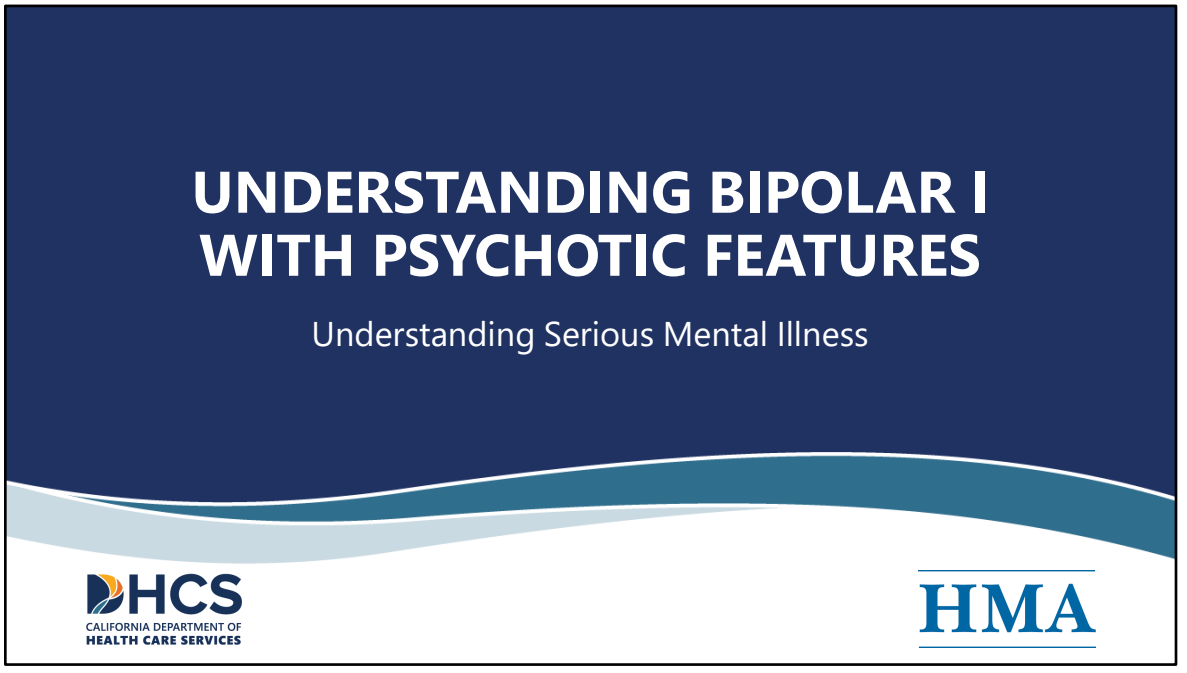
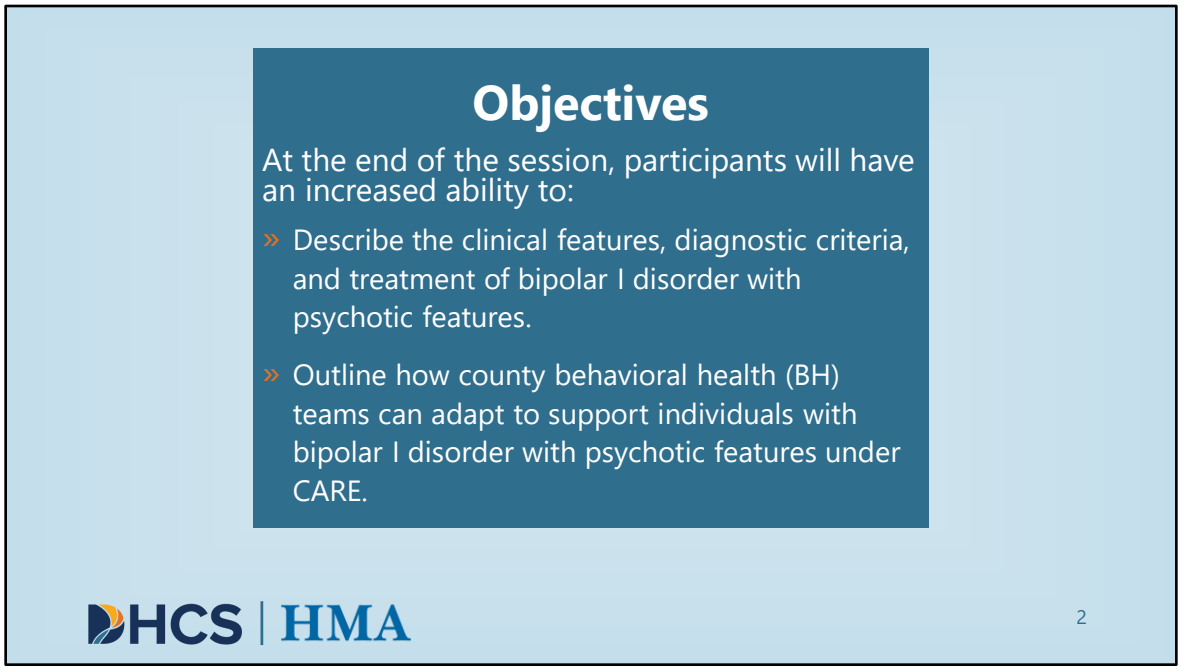


