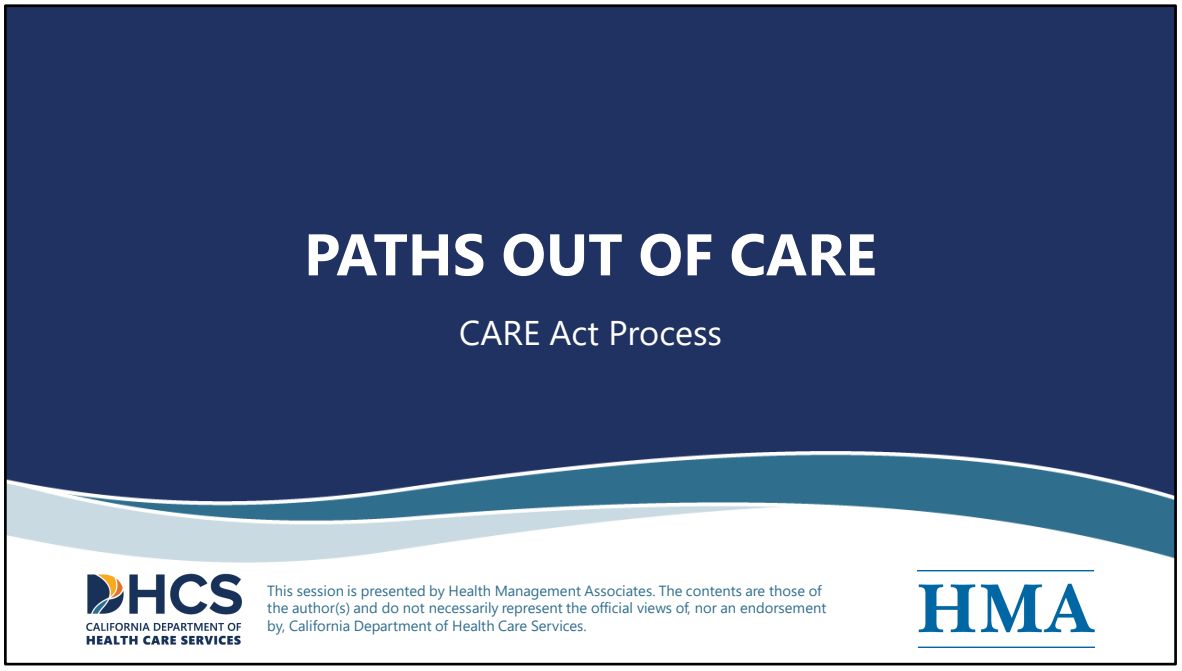
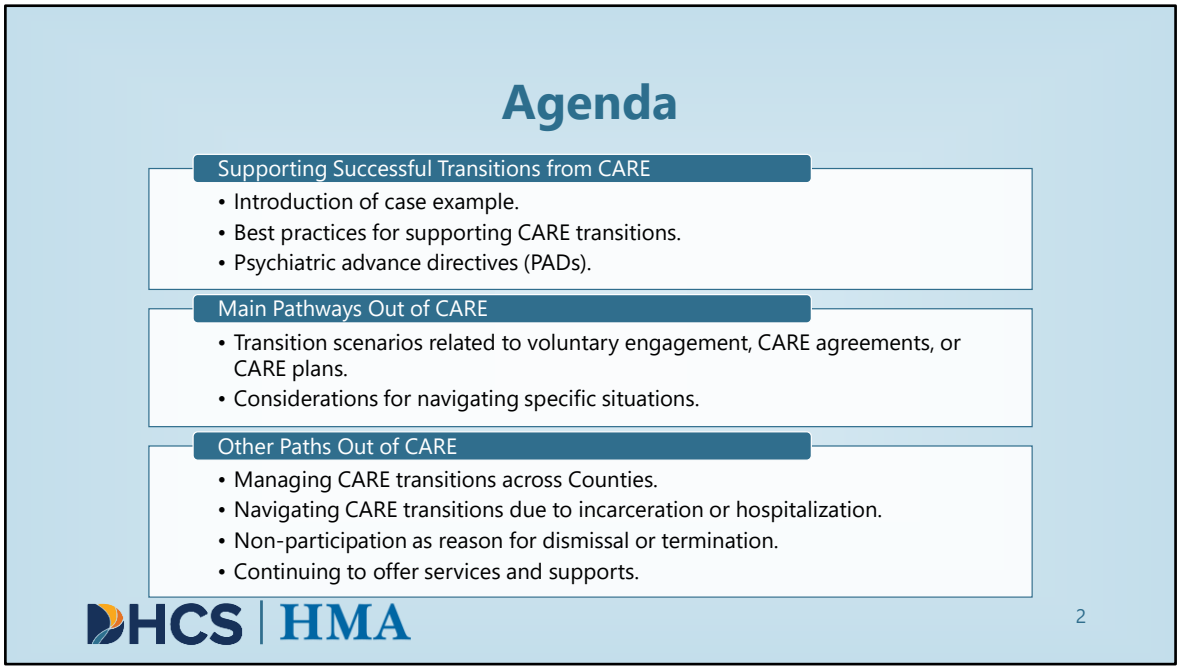


[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

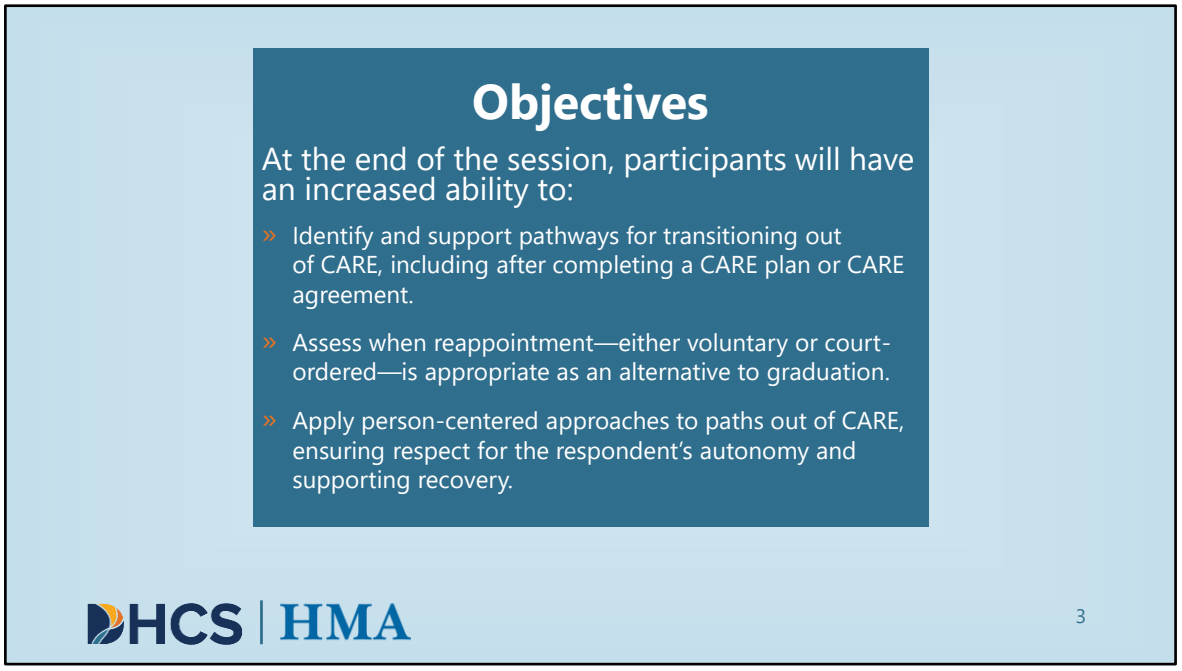
Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.



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

Today's agenda covers the many paths out of CARE, with a focus on how the behavioral health team can best support these transitions for the CARE respondent.

- Supporting Successful Transitions from CARE
    - Introduction of case example.
    - Best practices for supporting CARE transitions.
    - Psychiatric advance directives (PADs).
- Main Pathways Out of CARE
    - Transition scenarios related to voluntary engagement, CARE agreements, or CARE plans.
    - Considerations for navigating specific situations.
- Other Paths Out of CARE
    - Managing CARE transitions across counties.
    - Navigating CARE transitions due to incarceration or hospitalization.
    - Non-participation as reason for dismissal or termination.
    - Continuing to offer services and supports.



[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:

- Identify and support pathways for transitioning out of CARE, including after completing a CARE plan or CARE agreement.
- Assess when reappointment—either voluntary or court-ordered—is appropriate as an alternative to graduation.
- Apply person-centered approaches to paths out of CARE, ensuring respect for the respondent's autonomy and supporting recovery.

