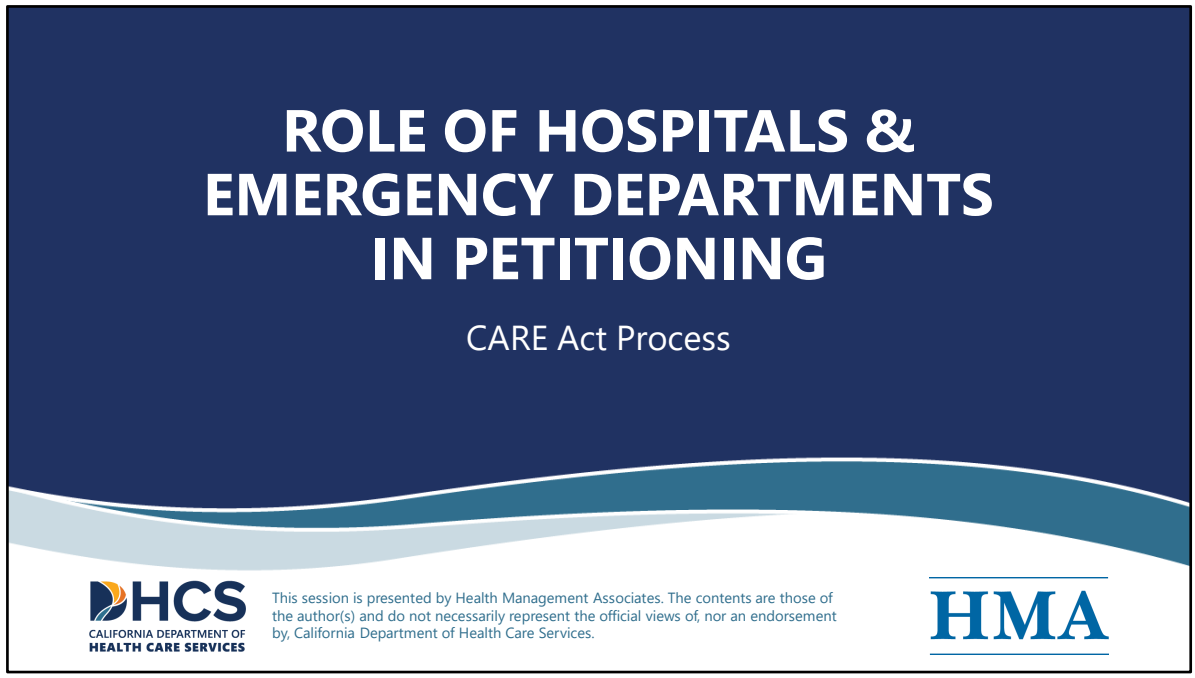
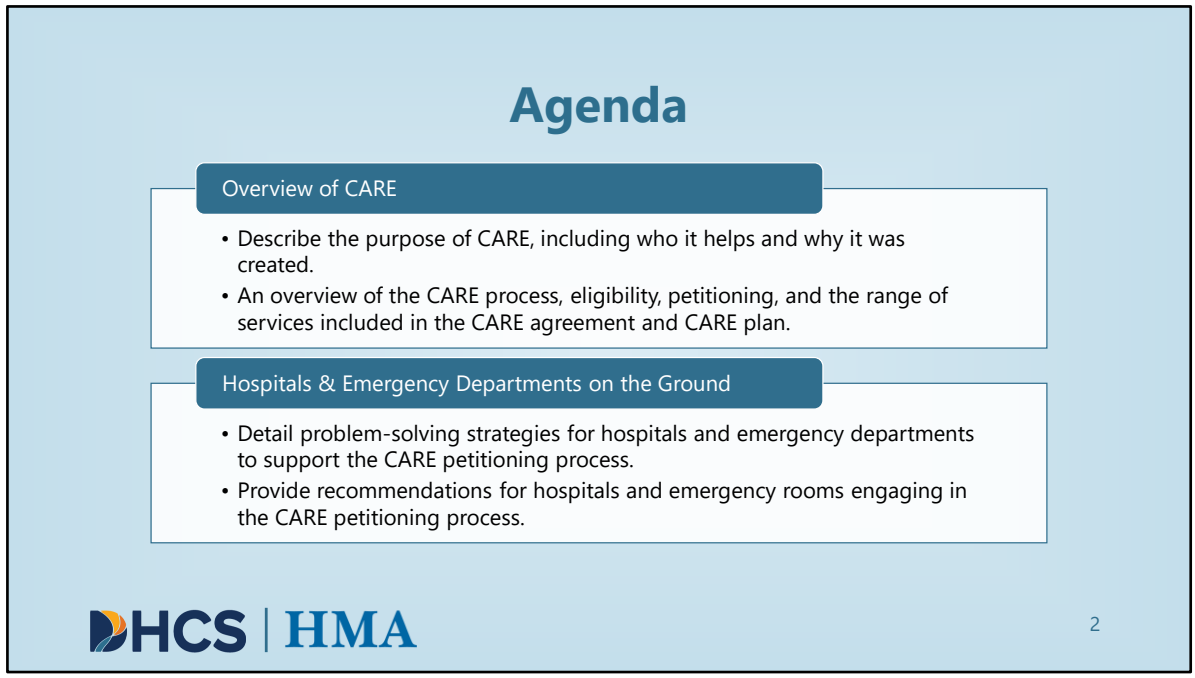


[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

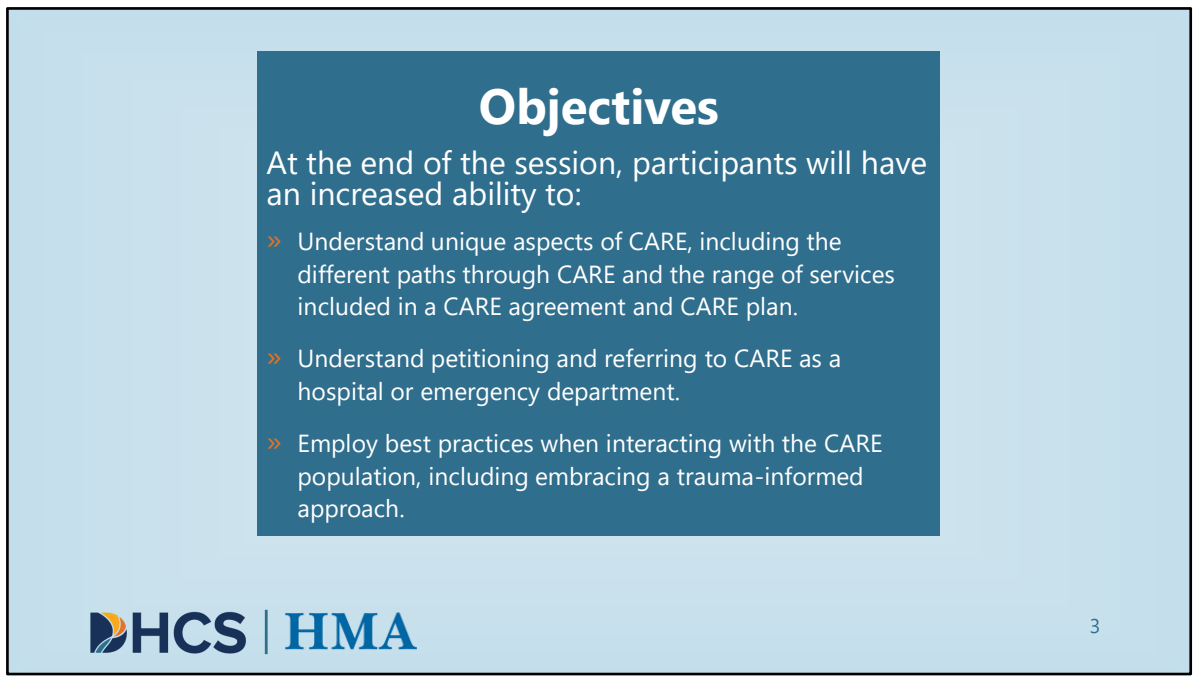
Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.



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

In today's training, we will discuss:

- Overview of CARE:
    - Describe the purpose of CARE, including who it helps and why it was created.
    - An overview of the CARE process, eligibility, petitioning, and the range of services included in the CARE agreement and CARE plan.
- Hospitals & Emergency Departments on the Ground:
    - Detail problem-solving strategies for hospitals and emergency departments to support the CARE petitioning process.
    - Provide recommendations for hospitals and emergency rooms engaging in the CARE petitioning process.



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

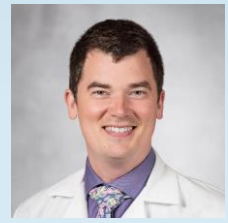
At the end of the session, participants will have an increased ability to:

- Understand unique aspects of CARE, including the different paths through CARE and the range of services included in a CARE agreement and CARE plan.
- Understand petitioning and referring to CARE as a hospital or emergency department.
- Employ best practices when interacting with the CARE population, including embracing a trauma-informed approach.