[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

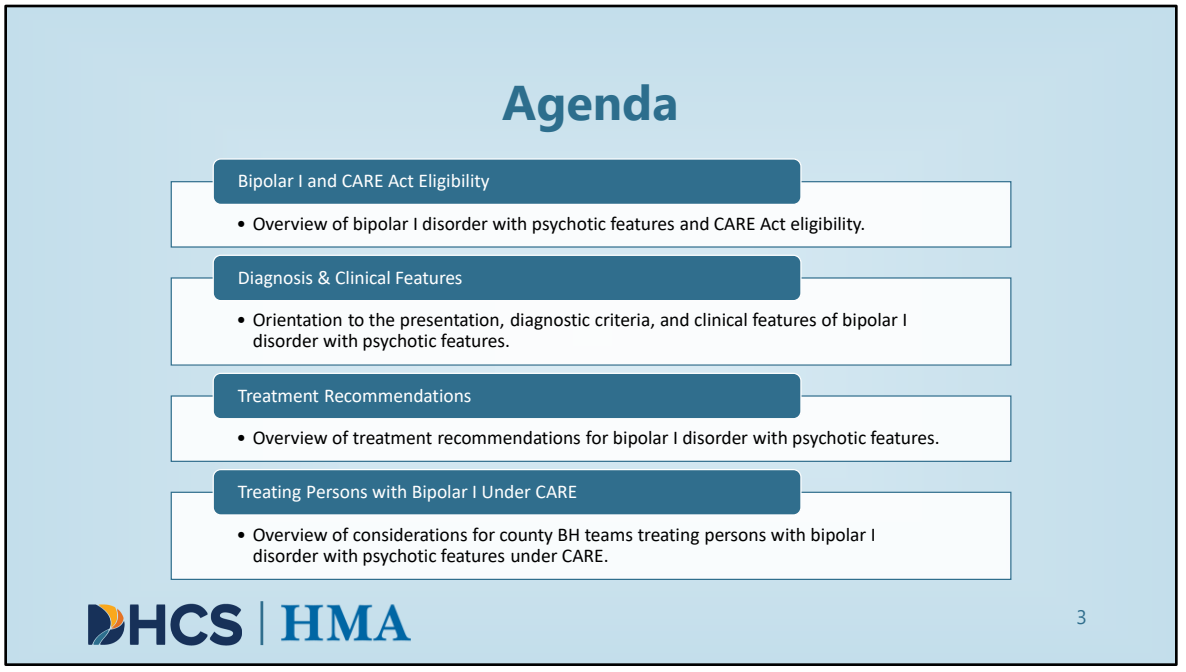
Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.



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

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

- Describe the clinical features, diagnostic criteria, and treatment of bipolar I disorder with psychotic features.
- Outline how county behavioral health (BH) teams can adapt to support individuals with bipolar I disorder with psychotic features under CARE.



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

In this training, we will discuss the following:

Bipolar I and CARE Act Eligibility
- Overview of bipolar I disorder with psychotic features and CARE Act eligibility.

Diagnosis & Clinical Features
- Orientation to the presentation, diagnostic criteria, and clinical features of bipolar I disorder with psychotic features.

Treatment Recommendations
- Overview of treatment recommendations for bipolar I disorder with psychotic features.

Treating Persons with Bipolar I Under CARE
- Overview of considerations for county BH teams treating persons with bipolar I disorder with psychotic features under CARE.