Presenters

DEBORAH ROSE, PSYD

Principal
Health Management Associates

LEELA KAPUR, JD

Mental Health Law Lead
Health Management Associates

DHCS | HMA

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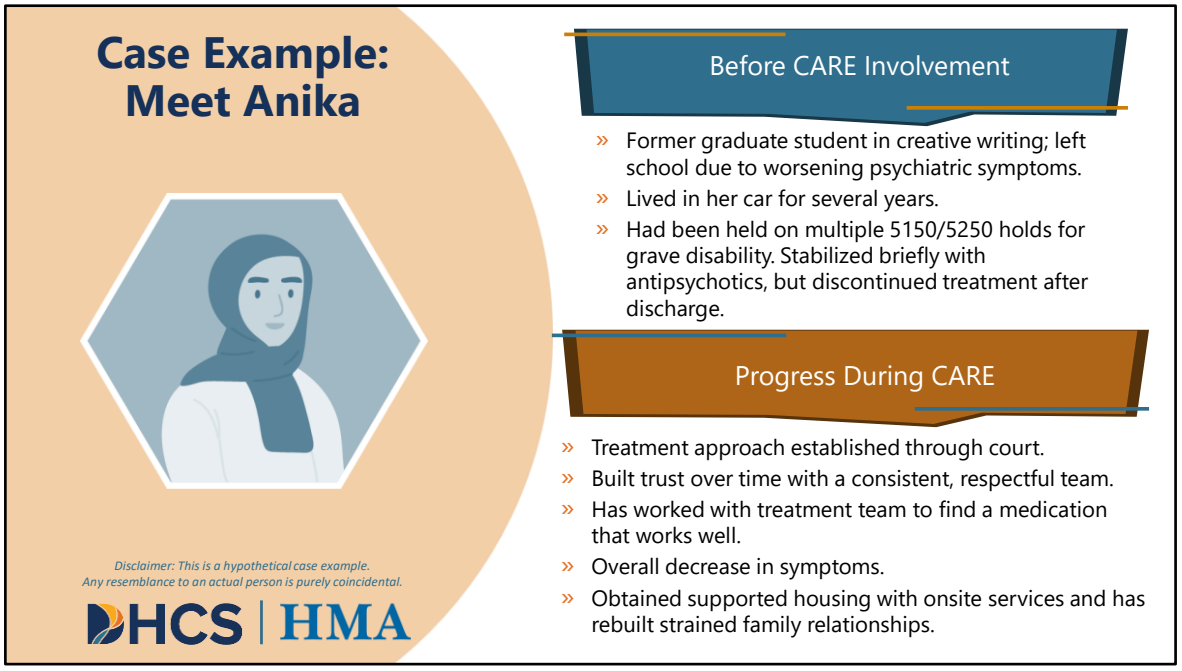
[Slide Image Description: This slide includes images of the presenters of this training on a light blue background.]

Dr. 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.

Leela Kapur, JD has more than 30 years of public service as an attorney representing Los Angeles County and the City of Los Angeles and has experience as counsel for the County's Departments of Health and Mental Health.

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

Before we go into a few example scenarios of how one could transition out of CARE, we wanted to start with a case example, to help us keep in mind an individual that might be going through CARE. We also wanted to provide an overall look at the CARE process and some best practices for supporting CARE transitions, regardless of when they happen.



[Slide Image Description: This slide shows a silhouette of a person representing Anika with some aspects of her CARE involvement and progress listed.]

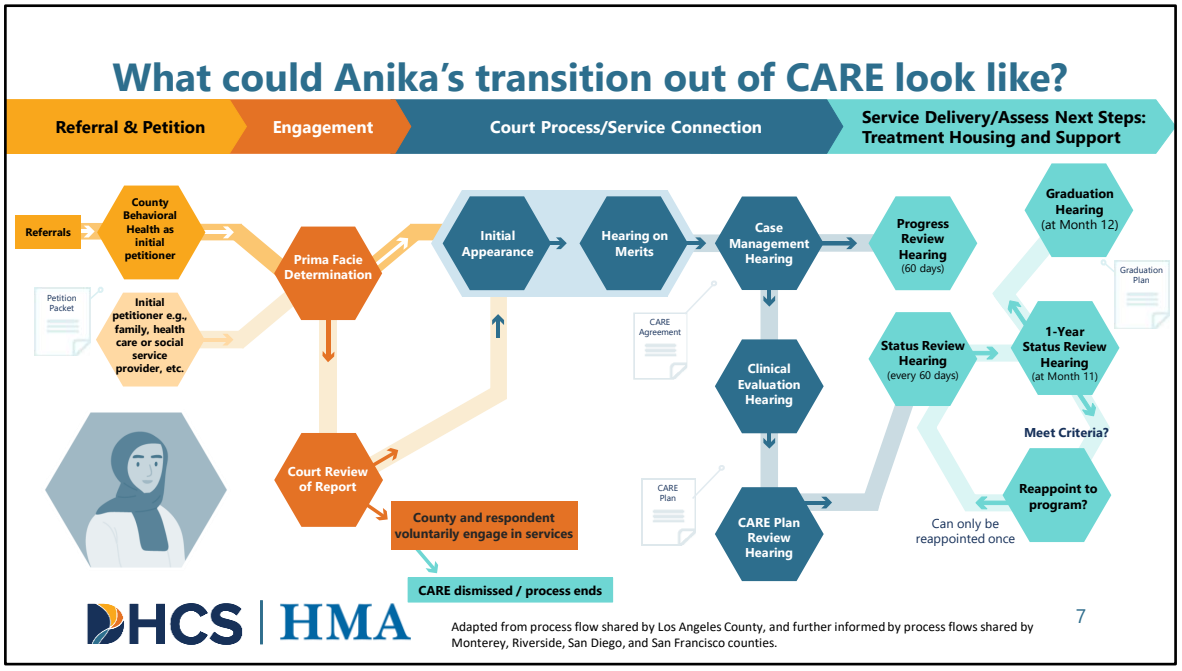
During this training, we will be using a case example that centers on Anika, a 40-year-old woman diagnosed with schizophrenia, as she approaches the transition out of CARE. After a sustained period cycling through hospitalizations and disengagement from services, Anika has gradually stabilized through coordinated CARE supports. With consistent engagement, appropriate treatment, and trusted relationships, Anika has made significant progress while participating in the CARE process. Now, as she prepares to transition out of CARE, her case offers an opportunity to explore what successful transitions can look like, whether by way of a CARE plan or a CARE agreement.

Anika before CARE Involvement:

- Former graduate student in creative writing; left school due to worsening psychiatric symptoms including auditory hallucinations, paranoid delusions, and disorganized behavior.
- Lived in her car for several years; primarily stayed around a park and public library.
- Had been held on multiple involuntary holds for grave disability. Stabilized briefly with antipsychotics, but discontinued treatment post-discharge.

Progress during CARE

- Initially reluctant to participate in CARE, but built trust over time with a consistent, respectful CARE team.
- Has worked with treatment team to find a treatment plan that works well, including a medication regimen.
- Reported decreased hallucinations and paranoia, although does experience symptoms and has periods of decreased stability.
- Obtained supported housing with onsite services and has rebuilt strained family relationships.



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

The CARE Act process can take different pathways through the civil court, and this includes different ways that an individual may transition *out* of CARE. This training will include some process-related considerations as well as some best practices for supporting a person's transition out of CARE.

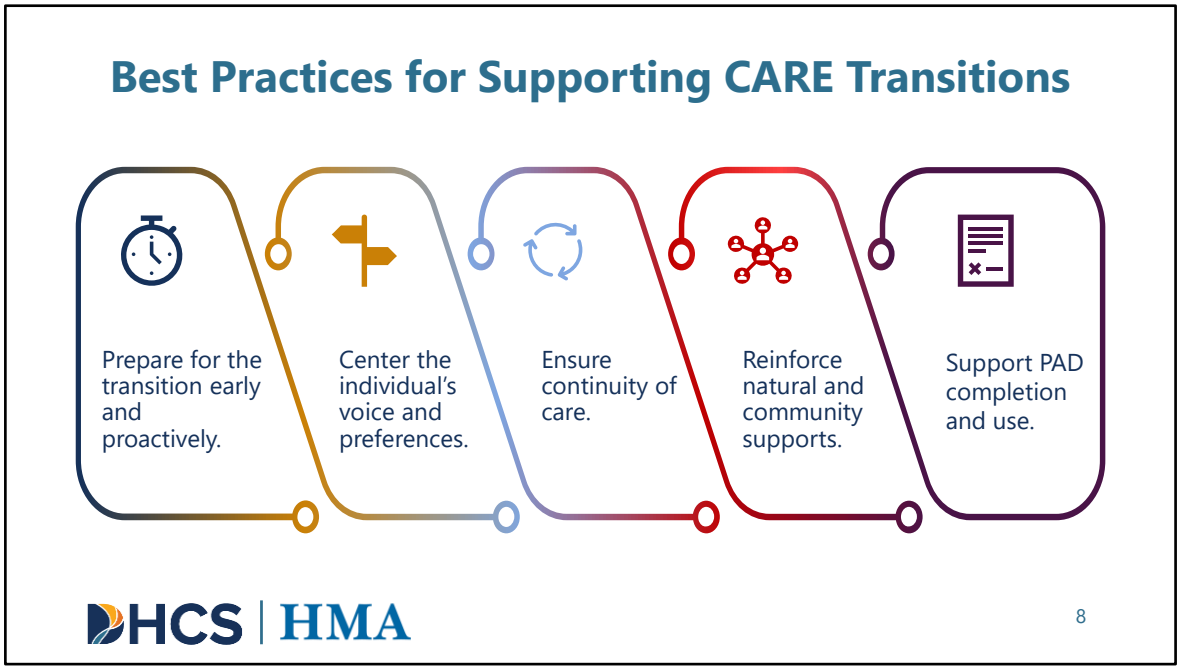
Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH) agency.
2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a prima facie determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.
    - 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.

4. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the initial appearance).
5. If the respondent still meets the criteria, then there will be a case management hearing.
    - If it is 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).
6. If it is determined at the case management hearing that a CARE agreement is not likely to be reached, the court will order a clinical evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
7. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
8. There will then be a status review hearing at least every 60 days.
9. At month 11, there will be a one-year status review hearing to determine next steps:

    1. The respondent will graduate (and have a graduation hearing at month 12).
    Or,
    2. The respondent will be reappointed to the program, which can only happen once.



