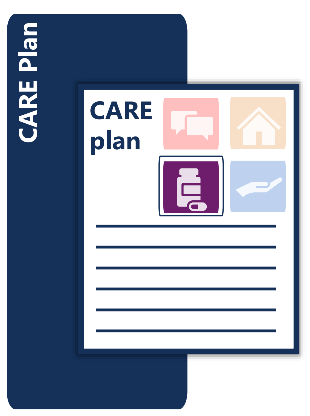
Behavioral health services may include Full Service Partnership (FSP), assertive community outreach (ACT), or other outreach/intensive case management team.

Services may include:

- Mental health and substance use disorder services.
- Intensive community outreach that may come in the form of ACT or FSP, which are about meeting the client where they are.
- Case management with a care manager or care navigator that aligns services among providers.
- Medication management.
- Skill building and employment services.
- Peer support that is essential for recovering individuals or individuals that have experienced recovery.

- Community health workers.
- Other social determinants of health (SDOH) services that could include access to food, nutrition, and transportation.

Medically Necessary Stabilizing Medications



» A court may order medication if it finds…by clear and convincing evidence, the respondent **lacks the capacity to give informed consent** to the administration of medically necessary stabilization medication.

- Medically Necessary
- Stabilization Medications
    - Primarily consist of antipsychotic medication
    - Shall not be forcibly administered

For more information, visit the 2022 California Welfare and Institutions Code – 14059.5. (a), the 2022 California Welfare and Institutions Code - 5977.1(3), and the 2022 California Welfare and Institutions Code - 5971(p).

DHCS | HMA

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[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Plan" with a description of what medically necessary stabilizing medication services could be provided.]

Maria (a person seen in homeless encampment with clear lack of capacity to give informed consent) helps to illustrate the need for medically necessary stabilizing medication. The capacity to give informed consent involves understanding the basic elements for the condition being treated, reasons for treatment, how medication is supposed to assist with treatment, and what not taking the medication means.

A court can determine that medication is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (WIC Code §14059.5(a)). Stabilization Medications or medications included in the CARE plan that primarily consist of antipsychotic medications can be given to reduce symptoms of hallucinations, delusions, and disorganized thinking. Stabilization medications may be administered as long-acting injections if clinically indicated. Stabilization medications shall not be forcibly administered. (Cal CARE Act 5971(p)).

For more information, visit the 2022 California Welfare and Institutions Code – 14059.5. (a), the 2022 California Welfare and Institutions Code - 5977.1(3), and the 2022 California Welfare and Institutions Code - 5971(p).

Housing Resources/Supports & Social Services

» Which may include
- Permanent Supportive Housing
- Interim Housing Models (Bridge)
- Affordable Housing Models
- Community-Based Housing

» Multiple Housing Resources & Community Services highlighted in WIC Section 5982 (a)(3)(4)
- Including services available to indigent residents

» BH Bridge Housing program includes prioritization for CARE respondents.

DHCS | HMA

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[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Plan" with a description of what housing resources/supports and social services could be provided.]

Types of housing supports may include:
- Permanent Supportive Housing
- Interim Housing Model (Bridge)
- Affordable Housing Models
- Community-Based Housing

Refer to Section 5982 of the statute for examples:
- No Place Like Home Program
- California Housing Accelerator
- The Multifamily Housing Program

Note that BH Bridge Housing program includes prioritization for CARE respondents.

Individualization

» CARE agreements and CARE plans must be individually tailored to the needs of the client.
» Consider whole-person needs within the parameters of what can be included in CARE plan
  - Housing
  - Mental health needs
  - SUD needs
  - Peer supports
  - Other community supports

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[Slide Image Description: This slide shows a graphic of an individual writing on a piece of paper and a short description of tailoring CARE agreements and CARE plans to the individual is given.]

CARE agreements and CARE plans must be individually tailored to the needs of the client.