Presenters

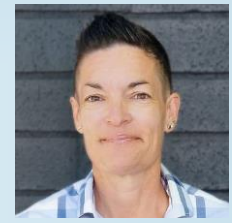
DEBORAH ROSE, PSYD

Associate Principal
Health Management
Associates



AARON MEYER, MD

Psychiatrist, UCSD
San Diego County



JODI NERELL, LCSW

Director - External
Affairs/Community
Health, Mental Health &
Addiction Services,
Sutter Health

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

Deborah Rose, PsyD, from Health Management Associates is a licensed clinical psychologist with a history of designing and scaling new initiatives in behavioral health services. She has extensive experience working with social service agencies, behavioral health centers, care coordination, supported housing, and services for unhoused populations. Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in community-based agencies and carceral settings. Earlier in her career, Dr. Rose oversaw Kendra's Law, an Assisted Outpatient Treatment (AOT) program in New York City. She was also Deputy Director of Behavioral Health across the Rikers Island jail system. She has strived to improve access to and delivery of person-centered services for adults living with mental illness, substance use disorders, and co-occurring conditions.

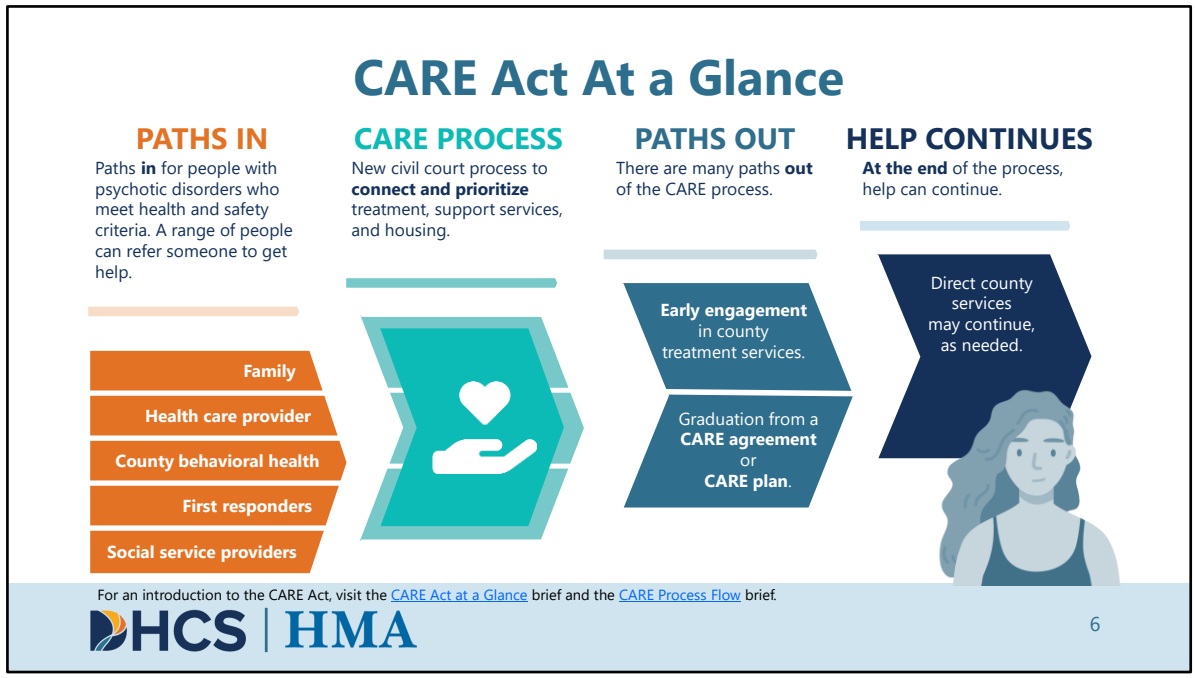
Dr. Aaron A. Meyer is a psychiatrist in San Diego, California and is affiliated with UC San Diego Health - La Jolla and Hillcrest Hospitals. Dr. Meyer works with the City of San Diego as their first Behavioral Health Officer, assisting first responders with patients who frequently utilize emergency services. His professional interests include treatment of

people with severe substance use disorders and co-occurring cognitive disorders, the intersection of probate and LPS, and increasing access to care.

Jodi Nerell, LCSW is the Director of Local Mental Health Engagement for Sutter Health. In her role, Jodi facilitates cross-sector and interdisciplinary partnerships to better serve the behavioral health needs of the community. This includes addressing opportunities for innovation in the community setting specific to mental health and addiction. Prior to her current role, Jodi has worked as the Director of Behavioral Health Integration at Sacramento Covered and Senior Program Health Coordinator at the Sacramento County Department of Health and Human Services. Jodi focuses on addressing ongoing systematic, programmatic, and operational issues for populations with complex health/social needs who are often faced with seeking care in acute settings due to lack of availability to, or access to, outpatient behavioral health care.

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

In this first section, we will provide an overview of CARE, including its purpose, who it helps, and why it was created. We will also detail the CARE process, eligibility, petitioning, and the range of services included in the CARE agreement and CARE plan.



[Slide Image Description: This slide shows the CARE Act at a glance with an icon image of an individual and a heart hovering over a hand.]

The CARE Act creates a new pathway to deliver mental health and substance use disorder services to a subset of Californians with the most complex behavioral health conditions who too often suffer in homelessness or incarceration without treatment.

The CARE Act is more than just a process: it is a way to connect individuals to services in their communities. There are many paths in, and there are individualized paths out. Each path begins when someone files a petition, which means that the petitioner believes someone is eligible and would benefit from additional support. In this process, that individual is referred to as the "respondent," or the person being connected to services. You could know them as a patient or client.

The goal is to give personalized support that someone would benefit from. Think of how hospitals and emergency departments could help an individual get on a path to receive help.

For an introduction to the CARE Act, visit the CARE Act at a Glance brief and the CARE Process Flow brief.

1. Paths in:
    - There are several potential people who can start the process in for people with schizophrenia spectrum and other psychotic disorders who meet health and safety criteria. A range of people can refer someone to get help.
    - Those that can "petition" for an individual to be considered for CARE Act services include:
        - Family member (parent, spouse, sibling, child or grandparent).
        - Health care provider.
        - County behavioral health.
        - First responders.
        - Social service providers

2. CARE process:
    - The CARE process is a new civil court process to connect and prioritize treatment, support services, and housing.
    - The three main paths to services triggered by a petition include voluntary engagement with services, the CARE agreement, and the CARE plan. All these paths essentially connect the individual with treatment, services, and support.
    - Voluntary engagement:
        - The individual engages early with county behavioral health (BH) and accepts services voluntarily. In which, services and supports can be provided outside of the CARE process.
    - The CARE agreement:
        - Treatment, services, and supports take place within the CARE process.
        - All parties are in agreement on the treatment and services that support the recovery of the CARE participant.
        - A CARE agreement is approved by the court.
    - Finally, the CARE Plan:
        - Treatment, services, and supports again take place within the CARE process.
        - In this case, if parties were not able to reach an agreement, the court will adopt elements of the parties' proposed plan(s) into a CARE plan that supports the recovery of the CARE participant.
    - The key here is that all of this is triggered by that initial referral, or petition. By referring or petitioning someone to CARE, a wide net is cast to engage them in services.

1. Paths out:
    - There are many paths out of the CARE process.
        - Early on in the court process, the county BH agency will attempt to engage the individual in treatment services. At this point, it may be possible to divert the respondent from the CARE process through this engagement.
        - Other paths out of the CARE process can include a graduation from a CARE agreement or CARE plan.
2. Help continues:
    - At the end of the process, help can continue.
    - Direct county services may continue, as needed.

[Slide Image Description: This slide shows 10 boxes that depict ways the CARE model can help.]

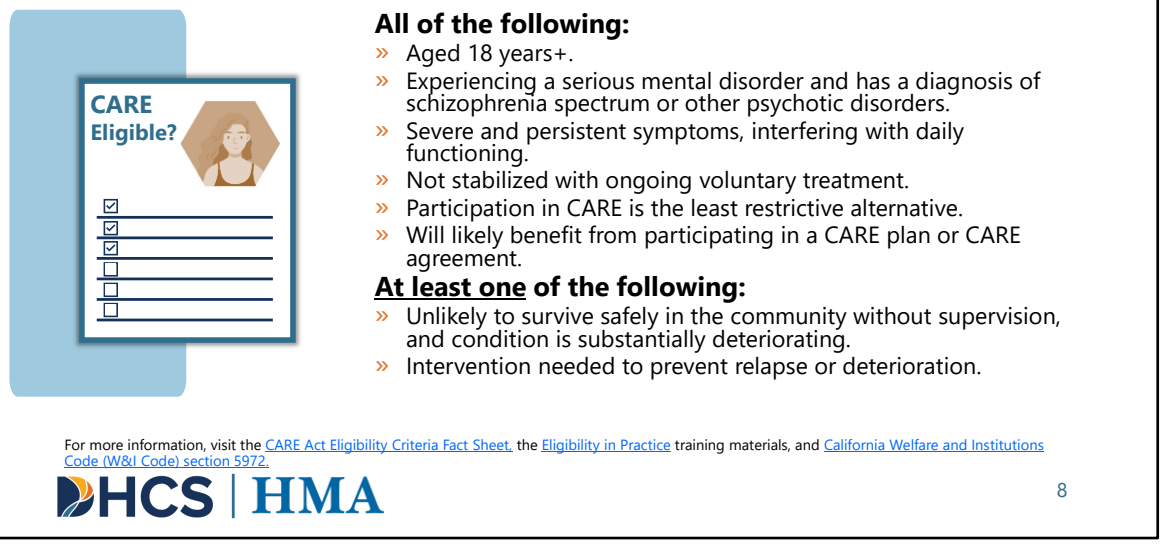
The CARE Act process aims to serve as an upstream intervention and support for individuals with schizophrenia spectrum or other psychotic disorders, which may assist in preventing hospitalizations, incarcerations, and Lanterman–Petris–Short (LPS) conservatorships.