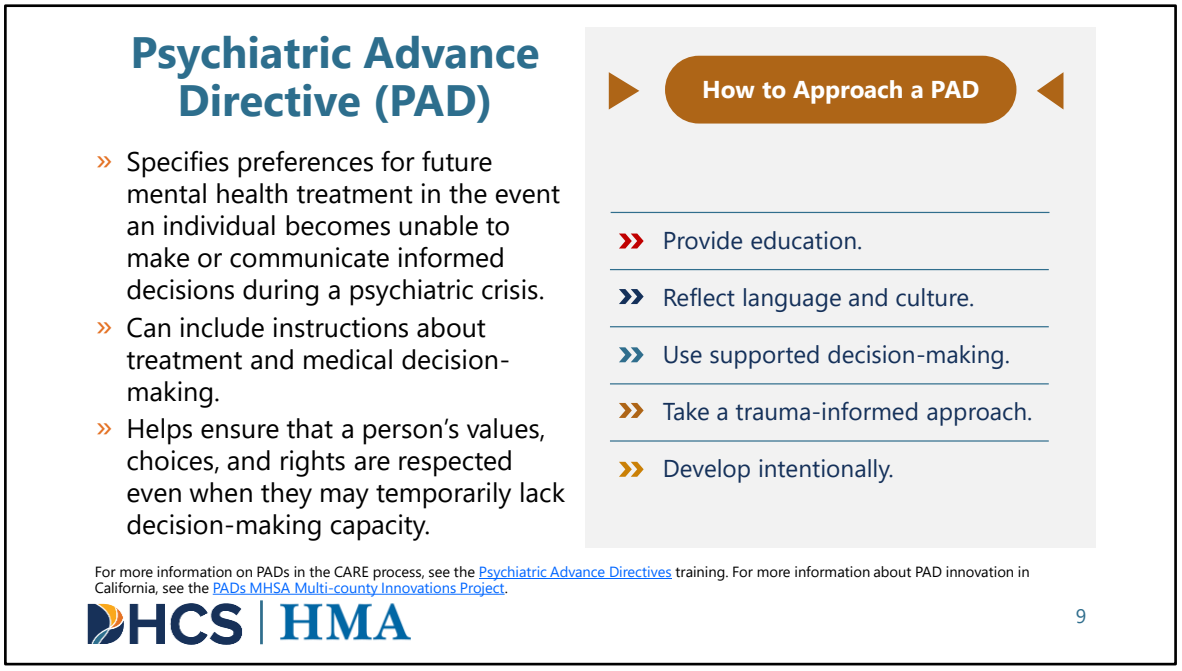
[Slide Image Description: This slide shows icons representing the best practices and colored lines surrounding the best practices for supporting CARE transitions.]

In the next section, we'll explore considerations for each main pathway through CARE. No matter which path is taken, remember effective transition planning begins on day one.

- **Prepare for the transition early and proactively.**
    - Begin planning for transitions well before the court process ends.
    - Introduce concepts like graduation, PADs, and ongoing supports early in the CARE process.
- **Center the individual's voice and preferences.**
    - Use shared decision-making to ensure the exit process reflects their goals, values, and needs.
    - Use strengths-based, non-judgmental language (e.g., "graduating CARE," "transitioning," not "failing out").
    - Celebrate effort, growth, and resilience while avoiding reinforcing stigma related to behavioral health, court involvement, or housing instability.
- **Ensure continuity of care.**

- Make sure all CARE partners (e.g., clinicians, volunteer supporters, counsel, peer supporters, care coordinators) are aligned on the exit plan.
- Make warm handoffs to ongoing providers, peer supports, or new jurisdictions when needed.
- Confirm that referrals, benefits, and services won't be disrupted during or after transition.

- **Reinforce natural and community supports.**
  - Engage trusted supporters in exit planning (e.g., family, friends, faith groups, peers).
  - Provide education and tools to help those supports stay connected beyond CARE.
  - Celebrate relationships built during CARE, especially when those will continue post-exit.
- **Support PAD completion and use.**
  - Encourage every respondent exiting CARE—for whatever reason—to develop a PAD.
  - Help individuals articulate treatment preferences, contacts, and crisis plans.
  - Make sure PADs are shared with providers and stored accessibly.



[Slide Image Description: This slide shows a bubble around "How to Approach a Pad" and colored bullet points that list how to approach creating a PAD.]

A **Psychiatric Advance Directive (PAD)** is a self-directed legal document that allows a person to specify their preferences for future mental health treatment in the event they become unable to make or communicate informed decisions during a psychiatric crisis. It can include instructions about medications, hospitalization, and other supports, and allows the individual to appoint a trusted person to advocate on their behalf. PADs help ensure that a person's values, choices, and rights are respected even when they may temporarily lack decision-making capacity.

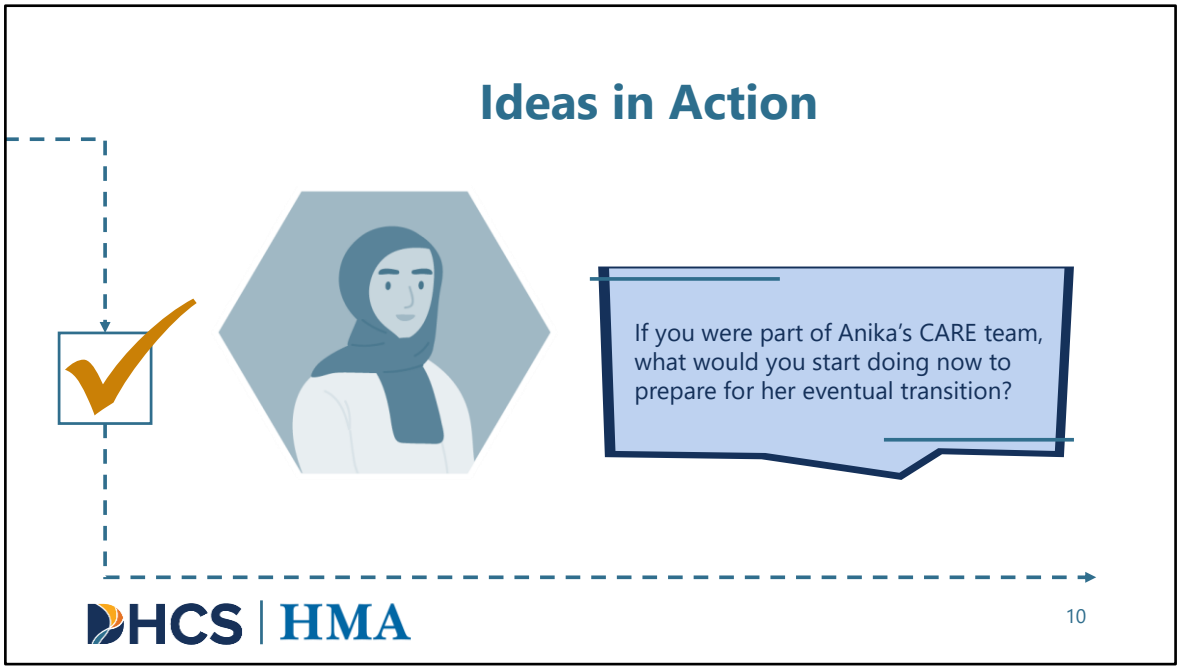
Our Psychiatric Advance Directives training provides more details about how a PAD can be developed and used, and it includes some information about PAD innovation in California (see PADs MHSA Multi-county Innovations Project).

Some principles on how to approach the development of a PAD:

- **Provide education.** When you approach a CARE participant about a PAD, remember to explain the purpose of a PAD and how it would benefit them. Let them know what a process could look like and the types of things that they can include.

- **Explained in a language that meets the individual where they are.** Ex: “A PAD makes sure that the doctors know what kind of care you want/don’t want, which medications help you and which make things worse, and who we should call in an emergency. You can change your mind on any of these decisions at any time and update the document.”
- **Reflective of language and culture.** PADs must be culturally and linguistically appropriate and accessible (e.g., language, spiritual practices, preferred supports).
- **Using supported decision-making.** The PAD should be developed to maximize the autonomy and decision making of the individual.
- **Taking a trauma-informed approach.** Previous involuntary treatment likely felt traumatic to the CARE participant, so some of the PAD conversations may be triggering.
- **Developed intentionally**. Not just a check mark; time must be intentionally dedicated to PAD discussion over several sessions, if necessary. Help the client fill out paperwork and support them with psychoeducation, as necessary.

https://care-act.org/training-material/psychiatric-advance-directives/
https://www.padsca.org/what-are-pads



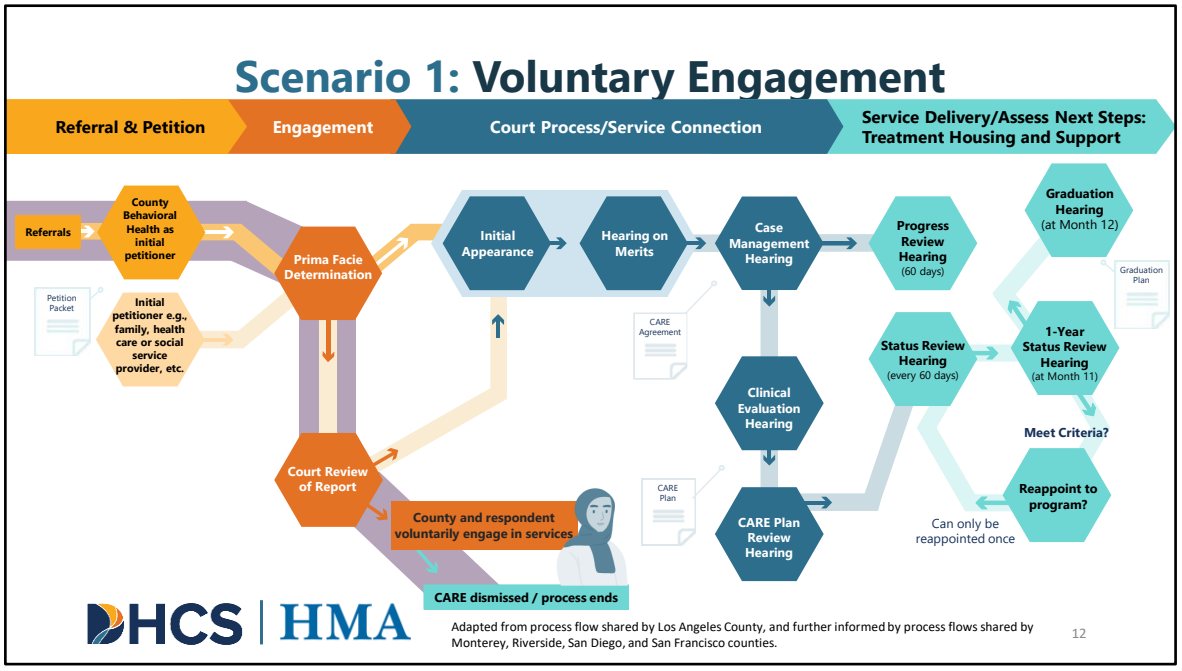
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

If you were part of Anika's CARE team, what would you start doing now to prepare for her eventual transition?