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

Laura Collins, from Health Management Associates, is a licensed clinical social worker with 25 years of experience in psychiatry across the behavioral health continuum, with extensive knowledge of, and involvement with clinical, civil and forensic processes for persons with mental illness. She has worked on the ground in emergency departments, inpatient psychiatric units, and outpatient services as both a psychiatric social worker and administrator.

Content informed by Dr. Katherine Warburton is the Statewide Medical Director for the California Department of State Hospitals, which has over 6,000 beds and is the largest forensic inpatient system in the county. She is an Associate Professor on the Volunteer Clinical Faculty within the UC Davis Division of Psychiatry and the Law. Dr. Warburton is board certified in psychiatry and forensic psychiatry. Her areas of interest include public policy, public forensic mental health care delivery systems, and inpatient aggression. She has presented both nationally and internationally and has published multiple peer reviewed articles on a variety of forensic topics. Dr. Warburton has produced two textbooks: Violence in Psychiatry and Decriminalizing Mental Illness. She is working on a third related to the treatment of schizophrenia. Dr. Warburton works at the national level on the board of directors for NRI and as a non-federal member of the Interdepartmental Serious Mental Illness Coordinating Committee.

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

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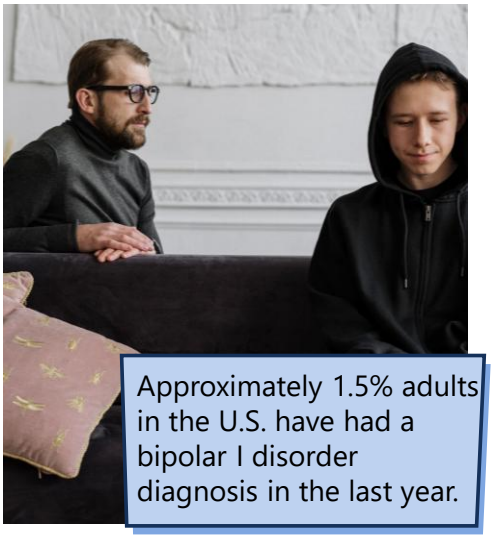
CARE Eligibility Expansion

Senate Bill (SB) 27

- SB 27 added bipolar I disorder with psychotic features, except psychosis related to current intoxication as an eligible diagnosis for CARE eligibility.



Approximately 1.5% adults in the U.S. have had a bipolar I disorder diagnosis in the last year.

See the updated Eligibility Fact Sheet for a list of **eligible diagnosis** and SB 27 Amendments Brief for additional information on SB 27's provisions.

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[Slide Image Description: This slide has information about bipolar I disorder with an image of an older man speaking to a younger man.]

Senate Bill (SB) 27 expanded the diagnostic criteria for the CARE Act. Originally, CARE Act eligibility required a diagnosis of schizophrenia spectrum and other psychotic disorders. SB 27 adds bipolar I disorder with psychotic features as an **eligible diagnosis** for CARE, effective January 1, 2026.

According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5-TR), approximately 1.5% of adults in the U.S. have been diagnosed with bipolar I disorder in the last year. Among these individuals, there is a smaller subset with psychotic features that take place during extreme mood episodes; these individuals may also present with symptoms and functional impairments that closely resemble those seen in chronic psychotic conditions.

See the updated Eligibility Fact Sheet for a list of **eligible diagnosis** and SB 27 Amendments Brief for additional information on SB 27's provisions.

Clinical Overlap & Equity in Access

- Bipolar I with psychotic features shares substantial symptom overlap with schizoaffective disorder—another CARE-eligible diagnosis.
- Including bipolar I with psychotic features ensures individuals with comparable clinical profiles can access CARE's services and supports with court oversight.
- This change supports equitable access to intensive services for those who need them, regardless of diagnostic label.

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[Slide Image Description: This slide has information about bipolar I disorder with psychotic features and an image of someone sitting across from a younger man seated on a sofa.]

Notably, bipolar I disorder with psychotic features shares substantial symptom overlap with schizoaffective disorder, bipolar type (another CARE-eligible diagnosis), including the presence of mood episodes accompanied by psychosis. Including bipolar I with psychotic features as an eligible diagnosis, helps ensure that individuals with comparable clinical profiles have equitable access to the structured care, services, supports and court oversight provided through CARE.

Other CARE Eligibility Criteria Still Apply

- A qualifying diagnosis alone does not guarantee CARE eligibility.
- Individuals must also meet criteria related to:
  - Current treatment engagement.
  - Level of functional impairment.
  - Safety and risk factors.
- Not all individuals with bipolar I disorder with psychotic features will meet these criteria.