Leveraging the state's investments in behavioral health and homelessness prevention, CARE ensures access to comprehensive and wraparound treatment, housing, and other services and supports to promote stabilization and recovery. CARE adds another option in the continuum of care, with the goal of helping individuals stabilize, move toward recovery, and thrive in community-based settings.

CARE includes the following approaches to support the success of eligible respondents:

- Trauma-informed outreach and engagement – behavioral health teams are being strategic and creative in locating and engaging respondents into their services, meeting the client "where they are at," and often starting with providing resources and meeting immediate needs to build rapport and trust.

- Wraparound services and coordination, multidisciplinary model of care – teams are typically considering the Assertive Community Treatment (ACT) or Full Service Partnership (FSP) model of care.
    - Linkage to other services, including CalAIM programs such as Enhanced Care Management (ECM) and Community Supports.
- Housing that ideally includes additional supports, which may include behavioral health services, case management, substance use disorder services, and peer support.
- Medications as a part of the comprehensive behavioral health services.
- Peer Recovery Supports may be an important part of an individual's recovery, with mutuality, mentorship, and coaching. In addition, many CARE teams are incorporating peer support into both their behavioral health teams and homeless outreach teams, which have been found to contribute to engagement efforts.
- Overall, the CARE Act uplifts the tenets of the recovery model, in that:
    - All components of the CARE agreement and CARE plan must be individualized to the respondent's needs and preferences.
    - CARE speaks to the development of a psychiatric advanced directive that outlines the respondent's treatment and personal preferences. These can be utilized in moments of crisis and also inform ongoing treatment planning.
    - CARE speaks to the volunteer supporter role – a person who is approved by the respondent to support the respondent in expressing their preferences, choices, and decisions.
- Please note that the CARE Act adds an element of county accountability to provide the services outlined in the CARE agreement and plan.
- CARE is the least restrictive alternative to conservatorship.



[Slide Image Description: This slide shows an image of a checklist with a person and a description of CARE Act eligibility criteria.]

The CARE Act stipulates eligibility, and we have that list up here. While it is good to have the eligibility in mind, the petitioner is not responsible for proving diagnosis. Rather, the petitioner should focus on documenting what you observe of someone and consider how they might benefit from the CARE process.

CARE eligibility criteria is defined as:

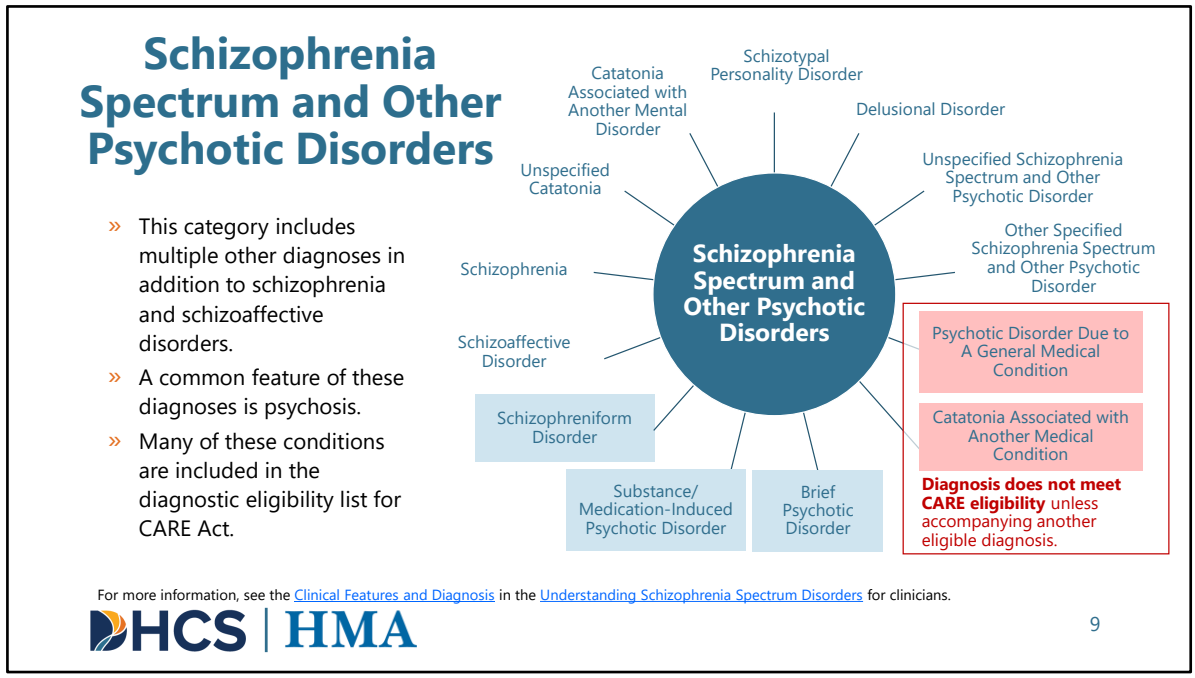
- The person is 18 years of age or older.
- The person is currently experiencing a severe mental disorder, as defined in California Welfare and Institutions Code (W&I Code) section 5600.3, paragraph (2), subdivision(b), and has a diagnosis identified in the disorder class schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (which we will go into next).
    - This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in

nature, including but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.
    - A person who has a current diagnosis of substance use disorder, as defined in California Health and Safety Code (H&S Code) section 1374.72, paragraph (2), subdivision (a), but who does not meet the required criteria in this section shall not qualify for the CARE process.
- The person is not clinically stabilized in ongoing voluntary treatment.
- Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.
- It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

At least one of the following is true:

- The person is unlikely to survive safely in the community without supervision, and the person's condition is substantially deteriorating.
- The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in W&I Code section 5150.

For more information, visit the CARE Act Eligibility Criteria Fact Sheet, the Eligibility in Practice training materials, and California Welfare and Institutions Code (W&I Code) section 5972.



[Slide Image Description: This slide shows a circle with arrows listing schizophrenia spectrum and other psychotic disorders.]

As petitioners, you do not need to be an expert in CARE or CARE eligibility, but you need to have a reason to believe someone *may* be eligible. Therefore, it is helpful to better understand the qualifying diagnoses. This slide depicts the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) conditions that are listed in the schizophrenia spectrum and other psychotic disorders chapter. All the CARE Act eligible diagnoses are contained in this chapter.

The DSM-5 chapter of schizophrenia spectrum disorders includes many different diagnoses with similar sounding names. These diagnoses are clumped into one grouping because psychosis is a feature of all of them. Each of these has somewhat different diagnostic criteria.

As noted, all CARE Act-eligible diagnoses are contained in this DSM-5 chapter. However, not all the diagnoses in the chapter are eligible for CARE. The two that are not eligible are psychotic disorder or catatonia that is associated with a general medical condition. These diagnoses must be accompanying another eligible diagnosis to meet

criteria for the CARE process.

There are other conditions where someone might experience psychosis that are not contained in this chapter (e.g., severe bipolar disorder or depression with psychosis). Even though these conditions may feature psychotic symptoms, they are neither contained in this chapter nor are they eligible for CARE.

Keep in mind that having an eligible diagnosis is just one of the eligibility criteria for CARE. For example, someone diagnosed with brief psychotic disorder, schizophreniform disorder (often associated with early diagnosis), or substance/medication-induced psychotic disorder would also have to meet eligibility criteria related to the "severity and persistent duration" of their symptoms as well.

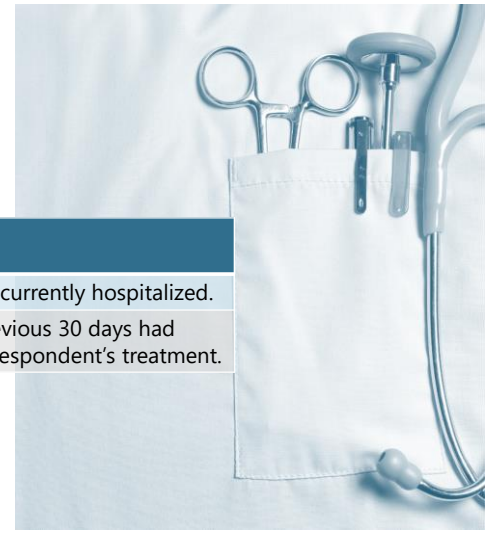
For more information, see the Clinical Features and Diagnosis in the Understanding Schizophrenia Spectrum Disorders for clinicians.

Who Can Petition?

Hospitals and emergency department staff are among eligible petitioners.

Eligible Petitioner	Includes designee?	Timing
Director of a hospital	Yes	The respondent is currently hospitalized.
Licensed behavioral health professional	Yes	Currently, or in previous 30 days had been, involved in respondent's treatment.

"Designee" includes individuals at the organization who have been identified by the director to complete the CARE-100.



For more information, visit CARE Act Resources For Petitioners and for additional details (such as timing) refer to W&I Code section 5974.

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[Slide Image Description: This slide shows an image of a clinician's shirt pocket and includes information about eligible petitioners.]