- You could begin discussing the idea of a graduation or transition plan early, so Anika has time to share what she feels she needs to stay stable. You could also start exploring whether she is interested in completing a PAD and help her understand how it could support her recovery.
- You could make sure all her providers and supports are coordinated and aware of her goals after CARE ends. This could include her housing case manager, her psychiatrist, and any family members she wants involved. You could also confirm that referrals and benefits are set up to continue without interruption, as she approaches her transition out of CARE.
- You could use shared decision-making to learn what matters most to Anika for her next steps, including any supports she wants to keep in place. You could also reinforce her strengths and help her build confidence that she can maintain progress without court oversight.
- You could talk with Anika about how she wants to celebrate her progress and what she wants the transition process to look like.

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

Now we'll look at an overview of the different pathways out of CARE, and how we can support success in managing these transitions for the CARE participant.



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

One path out of CARE is voluntary engagement, which can occur early in the CARE process after a petition has been found sufficient on its face (prima facie).

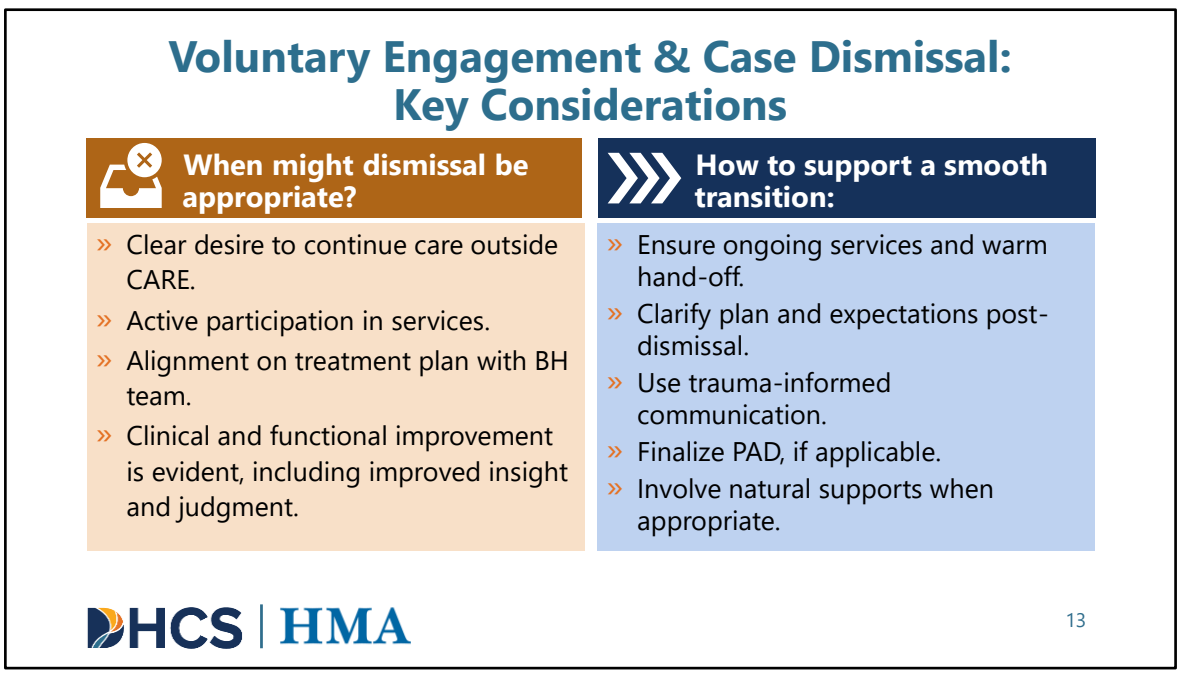
As you may know:

- Engagement efforts should begin as soon as the CARE process starts, including initial outreach to the respondent.
- When preparing its investigative report, county behavioral health (BH) documents the outcome of these efforts to engage the individual voluntarily.
- If the court determines that voluntary engagement has been successful and the person is actively participating in treatment, the court may dismiss the case.

For example, if Anika engaged with county BH and treatment providers, and the court—after reviewing the county's report—found that her engagement was effective and likely to continue, the case would likely be dismissed, and Anika would transition out of CARE. In this scenario, county BH should work with Anika to develop a treatment plan to help ensure she remains engaged in services after dismissal.

Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH) agency.
2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a Prima Facie Determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.
    - 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.
4. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the Initial Appearance).
5. If the respondent still meets the criteria, then there will be a Case Management Hearing.
    - If it is 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).
6. If it is determined at the Case Management Hearing that a CARE agreement is not likely to be reached, the court will order a Clinical Evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
7. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
8. There will then be a status review hearing at least every 60 days.
9. At month 11, there will be a one-year status review hearing to determine next steps:
    - The respondent will graduate (and have a graduation hearing at month 12) Or,
    - The respondent will be reappointed to the program, which can only happen once.



[Slide Image Description: This slide shows two boxes indicating when might dismissal be appropriate and how to support a smooth transition.]

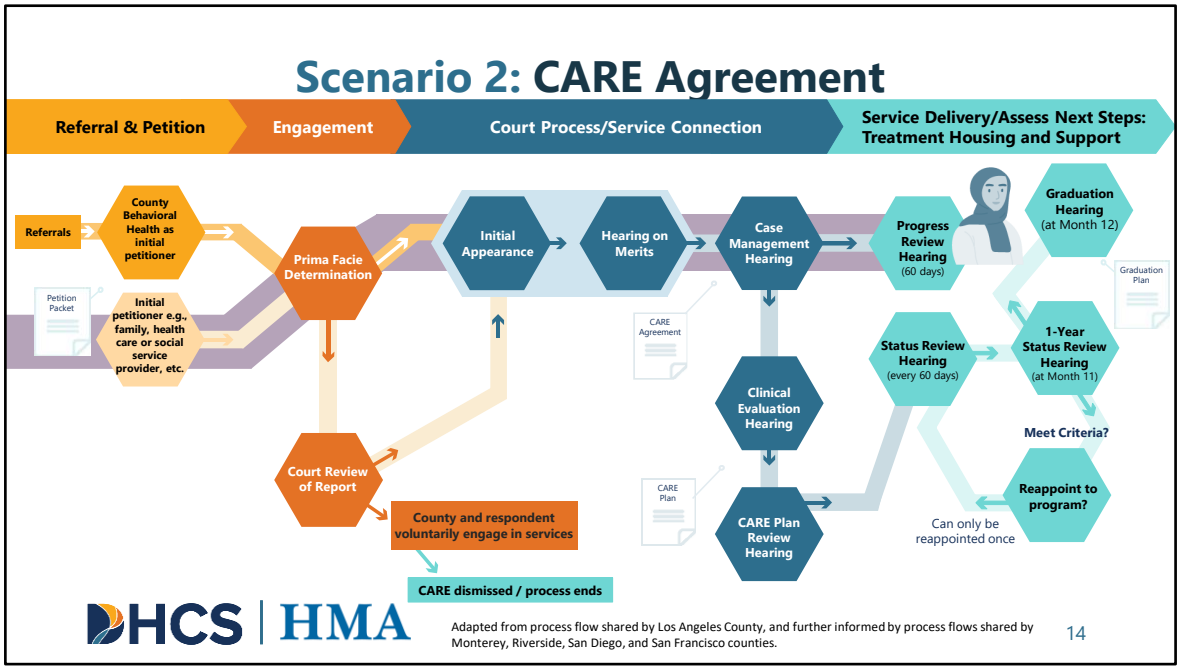
When determining whether a case should be dismissed due to voluntary engagement, courts and county BH can consider many of the same elements assessed during initial CARE eligibility, with an emphasis on evidence of sustained engagement and readiness to continue treatment without court oversight and county accountability.

Key factors to assess may include:

- The individual consistently expresses a clear desire to engage in services outside of the CARE process.
- The individual demonstrates active participation in treatment and supportive services, as shown through documented contacts and progress.
- Both the individual and the behavioral health team are aligned on the treatment plan and recommendations, which may include medications or other supports.
- The individual shows improved insight and judgment about their mental health needs and the benefits of ongoing treatment.
- There is observable clinical and functional improvement that is likely to be maintained without CARE court involvement.

Considerations for supporting a smooth transition:

- Make sure that ongoing providers and community supports are in place and arrange a warm hand-off to ensure continuity of care.
- Confirm that the individual understands the treatment plan and knows how to access services after dismissal.
- Provide clear, trauma-informed communication about the decision to dismiss and what it means.
- If applicable, develop or finalize a Psychiatric Advance Directive (PAD) to guide future care preferences.
- As appropriate, ensure any family members or natural supports are informed and involved in transition planning.
- Identify follow-up contacts or check-ins to support continued engagement.



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

Here is a second scenario illustrating another potential path out of CARE.

In this case, the individual has progressed to a CARE agreement, and all parties have agreed on the services and supports included in that agreement. Under statute, there is one required progress review hearing within the first 60 days. However, in practice, many courts and county BH agencies choose to continue holding regular status review hearings beyond that initial 60-day review. These additional hearings help track progress, update the CARE agreement as needed, and provide ongoing support.

Individuals who are making progress on their CARE agreements may be recommended for **completion** or **graduation** of the case at any point during the first year. Courts and county BH teams often work together with the individual to assess progress throughout the duration of the CARE agreement. Although formal “graduation” is outlined specifically for CARE plans in statute, many counties use the term “graduation” informally when referring to the completion of a CARE agreement. Courts have discretion in determining the timing of completion.

Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH) agency.
2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a Prima Facie Determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.
    - 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.
4. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the Initial Appearance).
5. If the respondent still meets the criteria, then there will be a Case Management Hearing.
    - If it is 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).
6. If it is determined at the Case Management Hearing that a CARE agreement is not likely to be reached, the court will order a Clinical Evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
7. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
8. There will then be a status review hearing at least every 60 days.
9. At month 11, there will be a one-year status review hearing to determine next steps:
    - The respondent will graduate (and have a graduation hearing at month 12) Or,
    - The respondent will be reappointed to the program, which can only happen once.