For additional information, see the Eligibility Fact Sheet, Eligibility in Practice training, and related FAQ.

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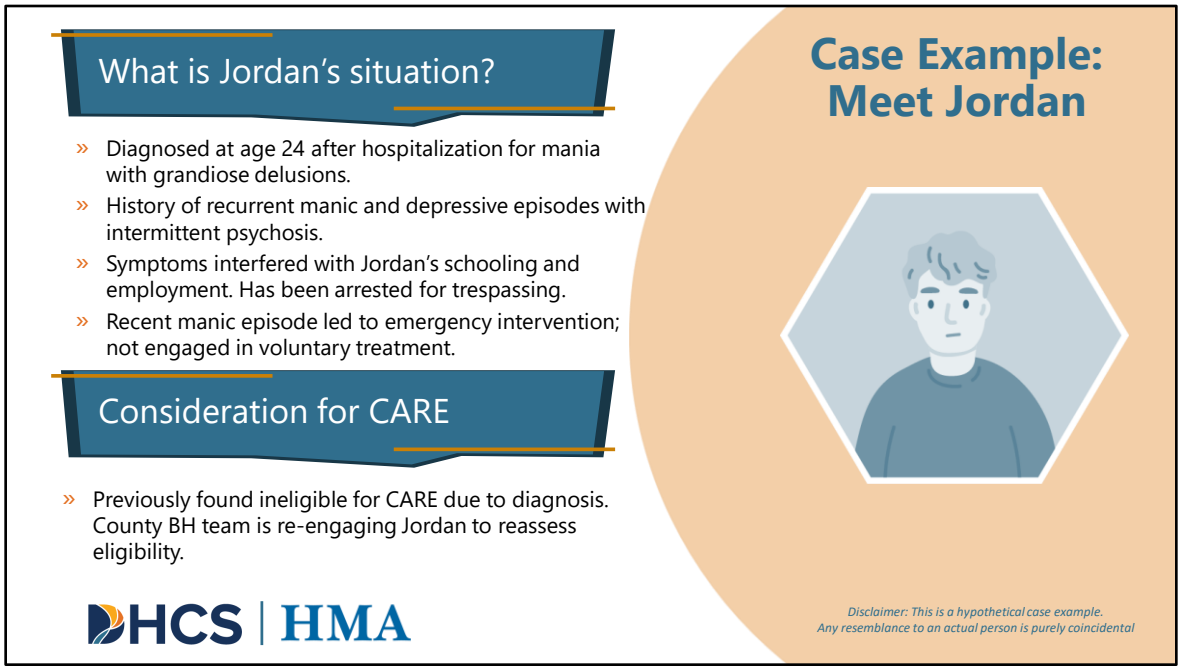
[Slide Image Description: This slide has information about CARE eligibility criteria and a portrait image of a person within a circular frame.]

Eligibility for CARE includes **additional criteria** regarding the person's current engagement in treatment, level of functional impairment, and certain safety and risk criteria. Having an eligible diagnosis is not sufficient on its own for acceptance into CARE. Not all individuals with bipolar I will meet the other CARE criteria, and other less restrictive alternatives may be more appropriate for receiving treatment.

For additional information, see the Eligibility Fact Sheet, Eligibility in Practice training, and related FAQ.