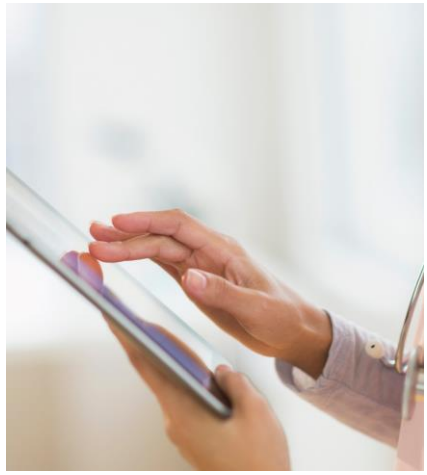
A petitioner could include lay individuals like a family member, roommate, or the individual themselves. A petition can also be filed by a number of system partners, which includes hospitals and emergency department staff.

- The director of a hospital (or designee) in which the respondent is hospitalized.
- A licensed behavioral health professional (or designee) currently, or in previous 30 days had been, involved in respondent's treatment.

Both of these petitioners include a "designee," or individuals at the organization who have been identified by the director to complete the CARE-100. A "designee" of the director of a hospital could, for example, include a psychiatrist, social worker, or other treatment team member.

Keep in mind that petitioners can partner with other petitioners to complete the petition. For example, if a first responder (another eligible petitioner) is completing the petition, hospital staff could help complete additional documentation (which we will discuss in a moment).

For more information, visit CARE Act Resources For Petitioners and for additional details (such as timing) refer to W&I Code section 5974.



Assessing for CARE Eligibility in Workflows

- Initial triage and assessment
- During psychiatric evaluation
- During care management, care coordination, and discharge planning activities
- Following behavioral incidents
- Proactive record review

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[Slide Image Description: This slide shows an image of a hand typing on a tablet.]

Consider where in your workflows clinicians and other staff can assess whether individuals are eligible for CARE, particularly when their symptoms or circumstances suggest they might benefit from social support interventions. These points include:

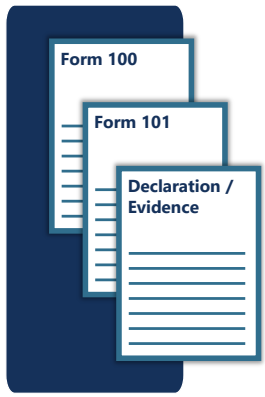
1. Initial triage and assessment: Upon admission to the emergency department or during the intake process for inpatient care, clinicians could evaluate the patient's mental health status, including any history of schizophrenia spectrum or other psychotic disorders. If the individual presents with psychosis, recurrent hospitalizations, or a decline in activities of daily living (ADLs) due to behaviors linked to their mental illness, staff could explore the option of a CARE referral. This could include admission related to a serious mental disorder, but it can also be prompted by admission related to a physical health concern that is exacerbated by their serious mental disorder.
2. During psychiatric evaluation: If the patient is evaluated by a psychiatrist or mental health specialist, particularly for long-term care or treatment planning, this is an appropriate moment to consider the eligibility for CARE. The psychiatrist may recognize that the patient’s symptoms are severe and persistent, their condition is interfering with ADLs, or their symptoms are significantly impeding their stability or independent functioning.

3. During care management or care coordination activities: When coordinating discharge planning or transfers to outpatient settings, social workers, case managers, or discharge planners should assess the patient's treatment history, housing stability, and ability to maintain access to services. If the patient has a history of repeated hospitalizations due to schizophrenia-related behaviors, CARE might be a good path to connect them to services that improve their stability.
4. Following behavioral incidents: In instances where patients living with schizophrenia spectrum and other psychotic disorders exhibit behaviors that necessitate security or law enforcement involvement, alternatives to incarceration or traditional legal action could be explored. A referral to CARE may divert the patient into treatment-oriented services.
5. Proactive record review: In addition to in-the-moment assessments, clinicians and hospital teams could proactively review patient records to identify those with a history of schizophrenia spectrum and other psychotic disorders and repeated hospitalizations. By flagging patients who might benefit from CARE early—particularly those with a history of homelessness, co-occurring substance use, and unstable symptoms—care teams can intervene before crisis situations arise. This proactive approach ensures that potential candidates for CARE are connected to resources and support services as part of their overall treatment plan.

Remember that discharge planning starts day one of the person's admission. Social workers, discharge planners, and treatment teams should think about petitioning or referring to CARE early in the admission, to create a fluid discharge plan that supports continuity of care.

The Petition

Write what you observe & know.
The judge has broad discretion when conducting the initial (prima facie) review of petition.



» **Petition to Commence CARE Act Proceedings (form CARE-100):**
- Allows for narrative information to support that the respondent meets eligibility criteria.

» **Plus, one of two things:**
- **Mental Health Declaration—CARE Act Proceedings (CARE-101 form):** Declaration from a licensed behavioral health professional who examined the respondent in the past 60 days (or has made multiple attempts).

OR

- **Declaration, evidence, or other documentation** of at least two intensive treatments (one within previous 60 days).

For more information on the mandatory forms, see Information for Petitioners – CARE 050, Information for Respondents – CARE 060, How to File the CARE – 100 Form, the CARE-100 form, CARE 101-form, and the CARE Act Resources for Petitioners One-Pager.

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[Slide Image Description: This slide describes the petition and includes three images representing Form 100, Form 101, and declaration/evidence.]

Let's talk about what's in the petition, as the information included with this form is used for the court to conduct its initial review. The goal of the petition is to provide sufficient information for the court to initially determine that the respondent meets or may meet the eligibility standard.

The Petition to Commence CARE Act Proceedings (also known as the CARE-100 form) was developed for use by all petitioners statewide. It's important to recognize that this form allows for narrative information.

- In addition to the CARE-100 form, you will need one of two things:
  - Option 1: Mental Health Declaration—CARE Act Proceedings (also known as the CARE-101 form) which is a declaration of a licensed behavioral health professional stating that they have examined the respondent in the past 60 days (or has made multiple attempts to examine them) and has reason to believe that the respondent meets the diagnostic criteria for CARE proceedings.
  - Option 2: Declaration, evidence, or other documentation of at least two intensive treatments (one within previous 60 days).

As hospital and emergency department staff, it's important to understand that the petition isn't a test about getting it "right or wrong." It's about providing what you observe and know and documenting this information in response to the questions. You only need to have a reasonable belief that the individual qualifies for CARE. The judge has broad discretion when reviewing your petition when conducting the initial (prima facie) review of the petition.

For more information, on the mandatory forms, see Information for Petitioners – CARE 050, Information for Respondents – CARE 060, How to File the CARE – 100 Form, the CARE 101 form, and the CARE Act Resources for Petitioners One-Pager.

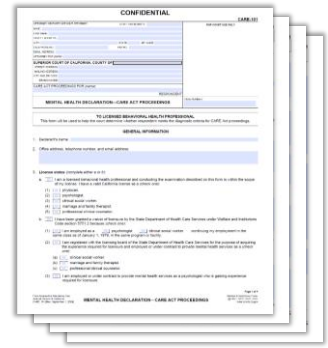
The Petition Forms & Documentation

Petition

CARE-100 form

Mental Health Declaration

CARE-101 form



For more information about the petition process, including completing required forms, see the video tutorial series on Petitioning for System Partners.

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[Slide Image Description: This slide includes two images representing CARE Form 100 and CARE Form 101.]

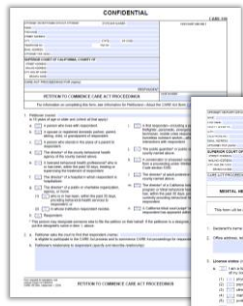
Here are what those two forms look like. Both are fillable PDFs, and both forms allow for narrative descriptions and to attach additional documentation. Also, if you're attaching a Mental Health Declaration or CARE-101 form, there are several areas (specifically about eligibility) that you will not need to fill out in the Petition form. You will simply check the box that indicates you are attaching that declaration.

In each of these forms, there is a portion to include biographical information, as well as information that will help a judge determine eligibility.

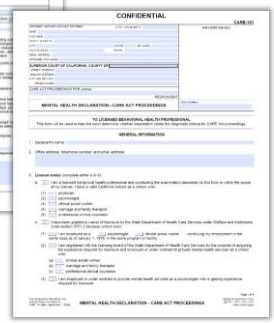
For more information about the petition process, including completing required forms, see the video tutorial series on Petitioning for System Partners.

The Petition Forms & Documentation

CARE-100 form



CARE-101 form



What to include?

- Confirmed diagnosis of schizophrenia spectrum or other psychotic disorders (when available)
- Observed behaviors and symptoms
- Declining mental/physical state and inability to meet basic needs
- Difficulty with self-care or accessing medical care
- Difficulty maintaining a residence, using transportation, or managing money
- Difficulty creating and maintaining relationships
- Refusing to engage in treatment or treatment is not effective at stabilizing symptoms

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[Slide Image Description: This slide includes two images representing the CARE 100 and CARE 101 forms.]