Transitioning from a CARE Agreement

Some considerations on whether someone with a CARE agreement is ready to transition out of CARE:

- Progress made on the CARE agreement, including an assessment of the individual's stability.
- Services and supports outlined in the CARE agreement have been provided to the individual, and the individual has engaged positively with recommended treatment, services, and supports.
- The individual no longer meets eligibility criteria.

No longer meeting CARE criteria may indicate that Anika is ready to transition out of CARE.

Consider:
- ✓ Clinical stability.
- ✓ Functional capacity.
- ✓ Safety, independence, and community connection.
- ✓ Continuity of care.

For more information on eligibility, see the Eligibility Fact Sheet.

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[Slide Image Description: This slide shows a graphic of a paper with the title "CARE Agreement." A silhouette of a person representing Anika and a description of transitioning from a CARE agreement is detailed.]

Some considerations on whether someone with a CARE agreement is ready to transition out of CARE:

- Progress made on the CARE agreement, including an assessment of the individual's stability.
- All services and supports outlined in the CARE agreement have been provided to the individual, and the individual has engaged positively with recommended treatment, services, and supports.
- The individual no longer meets eligibility criteria.

Throughout the CARE process, the behavioral health team should regularly assess eligibility. No longer meeting CARE criteria may indicate that completion or graduation from the CARE agreement is appropriate and that the individual is ready to transition out of CARE.

Let's consider these factors in the context of Anika:

Assessing clinical stability.

- Is Anika improving in managing her symptoms? Are her symptoms generally improving?
- Is she engaged in therapeutic interventions?
- Is she demonstrating a reduced risk of harm to self and no longer gravely disabled?
- Is she continuing to make progress toward her recovery goals?

Day-to-day functional capacity. This typically refers to activities of daily living (ADLs), such as basic personal care tasks.

- Is Anika able to participate in self-care activities and make reasonable decisions about her health?
- Is she becoming more independent with daily functioning, or accepting support as needed?

Safety, independence, and community connection. One hallmark of recovery is a sense of connectedness to others or the broader community, and this will look different for each person.

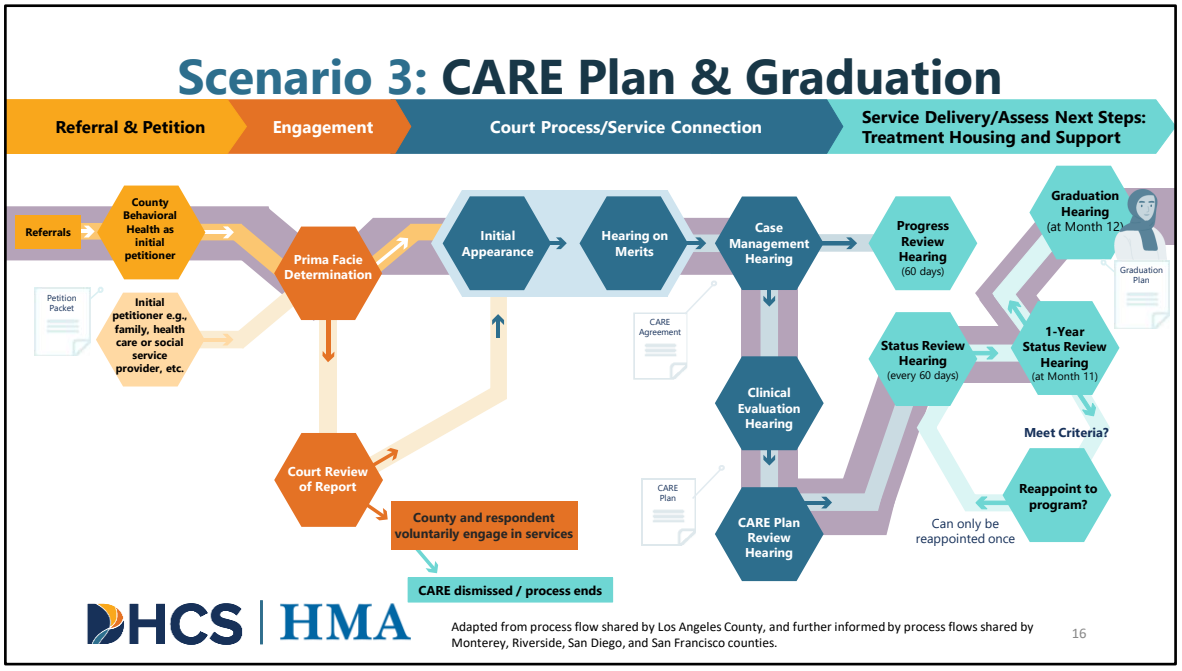
- Is Anika exploring meaningful activities, such as employment, education, faith-based involvement, or volunteer work?
- Is she engaged with formal and natural supports (e.g., social connections, family, pets)?

Continuity of care.

- Is Anika engaged in ongoing services, with a client-centered treatment plan in place?
- Is there a robust array of recovery services tailored to her needs and preferences?
- Are service providers aligned and coordinated around her ongoing treatment plan as she transitions out of the CARE process?

For more information on eligibility, see the Eligibility Fact Sheet.

https://care-act.org/wp-content/uploads/2023/06/FACT-SHEET-CARE-Act-Eligibility-Criteria-rem.pdf



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

This last scenario shows that the individual has entered into a CARE plan, and we will talk about what could be involved in the one-year status review hearing, options for reappointment vs. graduation, and graduation planning. We'll continue to reference CARE agreements in this section, as we are hearing that counties are replicating this process for CARE agreements as well as CARE plans.

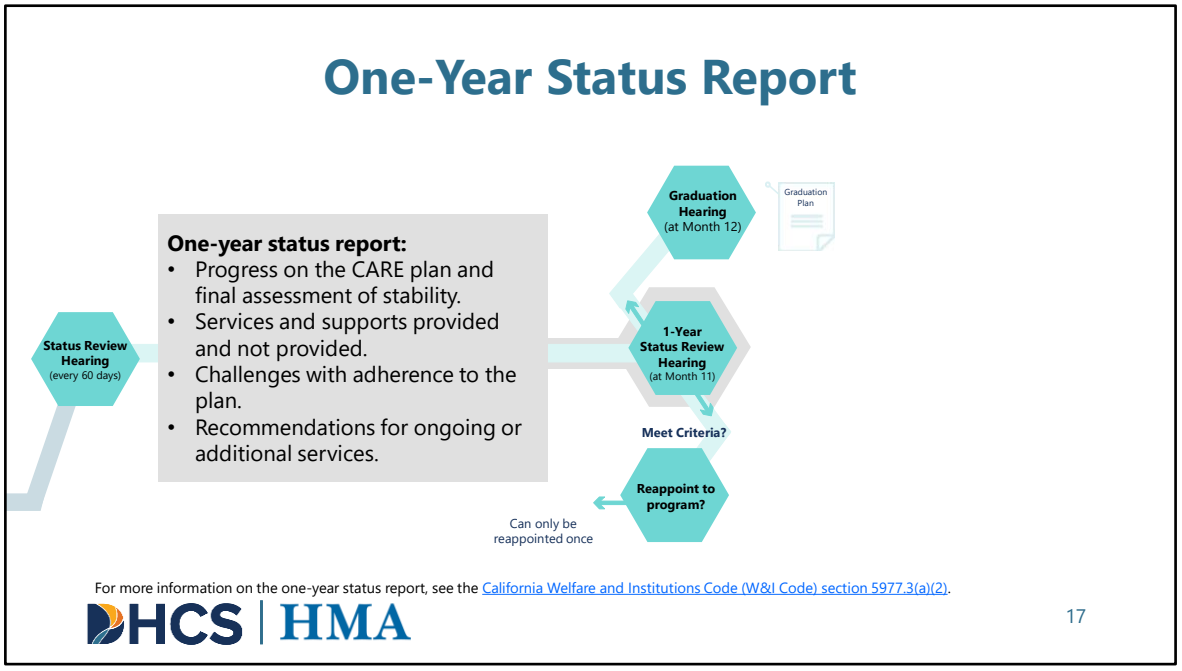
_____

Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH) agency.
2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a Prima Facie Determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.

- 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.

1. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the Initial Appearance).
2. If the respondent still meets the criteria, then there will be a Case Management Hearing.
   - If it is 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).
3. If it is determined at the Case Management Hearing that a CARE agreement is not likely to be reached, the court will order a Clinical Evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
4. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
5. There will then be a status review hearing at least every 60 days.
6. At month 11, there will be a one-year status review hearing to determine next steps:
   - The respondent will graduate (and have a graduation hearing at month 12) Or,
   - The respondent will be reappointed to the program, which can only happen once.



[Slide Image Description: This slide shows a process flow, highlighting the one-year status report.]

Eleven months after the CARE plan is approved, the court will hold a **one-year status review hearing** to evaluate progress and determine next steps.

At this point, county BH must file a report with the court that includes:

- A summary of progress on the CARE plan, including a final assessment of the respondent's clinical stability.
- Information on which services and supports were provided, and which were not.
- Any challenges the respondent experienced in adhering to the CARE plan.
- Recommendations for next steps, including any ongoing or additional services the county can provide or coordinate.