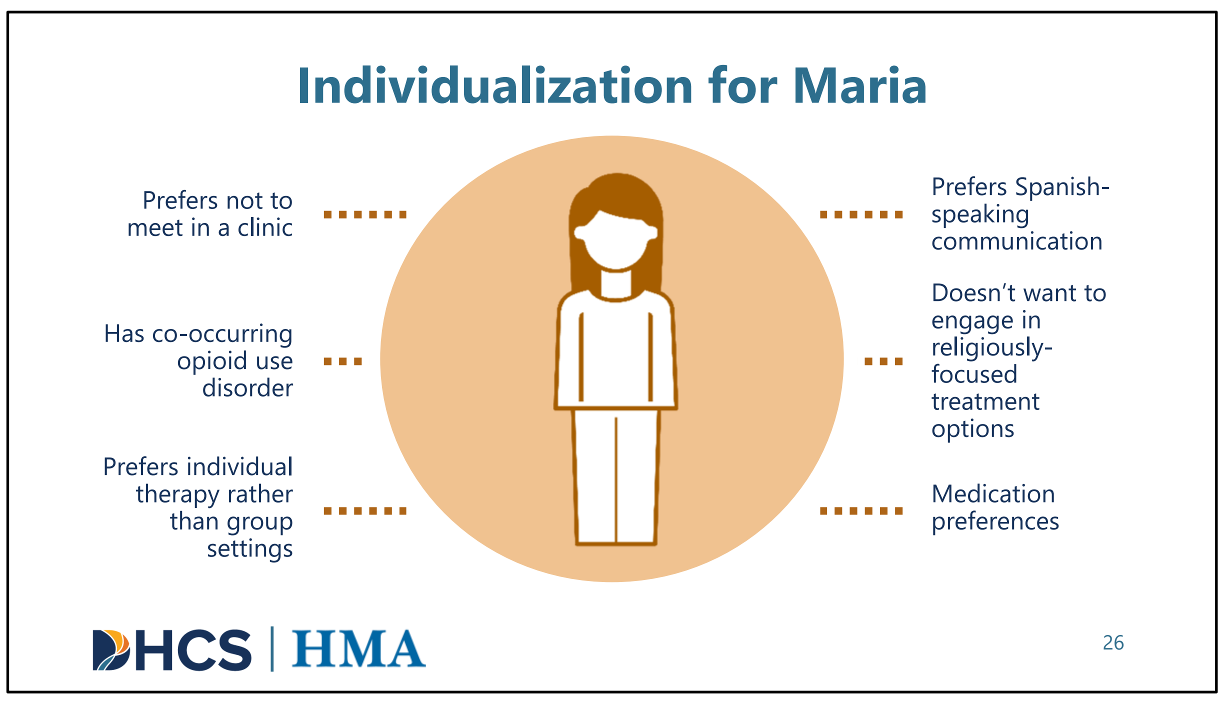
Clients engaged in the CARE Act often have had a myriad of experiences in the local social service sphere. It is important that we ask them about what they have tried, what worked, and what didn't. Additionally, nuance around client intersections of identity will come into play including: race, gender identity, mental health needs, disability, etc.

Providers are experts about what exists in our care system; it is our job to offer information and education to promote the client's choice/preferences. This will increase motivation and decrease resistance.

CARE Act Clients have multiple, complex, chronic needs that intersect, and it is important to consider the whole person needs. Needs often include:

- Housing
- Mental health needs
- SUD needs

- Peer supports
- Other community supports

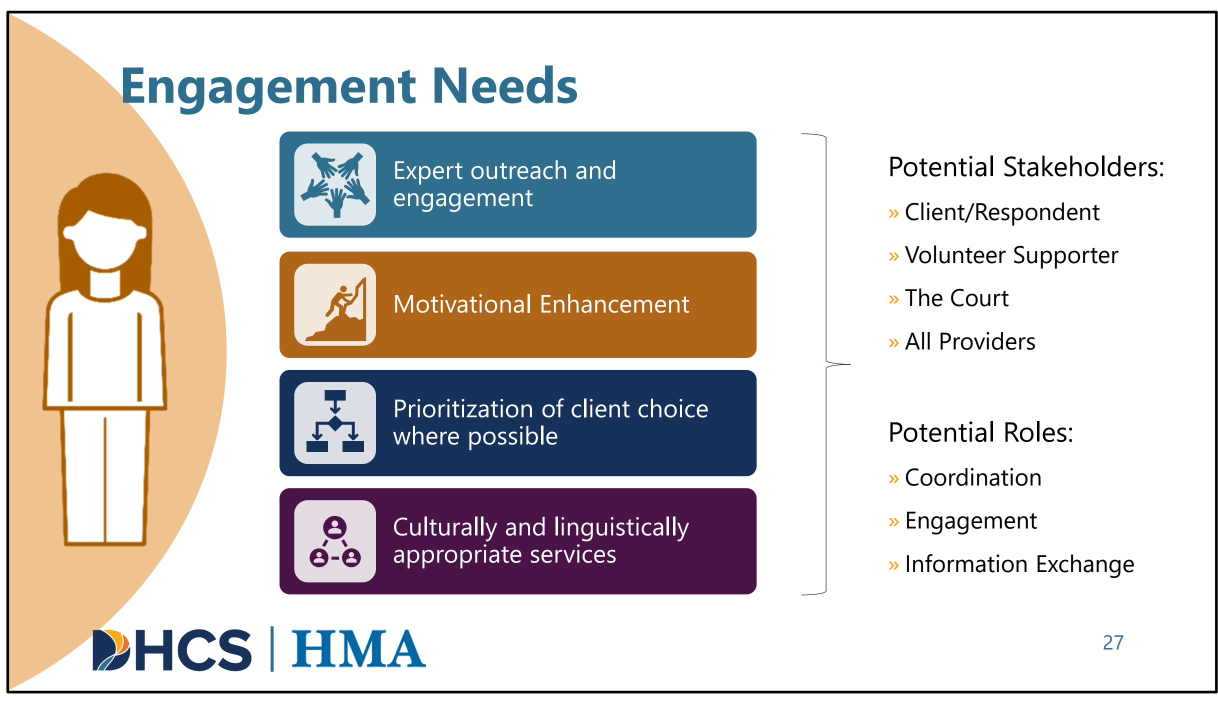


[Slide Image Description: This slide shows an orange silhouette of a person representing Maria in a lighter orange circle with Maria's unique needs listed to the sides.]

Let's consider Maria's unique needs, which would end up impacting her CARE agreement and plan.

- Maria prefers to not be in a clinic and has psychosis that involves not wanting to be in closed spaces.
- Maria also has schizophrenia and opioid use disorder.
- There are some explosive behaviors that have led to difficult interactions with police, peers, and family members.
- Maria prefers individual therapy rather than group therapy because it can feel overstimulating.
- Spanish is her first language.
- Maria has some religious-based trauma and prefers to not engage in religious-focused treatment options.
- Maria has a long history of medications that she has tried that have not worked, only

worked intermittently, or made her feel groggy and disconnected. Maria knows which medication she does and does not prefer.



[Slide Image Description: This slide shows four boxes that describe Maria's engagement needs and to the side are a list of potential stakeholders and potential roles for those helping with engagement.]