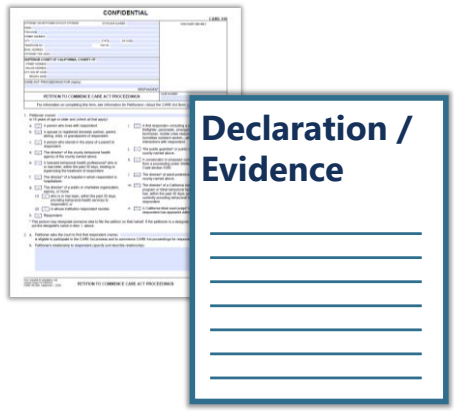
Things you would want to include as appropriate and possible:

- A confirmed diagnosis of schizophrenia spectrum or other psychotic disorders, if possible. Consider that you may not be able to confirm a diagnosis or you only have a provisional diagnosis, but include what you know.
- Observed behaviors and symptoms, such as delusional beliefs, paranoia, hallucinations, disorganized speech, or blunted emotions and affect
- Declining mental/physical state and inability to meet basic needs for food, clothing, or shelter
- Difficulty with self-care, like bathing, grooming, dressing appropriately for the weather, securing health care, or accessing medical care
- Difficulty maintaining a residence, using transportation, or managing money day to day
- Difficulty functioning socially, creating and maintaining relationships
- Repeated and ongoing refusal to engage in treatment. Or they accept treatment, but it is either interrupted or ineffective at stabilizing their symptoms

It may feel like some of the information is repetitive, but remember, your job as the petitioner is to help a judge determine if someone is eligible so include information that will help them make that determination.

The Petition Forms & Documentation

CARE-100 form



- The other option to support the petition is a declaration, evidence, or other documentation that the respondent was detained for at least two periods of intensive treatment, the most recent period within the past 60 days.
- What are examples of evidence?
  - Documentary evidence from the facility where the respondent was detained
  - A copy of the certification of intensive treatment
  - A declaration from a witness to the intensive treatment
  - Hospital discharge paperwork
  - Signed declaration from the petitioner if they have personal knowledge of the detentions
  - Family member's affidavit regarding knowledge of hospitalizations

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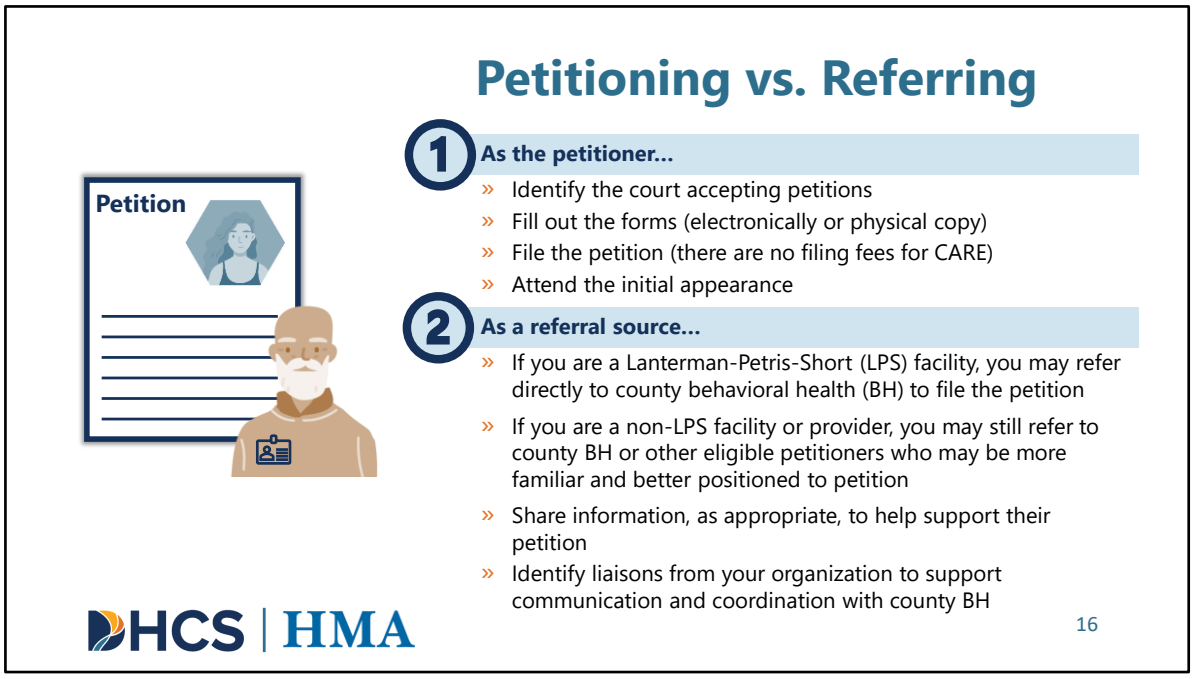
[Slide Image Description: This slide describes the petition and includes two images representing the CARE 100 form and declaration/evidence.]

The other option to support the petition is declaration, evidence, or other documentation that the respondent was detained for at least two periods of intensive treatment, the most recent period within the past 60 days.

What are examples of evidence?

- Documentary evidence from the facility where the respondent was detained
- A copy of the certification of intensive treatment
- A declaration from a witness to the intensive treatment
- Hospital discharge paperwork
- Signed declaration from the petitioner if they have personal knowledge of the detentions
- Family member's affidavit regarding knowledge of hospitalizations



[Slide Image Description: This slide shows an image of a petition with a person and a description petitioning vs. referring.]

When thinking about filing a petition, consider who is in the best position to file and if there is a way to collaborate to reach that goal. Hospitals and emergency departments may be able to complete the petition themselves (provided they are eligible petitioners), but they can also be a referral source as well.

1. As the petitioner, you would…
- Identify the court accepting petitions. For example, this could be listed on your county's CARE website or search for the court on your county's court website.
- Fill out the forms (electronically or hard copy).
    - Focus on what you know.
    - For those who are not clinical professionals, you do not need to know the specific diagnosis; just document observed behaviors and why you believe that the respondent may fit in the disorder class.
- File the petition according to your county's process, keeping in mind that there are no filing fees. This may be done in person, electronically, or via mail.
- Petitioners should plan on attending the initial appearance. We recommend that the

petitioner reach out to county BH to coordinate, as county BH will step in as the petitioner at the initial appearance or hearing.

2. As a referral source, there are a few different options depending on your facility and your role:

- If you are an LPS facility, you may refer directly to county BH to file the petition. This relates to the new guidance in Senate Bill (SB) 42 with regards to eligible facilities referring to county BH via a more formal referral process and includes time parameters for the county to conduct their evaluation and file a petition.
- If you are a non-LPS facility or provider, you may still refer to county BH or other eligible petitioners who may be more familiar and better positioned to petition. Other eligible petitioners could also include the individual themselves, who can self-refer.

- With either process, you will need to share information, as appropriate, to help support their petition, especially contact information.

- Identify liaisons from your organization to support communication and coordination with county BH. For example, in some counties, they have determined that county BH will help triage and submit petitions, and system partners have identified an individual or a team that can send the referral to the county. At a hospital emergency department, there could be a designated CA Bridge navigator that is an assigned liaison with county BH.

Petitions must be filed in the county in which the respondent resides, is found, or is facing criminal or civil proceedings. The county in which the petition is filed is most likely where the respondent will receive services, including housing, so consider which is the best option.

Referrals from Involuntary Holds

- Amendments to the CARE Act through Senate Bill (SB) 42 allow facilities to refer individuals who are under an involuntary hold to county BH for CARE consideration.
- Facility is to make a referral as soon as clinically indicated as part of discharge planning.
- Within 14 business days of referral, county BH agency is to assess individual and file petition if they determine individual meets or is likely to meet CARE criteria.
- A referral does not allow the facility to continue a hold solely to allow for county BH assessment if individual no longer meets the involuntary hold criteria.
- A referral to CARE does not preclude a referral to Assisted Outpatient Treatment (AOT).

For more information about updates in SB 42, see the Senate Bill 42 Amendments brief.

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[Slide Image Description: This slide outlines considerations for facilities to refer individuals who are under an involuntary hold to county BH for CARE consideration.]

Amendments to the CARE Act through SB 42 allow facilities to refer individuals who are under an involuntary hold to county BH for CARE consideration.

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For more information about updates in SB 42, see the Senate Bill 42 Amendments brief.

Petitioner's Role After Petition is Filed

- The original petitioner should be present and can make a statement at the initial appearance.
  - Many courts allow remote appearances.
- Original petitioners are replaced by county BH during the initial appearance, so would not be required to be present ongoing.