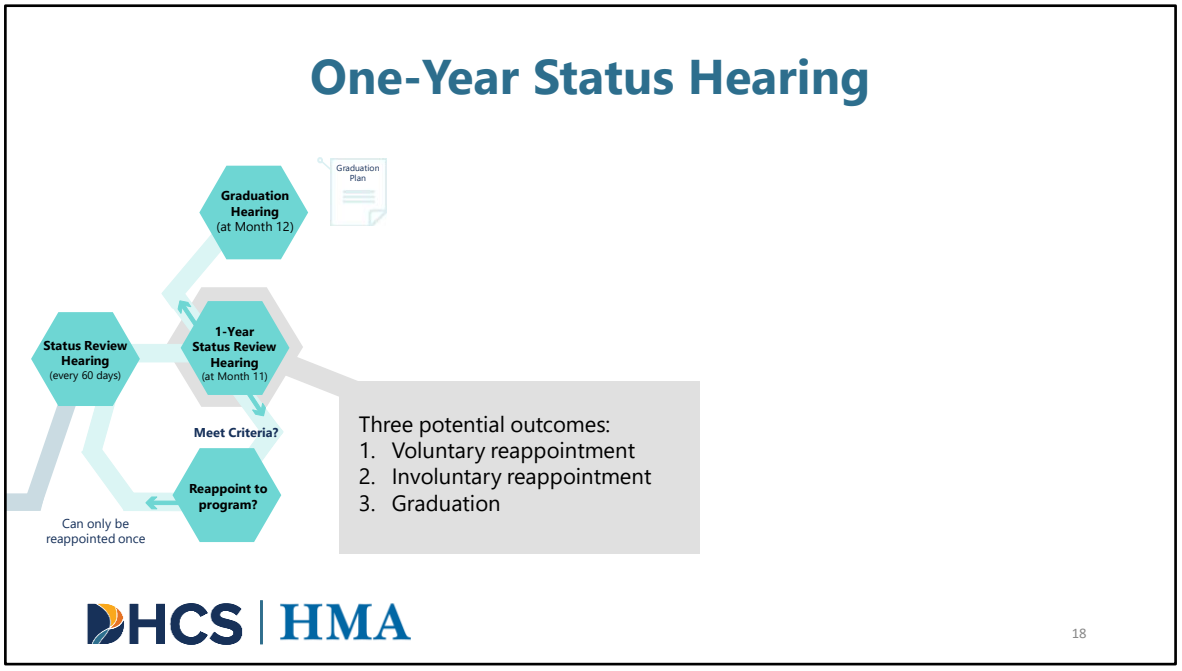
This report is shared with the respondent, their legal counsel, and volunteer supporter (as appropriate).

Based on the report and the hearing, the court will determine how to proceed. The options include:

- **Voluntary Reappointment:** The respondent agrees to continue participation in the CARE process.
- **Court-Ordered Reappointment:** The court orders continued participation for an additional period.
- **Transitioning Out of CARE:** The court determines that the CARE plan is complete, and the respondent no longer requires CARE court oversight.

For more information on the one-year status report, see the California Welfare and Institutions Code (W&I Code) section 5977.3(a)(2).

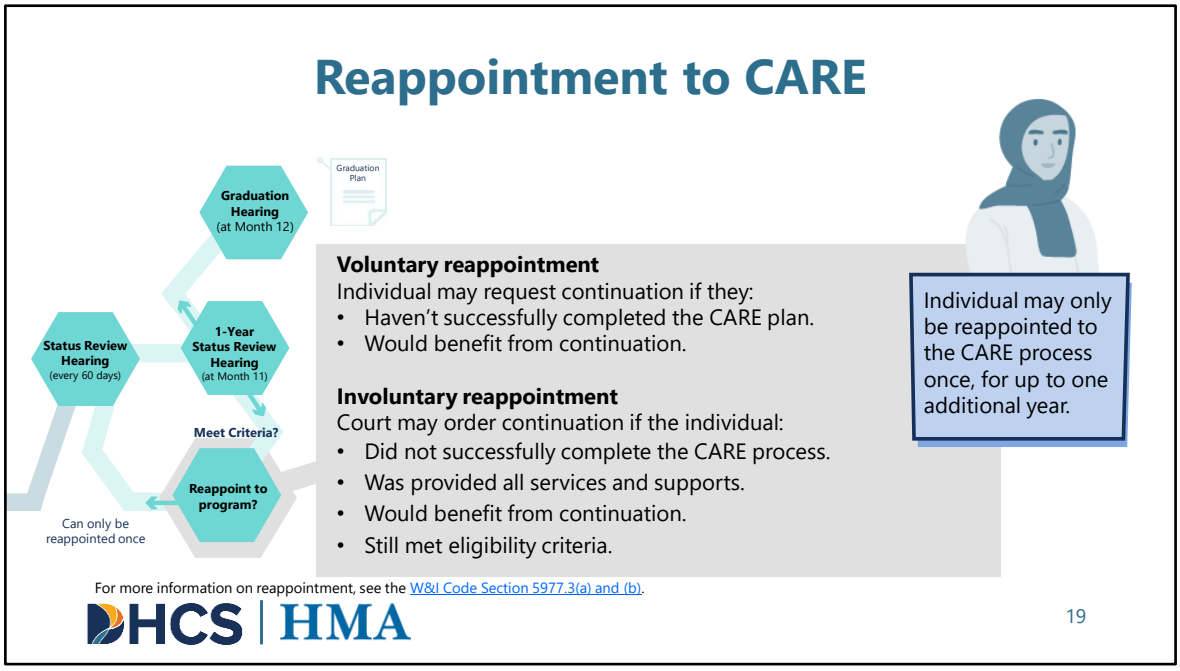
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5977.



[Slide Image Description: This slide shows a process flow, highlighting the one-year status hearing.]

Based on the report and the hearing, the court will determine how to proceed. The options include:

- **Voluntary Reappointment:** The respondent agrees to continue participation in the CARE process.
- **Court-Ordered Reappointment:** The court orders continued participation for an additional period.
- **Graduation:** The court determines that the CARE plan is complete, and the respondent no longer requires CARE court oversight.



[Slide Image Description: This slide shows a process flow, highlighting reappointment to CARE. A silhouette of a person representing Anika and a description of reappointment is detailed.]

Let's talk about reappointment to CARE and when it is appropriate. Again, keep in mind the statute only specifically outlines reappointment for individuals on a CARE plan, not a CARE agreement. But some courts and county BH are allowing individuals to be reappointed to a CARE agreement.

Voluntary reappointment.

- Anika can voluntarily elect to stay in CARE and, the court may permit the extension for up to one year if Anika:
    - Has not yet successfully completed the CARE plan and,
    - Would benefit from continuation of the CARE plan.
- Reasons Anika may want to extend the CARE plan:
    - Access to services and housing.

- Accountability and structure are helpful for her.

Court-ordered reappointment.

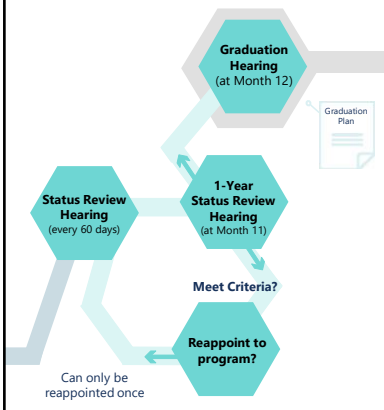
- The court may order Anika's involuntary continuation in CARE if the court finds:
  - Anika did not successfully complete the CARE process.
  - All required services and supports were provided to Anika.
  - She would benefit from continuation in the CARE process and,
  - She currently meets the CARE eligibility requirement.

Remember that a respondent may only be reappointed to the CARE process once, for up to one additional year, so the path out of CARE will occur at no later than 2 years.

For more information on reappointment, see the W&I Code Section 5977.3(a) and (b).

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5977.

Graduation Hearing & Plan



Developing the Graduation Plan

- Created together by the individual and county BH.
- Reflects the individual's goals, choices, and preferences.
- Incorporates similar elements as a CARE plan to promote continuity of care.
- May include a Psychiatric Advance Directive (PAD).

Court Process

- Graduation plan presented at the 12th-month hearing.
- Doesn't carry legal obligations for counties or agencies and can't be enforced in court.
- Graduation becomes official after the hearing.

For more information on graduation hearing and plan, see the W&I Code Section 5977.3(a)(3)(A).

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[Slide Image Description: This slide shows a process flow, highlighting the graduation hearing and plan.]

If Anika's path is graduation, she and county BH will jointly develop a graduation plan.

This is a mutually agreed-upon document (referred to as a **voluntary agreement** in statute) that outlines a strategy to support a successful transition out of CARE.

Planning should include:

- Use of a collaborative, shared decision-making approach that empowers the individual to make informed choices aligned with their needs and circumstances.
- Ensuring the individual's voice, choice, and preferences are reflected in the plan.
- Incorporation of similar elements as a CARE plan to promote continuity of care.
- Inclusion of a Psychiatric Advance Directive (PAD), if applicable.

The graduation plan will be presented to the court during the graduation hearing in the 12th month. Once this hearing is complete, the individual is officially graduated from the program. The graduation plan **cannot** place additional requirements on the county or other government entities and is not enforceable by the court—except for the terms of a PAD.

It is important to emphasize that the purpose and spirit of graduation—and developing a graduation plan—are equally relevant for individuals who have completed a CARE agreement. Courts are encouraged to hold this hearing for all participants at this stage of CARE. While statute does not require the parties to develop and present a graduation plan for CARE agreements, courts and county BH may choose to do so. This approach supports the development of an ongoing treatment plan to sustain continuity of services and helps celebrate the individual's success.

For more information on graduation hearing and plan, see the W&I Code Section 5977.3(a)(3)(A).

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5977.

[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.]

Graduation from a CARE plan or the transition from a CARE agreement would begin with a collaborative meeting that includes Anika and her attorney/public defender, the county BH team (including contracted providers), and any family members or natural supports Anika wishes to involve. The team could review progress toward treatment and recovery goals, such as improvements in clinical stability, daily functioning, and community connection.

A graduation plan would be developed jointly, documenting ongoing treatment, recovery supports, and community resources, with an emphasis on centering Anika's voice and preferences. If appropriate, the team could assist Anika in completing a Psychiatric Advance Directive as part of the planning process.

Prior to the final hearing, the county BH team could arrange a warm hand-off with community providers to support continuity of care. Trauma-informed approaches would be used to explain the graduation process clearly and to help celebrate her accomplishments.

Best practices incorporated into this process include:

- Shared decision-making at each step.
- A written graduation plan outlining next steps and key contacts.
- Proactive coordination with ongoing community providers.
- Involvement of natural supports in transition planning.
- Offering follow-up contacts after graduation to maintain engagement.