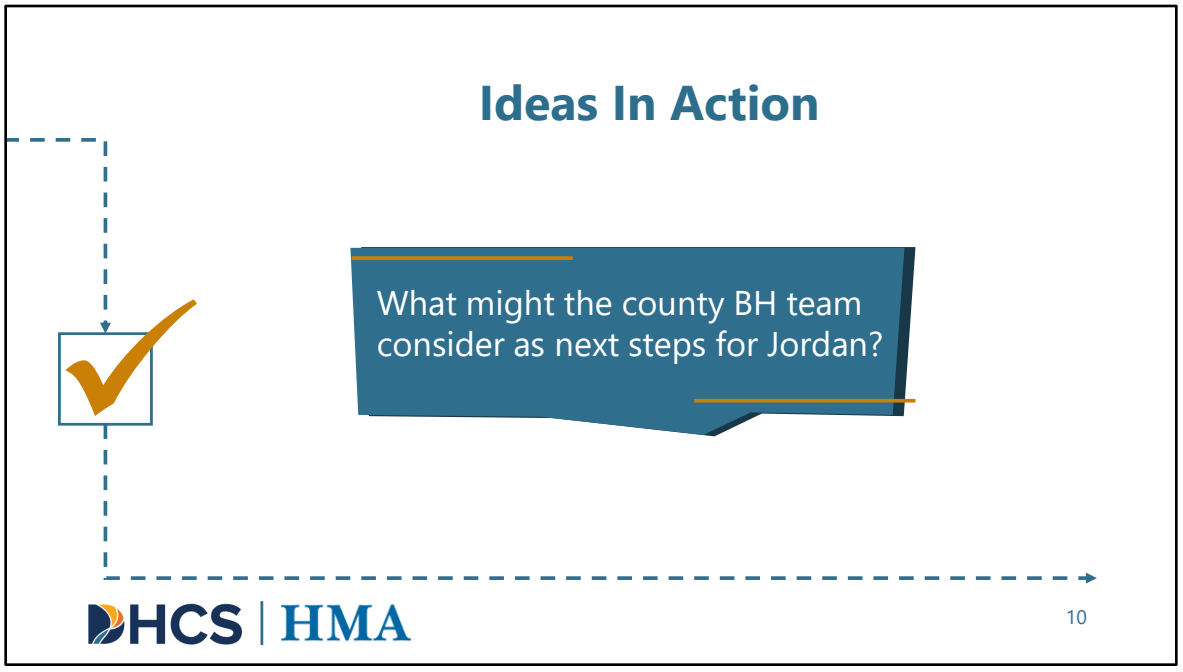
[Slide Image Description: This slide has information about a hypothetical case example of a person named Jordan who may be eligible for CARE under SB 27 and a portrait image of a person within a hexagonal frame representing Jordan.]

In order to discuss bipolar I with psychotic features, let's consider a fictional case.

- **Background:**
  - Jordan is a 45-year-old individual who was first diagnosed with bipolar I disorder at age 24 following a hospitalization for a manic episode that included grandiose delusions and impulsive behavior.
  - Over the years, Jordan has experienced several mood episodes—both manic and depressive—with intermittent psychotic features during the most severe phases.
  - Jordan had been periodically enrolled in trade school, but dropped out due to unmanaged symptoms.
- **Current Life Situation:**
  - He has had difficulty maintaining employment due to untreated mood episodes and inconsistent engagement with outpatient care, and he has been arrested recently for trespassing.

- During a recent manic episode, Jordan exhibited paranoid delusions and was brought to the emergency department by law enforcement after a public disturbance. He was not engaged in voluntary treatment at the time and had discontinued medications several months earlier.

- **Consideration for CARE:**
  - Jordan had recently been considered for CARE, but ultimately had not been found eligible by the court because he did not have a qualifying diagnosis.
  - The county BH team are doing outreach and engagement to consider if Jordan could now receive services and supports through CARE.



[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 might the county BH team consider as next steps for Jordan given the updates to eligible diagnoses?

To determine Jordan's eligibility under SB 27, the county behavioral health team would first confirm that Jordan has a qualifying diagnosis—bipolar I disorder with psychotic features. They would then assess whether Jordan meets the additional CARE criteria, including:

- Confirm Jordan's diagnosis and then begin to assess if he meets other eligibility. Review Jordan's history, current functioning, and risk factors to determine if CARE is the least restrictive and most appropriate option.
- Reach back out to Jordan to see if he is willing to engage and has interest in participating in CARE. Help him build rapport with the CARE team.
- Reach back out to the original petitioner to let them know about the addition of this diagnosis to CARE eligibility.

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

Classification and Diagnostic Criteria

- Bipolar I is a mood disorder defined by episodes of mania, depression, or mixed episodes.
- DSM-5 Diagnosis criteria:
  - At least one lifetime manic episode.
  - Mood disturbance must cause significant impairment or require hospitalization
- Psychosis is episodic and linked to mood.
  - Psychotic symptoms may occur during acute or depressive episodes.
  - Typically resolve when mood stabilizes.
  - No persistent psychosis between episodes.

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[Slide Image Description: This slide has information about bipolar I disorder classification and diagnostic criteria and a portrait image of a person representing Jordan, the hypothetical case example from the earlier slide, within a circular frame composed of multi-colored arrows.]

Overview of bipolar I as a mood disorder

- Bipolar I disorder is differentiated from the psychotic disorder class of illnesses in that it is classified as a mood disorder, characterized by episodes of mania, depression, and sometimes both (referred to as "mixed" episodes).
- According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5-TR), a diagnosis of bipolar I disorder requires:
  - At least one manic episode in the individual's lifetime, and
  - Symptoms of this disorder, including the mood disturbance must cause significant impairment in functioning or require hospitalization.