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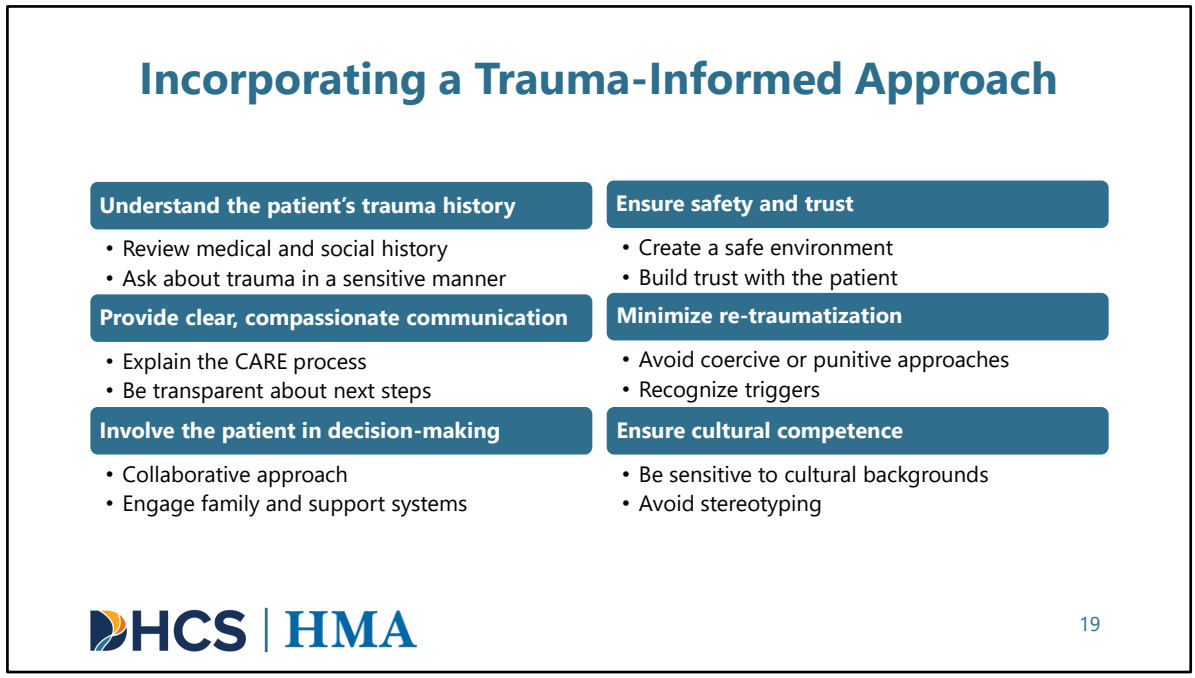
[Slide Image Description: This slide contains a picture of scales, representing the court process that occurs after a petition is filed.]

Let's talk about the petitioner's role after the petition is filed.

- The original petitioner should be present and can make a statement at the initial appearance. Please note that thus far, many courts are allowing remote appearances.
- During the initial appearance, the court will replace the original petitioners (including hospitals and emergency departments) with county BH, who will from then on be considered the petitioner. After that point, the original petitioner would not be required to attend future hearings.



[Slide Image Description: This slide shows eight boxes that depict ways to incorporate a trauma-informed approach.]

When hospital and emergency department staff are considering filing a petition to participate in CARE, consider ways that you can take a trauma-informed approach. This ensures that the patient's past experiences with trauma are acknowledged and respected, reducing the risk of re-traumatization and enhancing their engagement in the process.

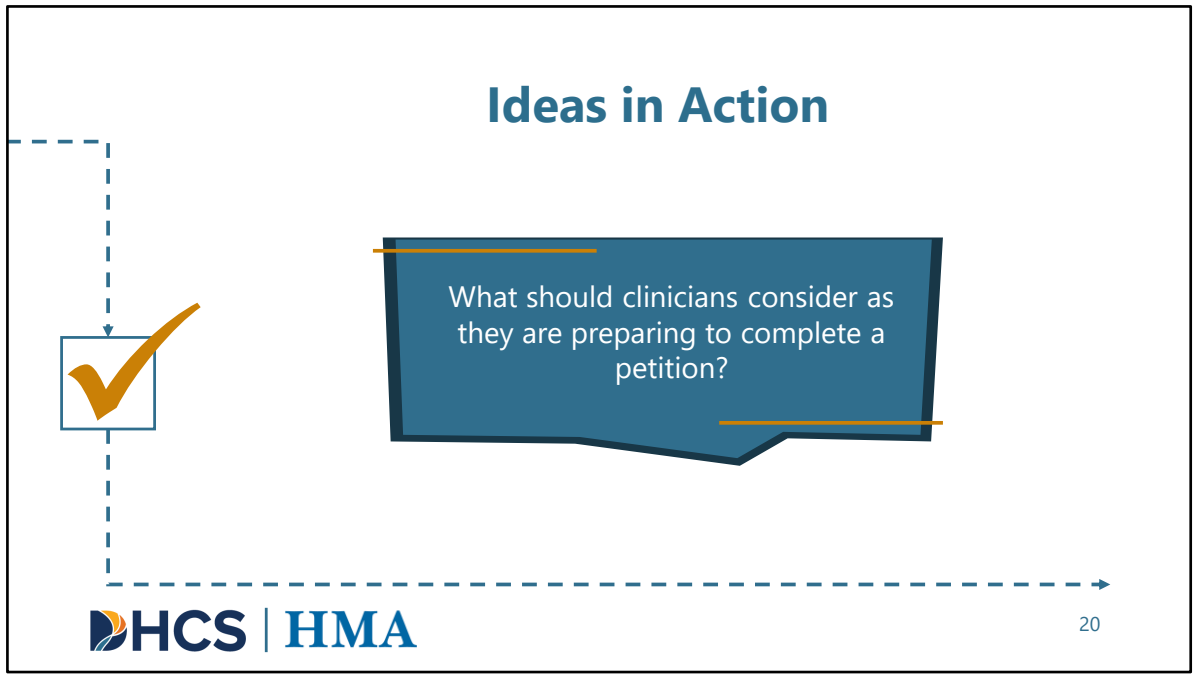
Here are key recommendations for taking a trauma-informed approach when filing a petition for CARE.

1. Understand the patient's trauma history.
    - Review medical and social history: Before filing the petition, review the patient's medical and psychiatric records for any history of trauma, including physical, emotional, or psychological abuse, neglect, or past involvement with the legal system. This information helps inform a trauma-sensitive approach.
    - Ask about trauma in a sensitive manner: During assessments, inquire about past trauma in a respectful, non-invasive way. Trauma may have played a role

in the patient's mental health struggles and understanding this context helps tailor support.

2. Provide clear, compassionate communication.
    - Explain the CARE process: Clearly explain why the CARE petition is being considered and that this process is meant to hold systems accountable to providing them support. Use straightforward language to describe how CARE connects the patient to outpatient wraparound services, focusing on the fact that CARE is about supporting the person's recovery and stability, and that it is not a mechanism of control or a punitive process.
    - Be transparent about next steps: Ensure the patient understands their rights, the purpose of the petition, and the potential benefits of participating in CARE. Reducing uncertainty helps prevent fear or anxiety, which can escalate symptoms of trauma.
3. Involve the patient in decision-making.
    - Collaborative approach: Whenever possible, involve the patient in decisions about their care, even as the CARE petition is considered. Engaging the patient in conversations about their needs and preferences provides them with a sense of control and respect, which is essential for a trauma-informed approach. This could even look like supporting an individual to self-petition, meaning that they file a petition on their own behalf.
    - Engage family and support systems: If appropriate, include the patient's family members, trusted friends, or other support systems in discussions. This can create a sense of safety and support that empowers the patient to engage in the CARE process. If appropriate, you can involve key individuals to potentially participate as a volunteer supporter during the CARE process itself.
4. Ensure safety and trust.
    - Create a safe environment: During discussions about the CARE petition, ensure that the environment is calm, private, and supportive. A peaceful and respectful atmosphere helps the patient feel safe and less likely to experience distress.
    - Build trust with the patient: Establish a trusting relationship by using respectful, non-judgmental language. Trust is critical in helping the patient understand that the CARE petition is intended to support their recovery, not to punish or control them.
5. Minimize re-traumatization.
    - Avoid coercive or punitive approaches: Filing a petition for CARE should not be framed as coercion or punishment. Emphasize that the goal is to connect the patient to services like housing, mental health care, and social support, rather than involuntary treatment or incarceration.
    - Recognize triggers: Be mindful of potential triggers that may arise during the petition process, such as past negative interactions with authority figures or feeling disempowered. Recognizing and avoiding these triggers helps reduce the likelihood of re-traumatization.

6. Ensure cultural competence.
    - Be sensitive to cultural backgrounds: Recognize that cultural differences may affect how the patient views the health care system and legal processes like CARE. Adapt your communication and care strategies to respect these differences and ensure that the patient feels heard and understood.
    - Avoid stereotyping: Trauma-informed care requires avoiding assumptions or stereotypes based on the patient's race, gender, or socioeconomic status, which can exacerbate feelings of marginalization or misunderstanding.



[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.]

What should clinicians consider as they are preparing to complete a petition?

- Take time to discuss before respondent gets a petition to explain your goal in referring them to CARE. Consider who should be a part of that discussion (e.g., psychiatrist, peer, family member if appropriate).
- Gather documentation (e.g., medical records, psychological evaluations) that supports the petition, including observations.
- Familiarize yourself with eligibility criteria, including qualifying diagnosis, but don't get caught up in having to know every detail. You just have to have a reasonable belief that they may qualify.
- Collaborate with others to gather information or complete the petition.

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

In this second section of the training, we will hear about work being done in hospitals and emergency departments on the ground.

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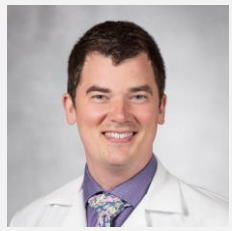
Hospital and Emergency Departments in San Diego County



AARON MEYER, MD

Psychiatrist, UCSD

Challenges and Solutions

- Assess the required time commitment for clinicians in the petition process and consider opportunities for delegation.
- Know the petition process and court requirements (e.g., if clinicians can submit forms directly to the court, remote court participation options).

Recommendations to Hospitals and Emergency Departments

- Collaborate with multidisciplinary teams to incorporate the CARE Act process into existing care coordination workflows within the hospital or emergency departments.
- Engage natural support systems, such as family members, peers, or community supporters, in patient discharge planning and the petition process.
- Handle all patient information with care, ensuring confidentiality is maintained.
- Foster strong relationships with county BH agencies.