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

We've been discussing if an individual is exiting CARE at the end of the CARE process. There are cases in which a case may be dismissed anytime during the process. Let's talk through some of those.

Managing CARE Transitions Across Counties

- **With consent**, a case can be moved to a county of residence.
  - County BH should work with the court to:
    - Notify the receiving county.
    - Coordinate a warm handoff and share treatment progress.
    - Ensure uninterrupted services.
- If the individual **does not consent**, the original county retains the case but should still coordinate care across counties.

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[Slide Image Description: This slide shows a graphic of the state of California and a silhouette of a person representing Anika.]

If Anika no longer resides in the county where the petition was filed, and she **consents**, the court proceedings **may be transferred** to her new county of residence.

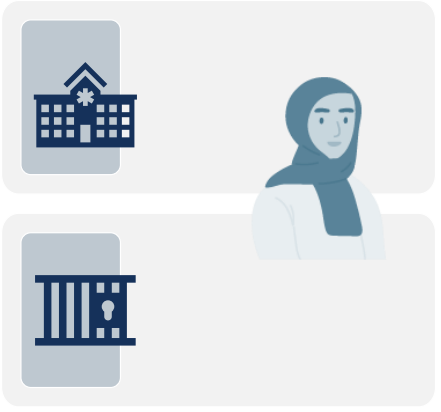
County BH should work with their own court and then **notify the receiving county (both the county BH and the court)** and **coordinate the transition** to ensure continuity of care. Your court will ultimately need to coordinate with the receiving court to transfer the case.

To support a smooth transfer, consider:

- A warm handoff between providers.
- Ensuring uninterrupted access to services.
- Sharing the CARE agreement or CARE plan, along with **treatment progress** and relevant documentation.

If Anika **does not consent** to the transfer, proceedings will continue in the **original filing county**. In that case, counties should still work together to **coordinate services** and manage care across jurisdictions.

Navigating CARE Transitions Due to Incarceration or Hospitalization



- Key factors to consider in case of incarceration or hospitalization:
  - How long is the hospitalization or incarceration?
  - Is it possible to continue providing services?
  - Is the individual still willing to engage?
  - Are there legal and jurisdictional issues?
  - Is there a risk to losing services and supports?
- County BH, with counsel guidance, should notify the court and may request hearings to discuss case status.
- If the case is resumed reassess the individual's eligibility and update the CARE agreement or CARE plan as needed.

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[Slide Image Description: This slide shows a graphic of a hospital and a jail, as well as a silhouette of a person representing Anika.]

In some cases, a CARE case may be dismissed or terminated because the respondent's circumstances have changed significantly, such as through incarceration or hospitalization. However, these situations are not straightforward and require careful consideration.

- The respondent's incarceration or hospitalization does not automatically trigger case dismissal. Several factors must be taken into account.
  - **How long is the hospitalization or incarceration?** Consider the estimated duration and type of incarceration or hospitalization. Although often difficult to predict, a brief period may not necessitate dismissal.
  - **Is it possible to continue providing services?** Evaluate the possibility of continuing services during this time. For example, the Full-Service Partnership (FSP) team might be able to maintain contact with or provide services to the individual while they are incarcerated.
  - **Is the individual still willing to engage?** The treatment team may have built

trust and rapport with the individual. Consider whether the respondent remains engaged in treatment or willing to participate despite the change in circumstances.

- **Are there legal and jurisdictional issues?** Consider if there are jurisdictional complexities if incarceration or hospitalization occurs out of county or state, which might complicate service delivery or case management.
- **Is there a risk to losing services and supports?** Consider whether dismissal could result in a gap in critical services and supports, potentially worsening the respondent's condition.

- These situations likely will require a discussion with respondent's counsel and the court.
  - County BH, with the guidance off their counsel, should notify the court.
    - Could be through progress or status hearing.
    - Can request court set a specific hearing to consider.
  - Court may consider suspending the proceedings, or dismissing the case allowing the petition to be re-filed.
  - If the case is resumed after a period of incarceration or hospitalization, consider:
    - Change in respondent's mental health status that suggests that CARE eligibility needs to be reassessed.
    - Updating the CARE plan or CARE agreement as necessary to reflect any changes in diagnosis or treatment needs.

Non-Participation as Reason for Dismissal or Termination

- Implications of non-participation in a CARE plan:
  - The court can terminate her participation in the CARE process.
  - County BH may continue to outreach and offer services outside of CARE.
  - Declining to comply with the CARE plan will be considered by the court in a Lanterman-Petris-Short (LPS) Act proceeding.
  - Information about non-adherence to medications cannot be included
- These implications do not apply to a decision to not participate in a CARE agreement.

For more information on non-participation, see the W&I Code Section 5979(a)(1).

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[Slide Image Description: This slide shows a graphic of a paper with the title “CARE Plan: DECLINE.” A silhouette of a person representing Anika and a description of the process if Anika declines to participate in the CARE plan is detailed.]

If at any time in the CARE proceedings, the court determines that a respondent is not participating in the CARE process or is not adhering to their CARE agreement or CARE plan, the court may terminate the respondent’s participation in CARE. The court shall not consider nonadherence with medication under the CARE plan as reason for dismissal. It’s important to remember that while Anika’s CARE plan is court ordered, it is not criminal court. Meaning, there are limits to what can happen if Anika does not want to participate, and there are no criminal consequences nor penalties for contempt of court. She will not suddenly have a probation officer or something to that effect.

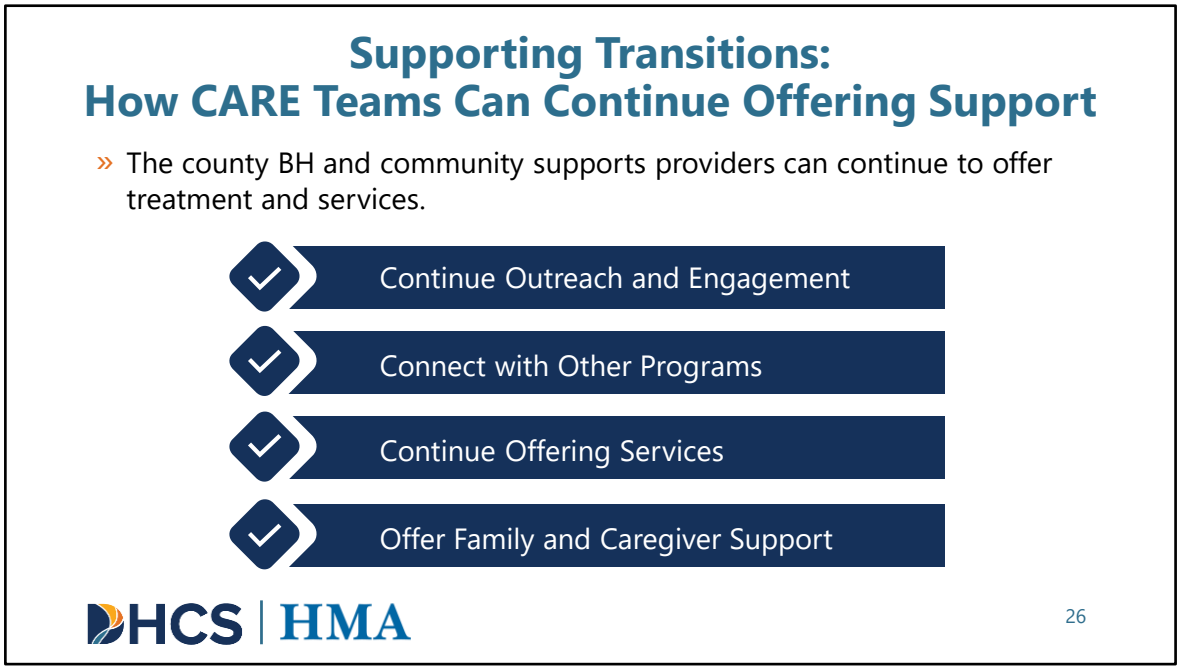
What are the consequences?

- There are no penalties to a respondent who doesn’t complete their CARE agreement or CARE plan.
- Anika's failure to comply with the CARE plan will be considered by the court in a Lanterman-Petris-Short (LPS) Act proceeding (i.e., 5150/5250, conservatorship) if one is held within 6 months of the termination of the CARE plan. This fact shall

create a presumption for the LPS court that the respondent needs additional intervention beyond the services and supports provided by the CARE plan.
    - The termination of a CARE plan doesn't *automatically* trigger LPS proceedings.
    - Information about non-adherence to medications cannot be included.
- If the court has ordered a CARE plan (not a CARE agreement), it has the discretion to keep the case open for up to a year. If the court dismisses the case, county BH and community support providers can continue outreach to the individual to offer treatment and other services and supports.
- Please note that these implications do not apply to a decision to not participate in a CARE agreement, although there is the possibility that the case may proceed to the CARE plan process, before dismissal for non-participation is considered.
- It's important to remember that the county can continue to outreach Anika and offer services outside of CARE.

For more information on non-participation, see the W&I Code Section 5979(a)(1).