With psychotic features

With bipolar I, psychotic symptoms can occur, but they emerge generally during extreme mood episodes (e.g., during an acute manic phase or major depressive episode) and typically resolve when the mood episode resolves. In between mood

episodes, individuals typically do not experience persistent hallucinations or delusions. This contrasts with schizophrenia and schizoaffective disorder—a condition characterized by a combination of mood disorder symptoms (such as depression or mania) and persistent psychotic features—where psychosis is the defining feature and can be continuous.

The mood symptoms of bipolar I tend to be more responsive to treatment than to the primary symptoms of schizophrenia. Many individuals who experience psychosis during a manic or depressive episode can achieve full remission of psychotic symptoms with proper treatment, remaining stable and functional in the community without the need for intensive, ongoing wraparound services.

Manic & Depressive Episode Features

Manic episodes may include:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep.
- Pressured or rapid speech.
- Racing thoughts.
- Distractibility.
- Increased goal-directed activity
- psychomotor agitation (e.g., pacing, fidgeting).
- Impulsive involvement in high-risk activities.

Depressive episodes may include:

- Depressed mood, hopelessness
- Lack of pleasure/interest in activities (anhedonia)
- Low energy/appetite, sleep disturbance
- Suicidal thoughts/ideation

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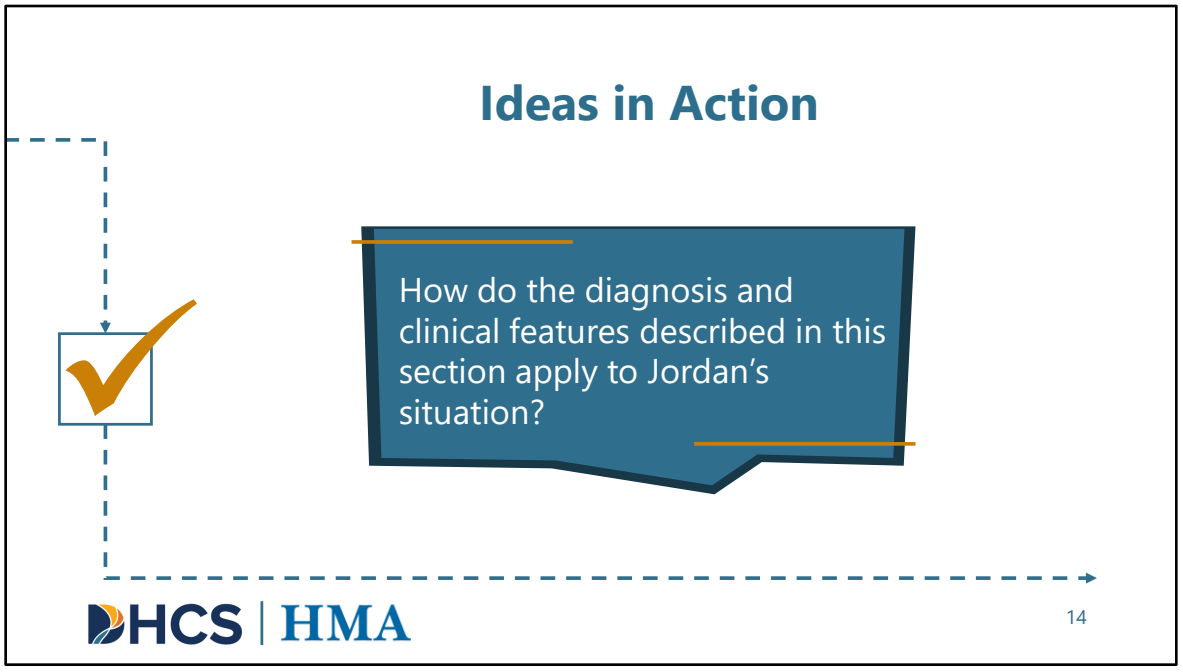
[Slide Image Description: This slide has information about manic episode features and an image of a two young people smiling sitting on railing on a boardwalk by some skateboards with a body of water and a city scape behind them.]

During a manic episode of bipolar I, individuals may exhibit an abnormally elevated, expansive, or irritable mood along with increased energy and activity. Manic episodes often involve symptoms such as:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep.
- Pressured or rapid speech.
- Racing thoughts (also referred to as flight of ideas).
- Distractibility.
- Increased goal-directed activity or psychomotor agitation.
- Impulsive involvement in high-risk activities (e.g. excessive spending sprees, risky sexual encounters, reckless driving).