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[Slide Image Description: This slide includes a photo of Aaron Meyer, as well as text describing common challenges/solutions and recommendations for hospitals and emergency departments petitioning in the CARE Act process.]

Dr. Aaron A. Meyer is a psychiatrist in San Diego, California and is affiliated with UC San Diego Health - La Jolla and Hillcrest Hospitals. Dr Meyer works with the City of San Diego as their first Behavioral Health Officer assisting first responders with patients who frequently utilize emergency services. His professional interests include treatment of people with severe substance use disorders and co-occurring cognitive disorders, the intersection of probate and LPS, and increasing access to care.

Challenges and Solutions:

- Assess the required time commitment for clinicians in the petition process and consider opportunities for delegation.
    - Clinicians should evaluate the time needed not only for completing the petition forms (e.g., 100 and 101) but also for potential court appearances. For clinicians with demanding schedules, knowing this in advance can help with planning and decision-making. Involve support staff when possible.
    - If clinicians are hesitant due to time constraints, they might benefit from

having a designated petitioner or advocate who can appear in court on their behalf. This could involve collaboration with emergency medical services (EMS) or other hospital staff.

- Know the petition process and court requirements.
    - Clarify whether the completed form should be submitted to a designated petitioner or directly to the court. Understanding this can streamline the process and alleviate anxiety.
    - Confirm if the local court allows remote participation to reduce the burden of physical appearance. This could significantly lower barriers for clinician involvement.

Recommendations to Hospitals and Emergency Departments:

- Collaborate with multidisciplinary teams to incorporate the CARE Act process into existing care coordination workflows within the hospital or emergency department.
    - Engage psychiatric liaison teams, social workers, and case workers early in the petition process. Their involvement can help with comprehensive assessments and identification of appropriate cases.
    - By integrating the CARE Act process into existing care coordination meetings and workflows, it becomes part of routine discharge planning, rather than an additional burden.
- Engage natural support systems, such as family members, peers, or community supporters, in patient discharge planning and the petition process.
    - This can help align the petition process with the principles of supported decision-making, which is a core element of the CARE Act.
- Handle all patient information with care, ensuring confidentiality is maintained.
    - Before sharing patient information, ensure the patient has signed a release of information form. If they decline, check if the information can still be sent directly to the court while maintaining confidentiality.
    - You may want to familiarize yourself with relevant legislation, such as SB 35 and SB 42, to understand the legalities around sharing patient information with court or county BH agencies.
- Foster strong relationships with county BH agencies.
    - Clear pathways and defined workflows between emergency departments and county BH agencies will help incorporate the CARE Act into routine care.

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Hospitals and Emergency Departments in Sutter Health

JODI NERELL, LCSW

Director - External Affairs/Community Health, Mental Health & Addiction Services

Sutter Health

Challenges and Solutions

- Provide clear expectations and training resources for staff.
- Clarify eligibility for CARE Act and what distinguishes it from other programs to avoid confusion.
- Streamline form completion by utilizing electronic health record (EHR) system data, simplifying form perception, and clarifying fee waiver requirements.

Recommendations to Hospitals and Emergency Departments

- Develop clear petition workflows and establish policies.
- Identify points of contact and roles in the petition process.
- Proactively identify and engage eligible patients.
- Leverage peers and support roles throughout the petition process.

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[Slide Image Description: This slide includes a photo of Jodi Nerell, as well as text describing common challenges/solutions and recommendations for hospitals and emergency departments petitioning in the CARE Act process.]

Jodi Nerell, LCSW is the Director of Local Mental Health Engagement for Sutter Health. In her role, Jodi facilitates cross-sector and interdisciplinary partnerships to better serve the behavioral health needs of the community. This includes addressing opportunities for innovation in the community setting specific to mental health and addiction. Prior to her current role, Jodi has worked as the Director of Behavioral Health Integration at Sacramento Covered and Senior Program Health Coordinator at the Sacramento County Department of Health and Human Services. Jodi focuses on addressing ongoing systematic, programmatic, and operational issues for populations with complex health/social needs who are often faced with seeking care in acute settings due to lack of availability to or access to outpatient behavioral health care.

Challenges and Solutions:

- Provide clear expectations and training resources for staff.
    - It is important to set realistic expectations about what the CARE Act process can achieve. Avoid over-promising to prevent staff burnout and frustration.

    - It can also be helpful to develop and distribute how-to videos and training materials to system partners. Use resources like CARE Act training videos to support staff in understanding and navigating the petition process.
- Clarify eligibility for CARE Act and what distinguishes it from other programs to avoid confusion.
    - It is important to provide clear guidance on how the CARE Act differs from other initiatives like Laura's Law or AOT. Consider developing internal documents and tools to clarify referral pathways and decision points.
- Streamline form completion by utilizing electronic health record (EHR) system data, simplifying form perception, and clarifying fee waiver requirements.
    - Health systems with EHRs are better positioned to efficiently complete forms by copying and pasting information directly from patient records into petition forms (e.g., 100 and 101). Encourage use of EHRs where available.
    - Mental health declaration forms, though lengthy, often take only about 10 minutes to complete and mainly require transferring information from existing records. Demystifying this process can increase participation.
    - Filing fees for CARE are waived, but you may be prompted to apply for these fees to be waived when submitting the petition on the court website.

Recommendations to Hospitals and Emergency Departments:

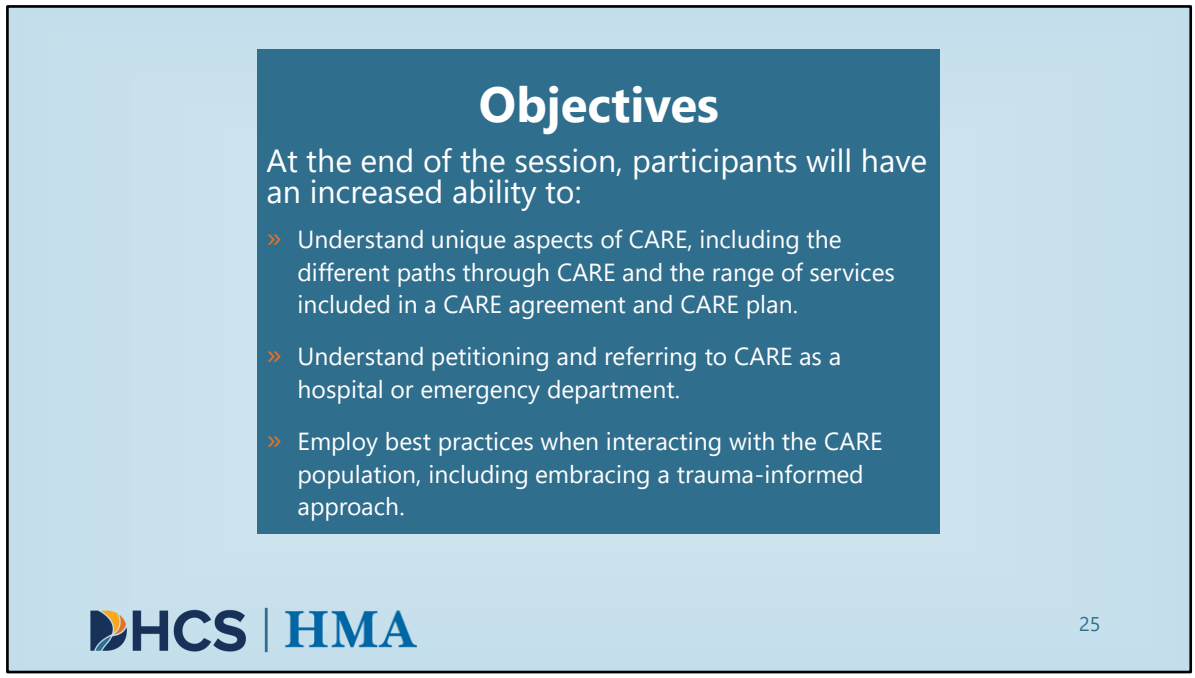
- Develop clear petition workflows and establish policies.
    - This can include petition submission processes, including whether forms go to the court or county BH and who needs to appear. For health systems across multiple sites and counties, this likely involves variation in county processes.
- Identify points of contact and roles in the petition process.
    - Identify and designate specific roles, such as social work or case management staff, to handle CARE Act conversations with patients. Develop a future plan to have a dedicated person or team for this purpose.
    - For psychiatric facilities, initiate the CARE Act process within the first 48 hours after admission if there is a qualifying diagnosis, leveraging early diagnosis and treatment planning.
- Proactively identify and engage eligible patients.
    - Health systems could proactively use diagnostic and utilization data (e.g., frequent emergency department visits for patients with severe mental illness) to identify potential CARE Act candidates. This data could then be shared with care teams to prioritize engagement.
    - In addition, it is beneficial to engage EMS, hospital staff, and street outreach teams who are familiar with high-utilization patients. Their insights can be used to connect eligible individuals to CARE Act resources.
- Leverage peers and support roles throughout the petition process.
    - Community health workers (CHWs), peer supports, and other non-clinicians could be used to complete petitions. These roles can assist in form preparation under the oversight of a BH professional, reducing clinician workload and

leveraging their relationship with the individual.