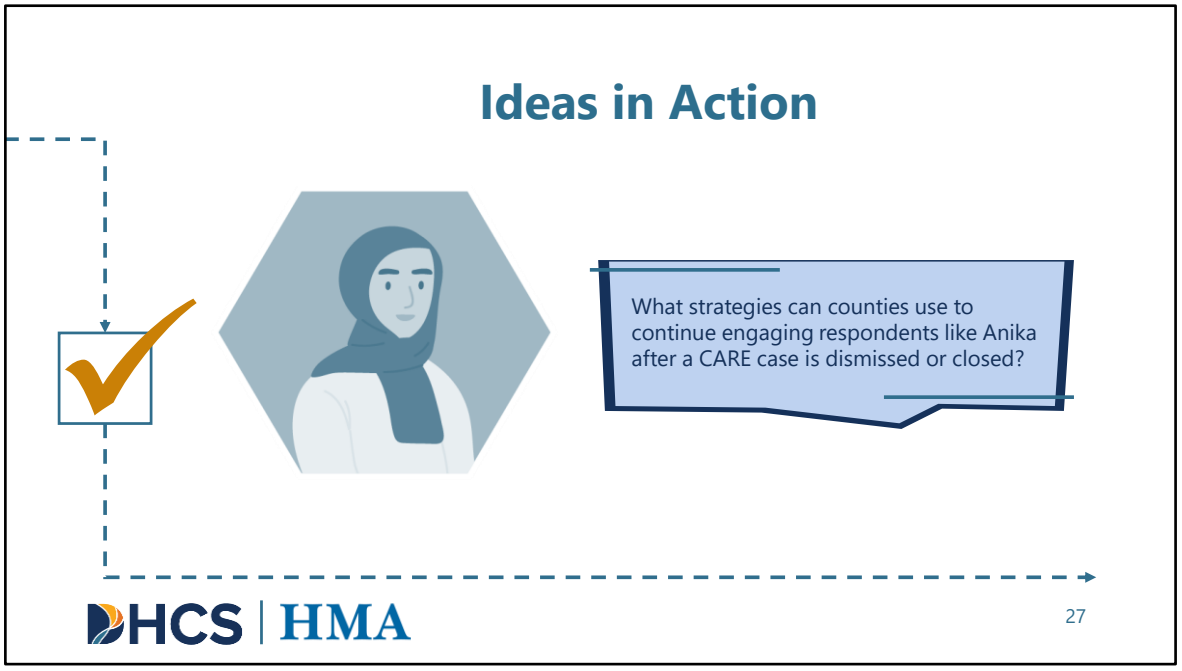
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5979.



[Slide Image Description: This slide shows a description of how CARE teams can continue offering support.]

When we think about the path out of CARE related to case dismissals or termination for non-participation, the county BH team is still encouraged to continue to work with the respondent and coordinate care, as appropriate to the circumstance. In some cases, the county BH and community supports providers can continue to offer treatment and services.

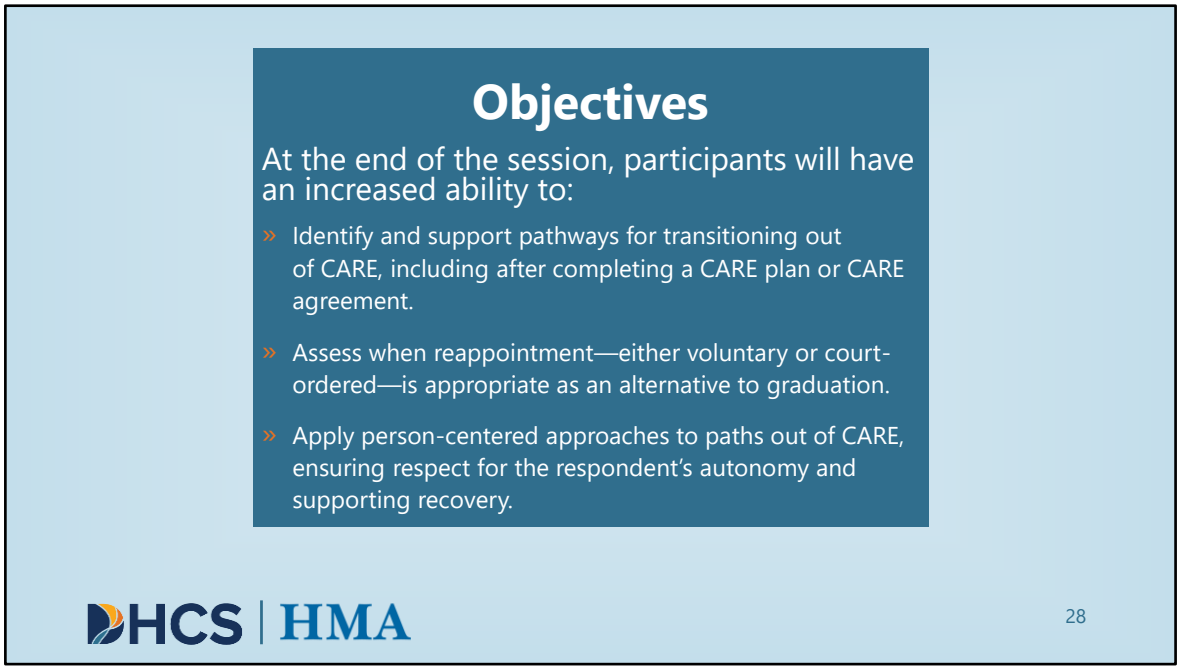
- **Continue outreach and engagement.** Continued efforts to build trust and encourage voluntary participation in mental health services. There might be an opportunity when the individual will be ready and interested in CARE.
- **Connect with other programs.** If eligible, the individual may be referred to other programs (e.g., AOT). The team should work to support a warm hand-off with the new provider.
- **Continue offering services.** The county can offer case management, therapy, medication management, housing, and peer support.
- **Offer to provide family and caregiver support.** Especially when a petition was filed by a family member, counties can offer to provide education and resources to family members to help encourage treatment.



[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 strategies can counties use to continue engaging respondents like Anika after a CARE case is dismissed or closed?

- Even after the CARE case ends, behavioral health providers can maintain outreach efforts—checking in periodically, offering services, and reminding Anika that care is still available.
- Peers or community health workers with lived experience often have more success building rapport with individuals like Anika, especially after formal processes end.
- Coordinate with shelters, crisis teams, housing providers, or trusted community organizations who might stay connected with Anika.
- Stay alert for re-entry into the system through other touchpoints (e.g., 5150 holds, hospitalizations), and re-offer engagement when appropriate.



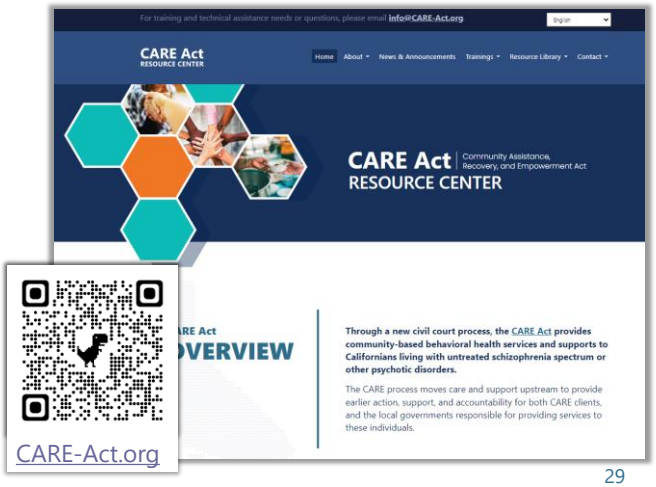
[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

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

- Identify and support pathways for transitioning out of CARE, including after completing a CARE plan or CARE agreement.
- Assess when reappointment—either voluntary or court-ordered—is appropriate as an alternative to graduation.
- Apply person-centered approaches to paths out of CARE, ensuring respect for the respondent's autonomy and supporting recovery.

CARE Act Resource Center

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



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 request training and technical assistance (TTA).

- Resources:
  - Training and Resource library:
    - We post all trainings to the CARE Act Resource Center; these include trainings that we have done live and also recorded trainings that 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.
  - Upcoming trainings: Upcoming trainings will be posted to this site, including registration information, speakers, and topics. Stakeholder communication will also highlight upcoming training opportunities.
  - 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 us:
    - Listserv
    - TA request form
    - Data TA request form
    - Stakeholder feedback form
    - Email: info@CARE-Act.org

https://care-act.us11.list-manage.com/subscribe?u=8ec8c1129c78ce744084103db&id=cbd28f0a2e
https://docs.google.com/forms/d/e/1FAIpQLSfPsaYxPzsE8GYjPRxgGqs5c8AuGTG8Ez_XpWOvrJYQYnJHow/viewform
https://docs.google.com/forms/d/e/1FAIpQLSeqgKj1SJRZhY_OEBhHCYRFghyJL7P3uDR0SGpxF5tMOsv_pw/viewform
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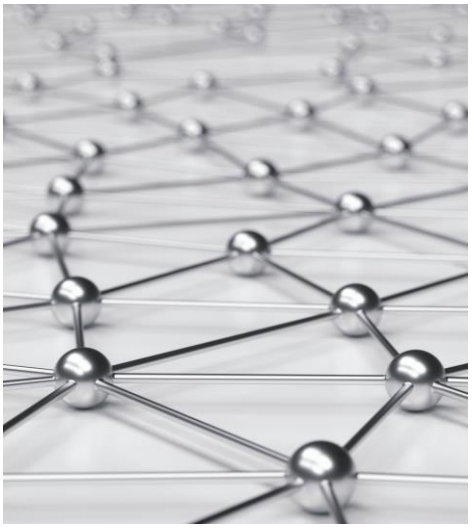
https://care-act.org/

Key Trainings & Resources

- Trainings
  - Pathways to Services in CARE
  - Psychiatric Advance Directives
  - Series: Trauma-informed Care for County Behavioral Health
  - Administrative Claiming for the CARE Act
  - Strategies for Outreach & Engagement in CARE
- Briefs
  - CARE Process Flow for County Behavioral Health
  - Claiming for Administrative Activities Related to CARE



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[Slide Image Description: This slide shows a number of interconnected metal balls.]

A few trainings and resources to highlight that are especially relevant include:

- Trainings
  - Pathways to Services in CARE
  - Psychiatric Advance Directives
  - Series: Trauma-informed Care for County Behavioral Health
  - Administrative Claiming for the CARE Act
  - Strategies for Outreach & Engagement in CARE
- Briefs
  - CARE Process Flow for County Behavioral Health
  - Claiming for Administrative Activities Related to CARE

https://care-act.org/trainings/training-materials-all/
https://care-act.org/training-material/psychiatric-advance-directives/
https://care-act.org/training-material/series-trauma-informed-care-for-volunteer-supporters/
https://care-act.org/training-material/care-act-sanctions-and-claiming-process/
https://care-act.org/training-material/strategies-for-outreach-engagement-in-care/
https://care-act.org/resource/care-process-flow-for-county-behavioral-health/
https://care-act.org/resource/claiming-for-administrative-activities-related-to-care/

[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**.