These mood disturbances during manic episodes are typically severe enough to cause marked impairment in social or occupational functioning and typically accompanied by psychotic features during the acute phase.

Depressive episodes can also occur in bipolar I disorder which typically include: depressed mood, lack of pleasure/interest in activities, low energy/appetite, sleep disturbance, psychomotor agitation/retardation. Suicidal thoughts are a common symptom of depression and in bipolar I, can also occur during mixed episodes where the individual experience symptoms of mania and depression concurrently or in rapid sequence. Irritability and agitation are also a marker of a mixed episode.



[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.]

How do the diagnosis and clinical features described in this section apply to Jordan's situation?

Jordan's history and current presentation are consistent with the diagnostic criteria for bipolar I disorder with psychotic features. At age 24, Jordan experienced a manic episode characterized by grandiose delusions and impulsive behavior that required hospitalization, fulfilling the requirement of at least one full manic episode with psychosis. Since then, Jordan has had recurrent manic and depressive episodes, with psychotic symptoms emerging during the most severe phases, such as paranoid delusions during a recent manic episode. These episodes have led to impairment in functioning, evidenced by repeated disruptions in education, unstable employment, and involvement with law enforcement. Importantly, Jordan's psychotic symptoms have occurred in the context of mood episodes rather than independently, which is consistent with the specifier "with psychotic features" rather than a primary psychotic disorder. Taken together, Jordan's clinical course demonstrates clear alignment with the diagnostic framework for bipolar I disorder with psychotic features.

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

Onset and Clinical Features of Bipolar I Disorder

- Onset typically occurs in late adolescence or early adulthood.
- Bipolar I follows an episodic course:
  - Recurrent manic, depressive, or mixed episodes.
  - Periods of full or partial remission between episodes.
- Episode frequency and stability vary widely across individuals.

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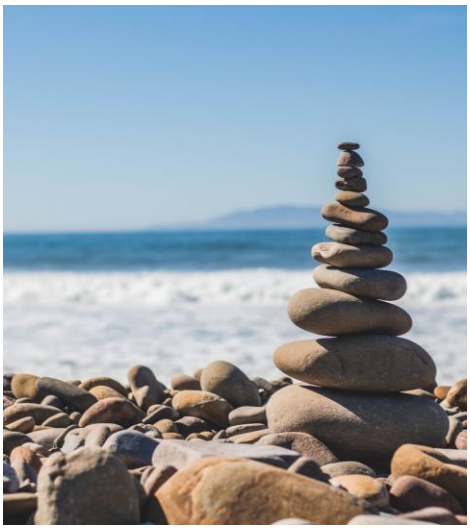
[Slide Image Description: This slide has information about the clinical features and onset of bipolar I disorder and an icon of a clock in front of a light blue circle and a brown outline of another circle.]

The onset of bipolar disorder usually occurs in late adolescence or early adulthood.

Bipolar I disorder tends to be episodic in its course. A typical pattern involves recurrent manic and depressive episodes over time, with periods of full or partial remission in between.

The duration of untreated manic episodes can range from weeks to months, and most individuals with bipolar I will experience multiple episodes (of mania, depression, or mixed) in their lifetime. However, not everyone has a regular cycle; some may have long stable intervals, while others have more frequent relapses.



Psychotic Symptoms During Acute Episodes

- Psychotic symptoms may occur during acute mania or severe depression and typically resolves with mood stabilization.
- Unlike schizoaffective disorder, individuals with bipolar I can often regain baseline functioning between episodes.
- Mood stabilizers can prevent escalation and reduce risk of psychosis.