- Aim to have peer support specialists at every point of service. Peers can assist with form completion and patient support, potentially increasing engagement and compliance. Health systems and hospitals may want to explore funding and billing options to sustain these roles.

[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.]

What advice do you have for those working in hospital and emergency department settings that are anticipating how to participate in the CARE process?



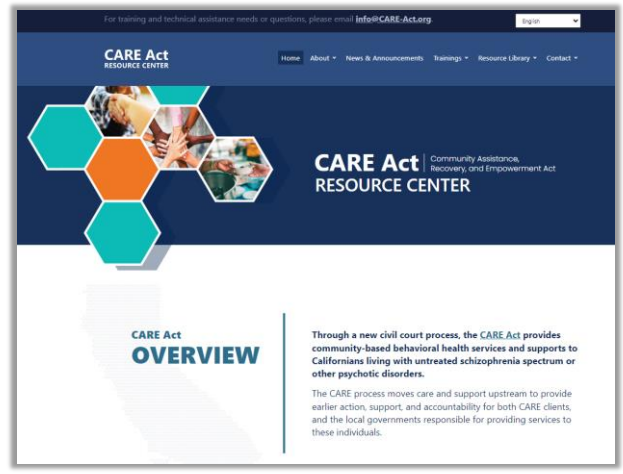
[Slide Image Description: This slide recaps the learning objectives for this training with a light blue background.]

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

- Understand unique aspects of CARE, including the different paths through CARE and the range of services included in a CARE agreement and CARE plan.
- Understand petitioning and referring to CARE as a hospital or emergency department.
- Employ best practices when interacting with the CARE population, including embracing a trauma-informed approach.

CARE Act Resource Center

- Resources:
  - Resources for Petitioners
  - Training and Resource library
  - County Directory
  - Frequently Asked Questions
- Ways to contact:
  - Listserv
  - Technical assistance (TA) request form
  - Data TA request form
  - Stakeholder feedback form
  - Email: info@CARE-Act.org



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[Slide Image Description: This slide shows a screenshot of the CARE Act Resource Center website, along with a QR code to scan and access the website.]

The CARE Act Resource Center is where you can find resources and also find ways to request training and technical assistance (TTA) or communicate.

- Resources:
  - We have consolidated resources for petitioners, where you can find how-to videos, fact sheets, and other helpful materials.
  - Training and Resource library:
    - We post all trainings to the CARE Act Resource Center; these include trainings that we have done live and also trainings that we record and are available asynchronously. The training materials include a video (with captions available) and a PDF of the slides and talking points that are tagged for accessibility.
    - We also post resources that have been created both by the TTA team and other useful links created by the Judicial Council of California (JC), California Health and Human Services (CalHHS), and other groups (e.g., Office of State Public Defender [OSPD]).

- County Directory: On the CARE Act County Website Directory page, we include links to Self-Help Centers (which can provide legal information and resources to people without a lawyer), links to NAMI, and county-specific links (including county CARE websites created by county BH and by courts in counties).
- FAQs: We frequently add FAQs to the Resource Center based off questions that come up during trainings, through TA requests, and other avenues. There is an option to search and filter FAQs by topic.

- Ways to contact:
  - Listserv
  - TA request form
  - Data TA request form
  - Stakeholder feedback form
  - Email: info@CARE-Act.org

Learn about Trauma-Informed Care

Definition

- Trauma-informed care is a set of principles that promote a culture of safety, empowerment, and well-being.

Why

- Individuals with schizophrenia spectrum and other psychotic disorders, as well as other mental health conditions, are likely to have experienced trauma.
- It is important to approach individuals with compassion and humility and to consider the whole person.

For more information on trauma-informed care and implications for the CARE Act, see the series for behavioral health (1, 2, 3) or volunteer supporters (1, 2, 3). Also, see the training on implicit bias.

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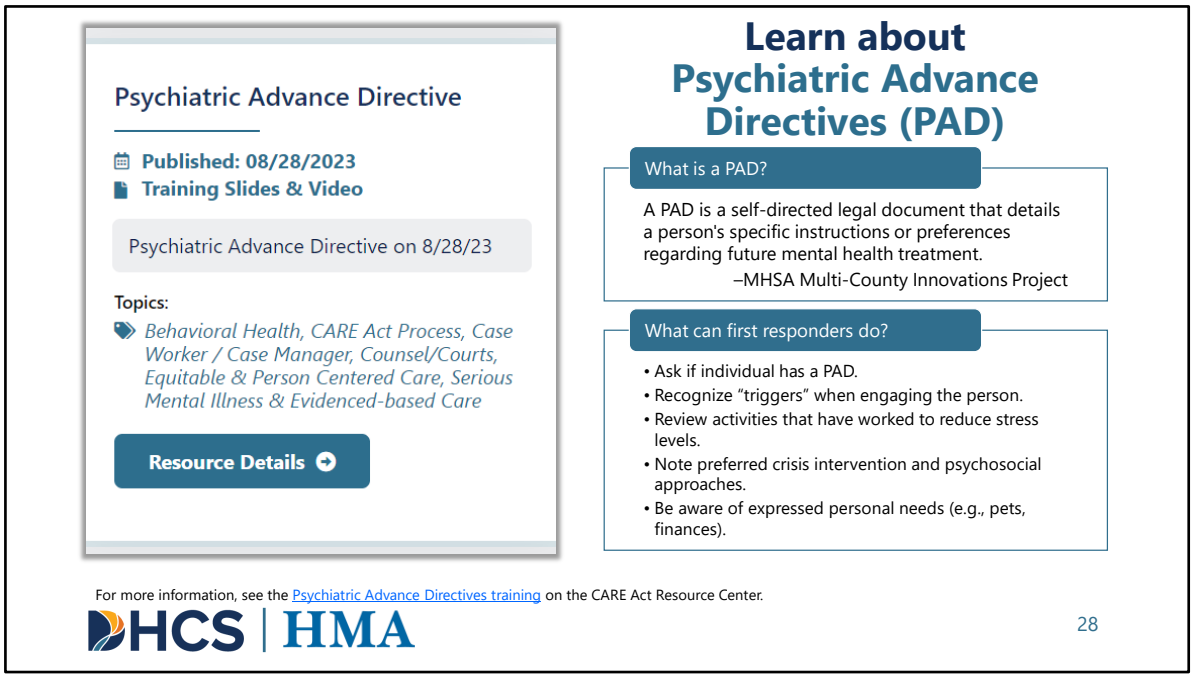
[Slide Image Description: This slide shows an image of an individual putting their arm around another individual's shoulder. The definition and description of trauma-informed care are listed.]

Trauma-informed care is another topic that would be a great next step to learning more. We have two series on trauma-informed care, including three modules for a volunteer supporter (which is more of a lay audience) and then one meant for county BH and courts/counsel, which has a training specifically on mitigating bias. Both series could be helpful for you.

For more information on trauma-informed care and implications for the CARE Act, see the series for behavioral health (1, 2, 3) or volunteer supporters (1, 2, 3). Also see the training on implicit bias.



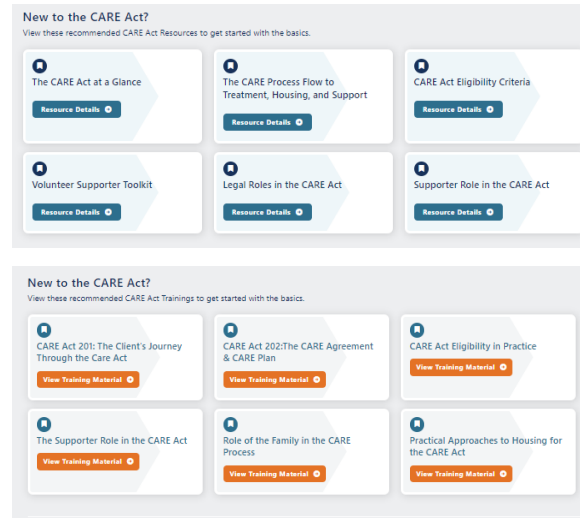
[Slide Image Description: This slides shows an image of the Psychiatric Advance Directive (PAD) training resource with a detailed description of the background, purpose, and use of PADs.]

The last training I wanted to highlight was about psychiatric advance directives (PADs). It can be helpful for you to know what a PAD is, how it is used, and what you can ask for when you encounter someone in the field.

For more information on PADs, please see the Psychiatric Advance Directives training on the CARE Act Resource Center.

Available Trainings and Resources

- Recordings and decks of live trainings, as well as asynchronous prerecorded trainings on many CARE process topics.
- Resources, fact sheets, toolkits, and FAQs.
- Recommended foundational CARE Act trainings and resources to get started with the basics.



[Slide Image Description: This slide shows a screenshot of the CARE Act Resource Center website, highlighting key trainings and resources for individuals that are new to the CARE Act.]

The CARE Act Resource Center training library includes recordings and decks of all live trainings, as well as asynchronous pre-recorded trainings. Topics include the CARE Act process, volunteer supporters, legal roles, housing, eligibility criteria, role of the family, role of the peer, data collection and reporting, and more. The new design also highlights foundational trainings and resources for those new to learning about the CARE process.

The CARE Act Resource Center resource library includes resources, fact sheets, toolkits, and FAQs, as well as links to other resources on CalHHS, DHCS, or JC's CARE websites.

[Slide Image Description: This slide shows the CARE Act Resource Center 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.**