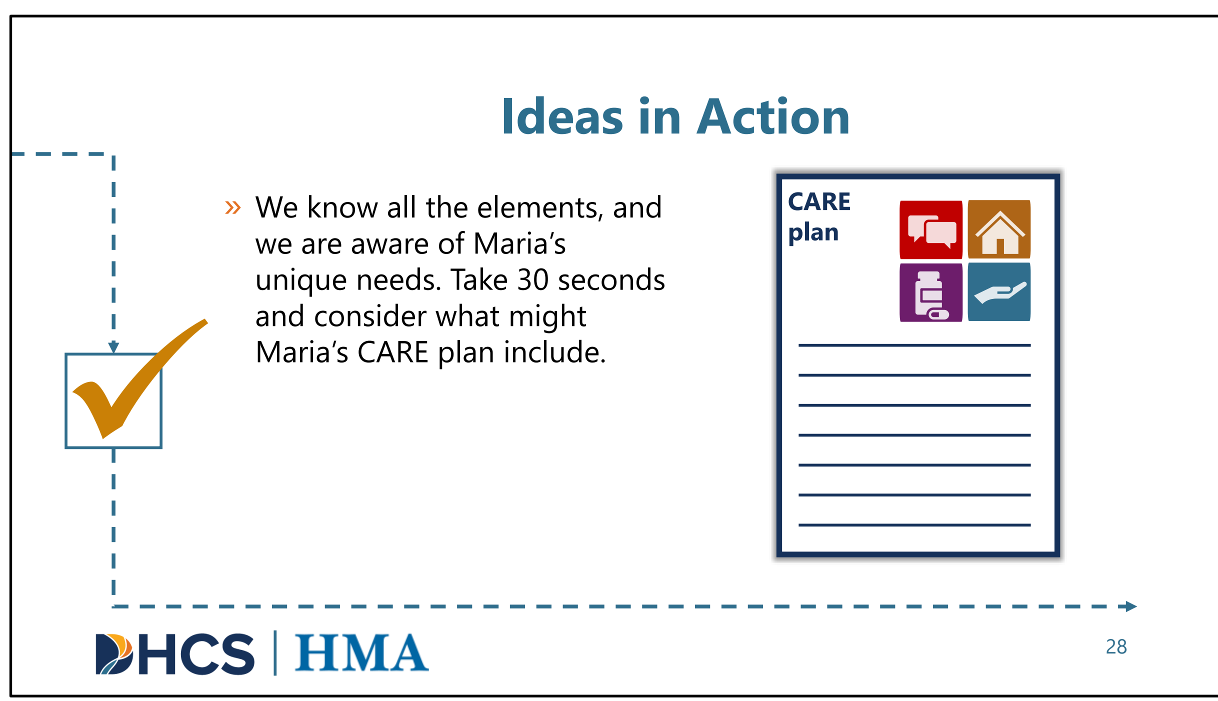
Being mandated to treatment/services can feel very overwhelming and potentially frightening to the clients being served. It is important to keep this front of mind. Framing the CARE Act purpose and services will be important to minimize fear and resistance. It's important to consistently highlight the desire to promote choice and help the client find an option that is likely to be a long-term fit.

The client will need:
- Expert outreach and engagement
- Motivational enhancement
- Prioritization of choice where possible
- Culturally and linguistically appropriate services

Additionally, there are many stakeholders with whom must be involved in coordination, engagement, and information exchange:
- The Client/Respondent
- Volunteer Supporter

- The Court
- All providers

All stakeholders will likely have differing communication preferences, availability, understanding of the social service landscape, and roles. Successful engagement caters to that nuance and synthesizes the variations in order to cohesively support the client.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Throughout this training, we talked about components of a CARE agreement and plan, and we also discussed the requirement for agreements and plans to be individualized. Consider how Maria's unique needs and preferences should impact her CARE agreement and plan. Take 30 seconds and consider what might Maria's CARE plan include.

Objectives

At the end of the session, participants will have an increased ability to:

- Identify the key points in the CARE Act process including the CARE agreement, CARE plan, and graduation plan.
- Describe the differences between voluntary engagement, CARE agreement, and CARE plan.
- Identify elements of a CARE agreement and CARE plan, including those services that may be prioritized for the CARE client/respondent.
- Describe at least three strategies for engaging the client/respondent into the CARE planning process.

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[Slide Image Description: This slide recaps the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Identify the key points in the CARE Act process including the CARE agreement, CARE plan, and graduation plan.
- Describe the differences between voluntary engagement, CARE agreement, and CARE plan.
- Identify elements of a CARE agreement and CARE plan, including those services that may be prioritized for the CARE client/respondent.
- Describe at least three strategies for engaging the client/respondent into the CARE planning process.

Again, we don’t anticipate that everyone will know exactly what they need to do by the end of this training, but our overall goal is that you have an increased ability to accomplish these objectives.

Next Steps

- Visit CARE-Act.org for resources (including recordings of past trainings) and to submit questions/TA requests.
- Receive notifications of trainings, TA, and other engagement opportunities by completing the form to join the communication listserv.

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[Slide Image Description: This slide shows bullets with next steps. It contains decorative arrows.]

Please let us know how we can best support your teams. Contact info@CARE-Act.org with questions, join the communications listserv, and submit requests and feedback for CARE Act TTA. Please also visit the CARE Act Resource Center website for training decks and recordings, which will be added two weeks after each training.

[Slide Image Description: This slide shows the CARE-act website and the email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing the CARE Act. The website is CARE-Act.org and our email address is info@CARE-Act.org.