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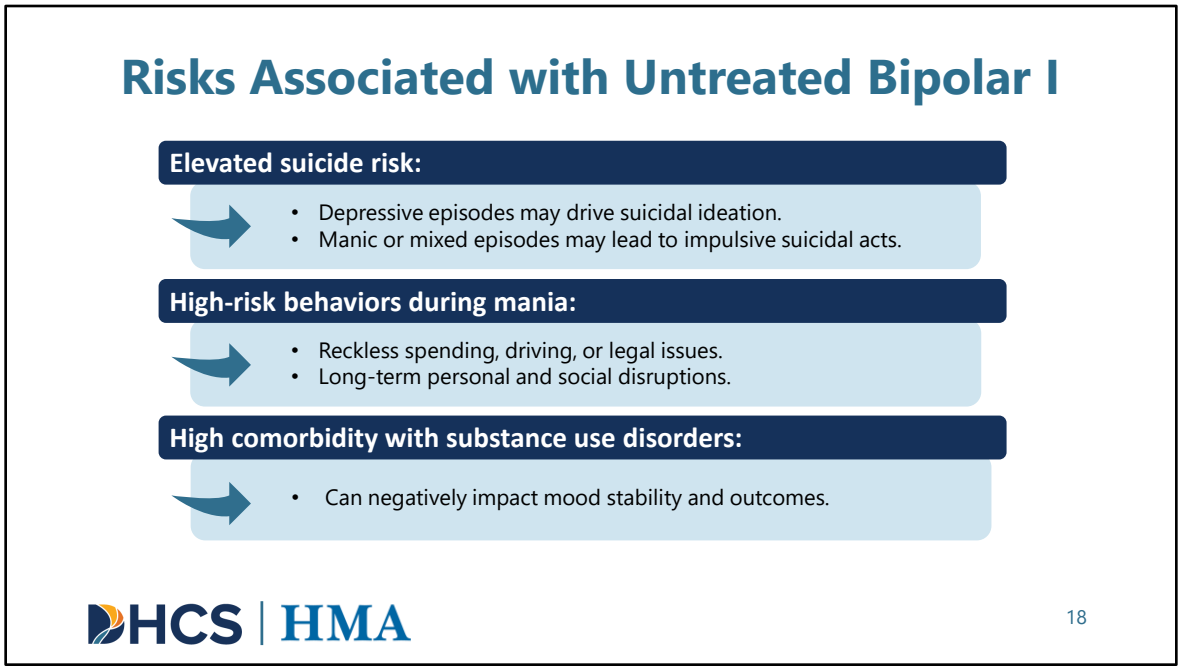
[Slide Image Description: This slide has information about psychotic features during acute episodes of bipolar I disorder and an image of a stack of increasingly small rocks on a rocky shore of the ocean.]

When psychotic symptoms are present in bipolar I, they typically occur during the height of mania or severe depression and generally resolve when the person's mood stabilizes. This intermittent nature means that persons with bipolar I disorder can often regain baseline functioning between episodes if effectively treated. In contrast, individuals with schizoaffective disorder may continue to have some ongoing symptoms even during periods of stability. Schizophrenia and schizoaffective disorders typically include chronic or enduring psychotic symptoms that are not contingent on mood. This means that a person with bipolar I, once stabilized, may not exhibit any psychosis or major functional deficits for long periods.

Individuals with bipolar I disorder usually have a lower incidence of anosognosia (lack of awareness of illness) compared to individuals with schizophrenia. Many individuals with bipolar I recognize changes in their mood or reality-testing, especially once the acute episode passes. As a result, they may be more amenable to engaging in voluntary treatment.

Mood-stabilizing medications can often prevent manic episodes from escalating to a more severe state, which in turn reduces the likelihood of psychosis and supports individuals in maintaining independent living and employment. Many persons are able to return to a high level of functioning – maintaining relationships, employment, and community roles.



[Slide Image Description: This slide has information about risks associated with untreated bipolar I disorder within a table with dark blue headers and light blue rows with darker blue arrows pointing to each.]

Bipolar I disorder carries significant risks, particularly if not adequately treated.

- **Elevated risk of suicide.** Both manic and depressive phases contribute to increase suicide risk. Depressive episodes can drive suicidal ideation, while manic episodes (or mixed states) can lead to impulsive suicidal or self-injurious acts.
- **Serious consequences.** During mania, individuals often engage in high-risk behaviors due to impaired judgment and loss of normal inhibitions. For example, lavish spending sprees that can cause financial ruin, reckless driving or thrill-seeking that leads to accidents, aggressive or legally problematic actions.
- **Personal and social disruptions.** Disruptions caused by an untreated manic episode can have long-term impact on a person's life.
- **Co-occurring substance use disorders.** There is a high comorbidity of substance use disorders in bipolar I; substance use can further destabilize mood and heighten the risk of adverse outcomes.

Impact of Treatment and Support Services

- Early and sustained intervention improves long-term outcomes.
- Mood stabilizers reduce episode frequency, hospitalization, and suicide risk.
- Psychotherapy and community supports can support functional, sustained recovery.

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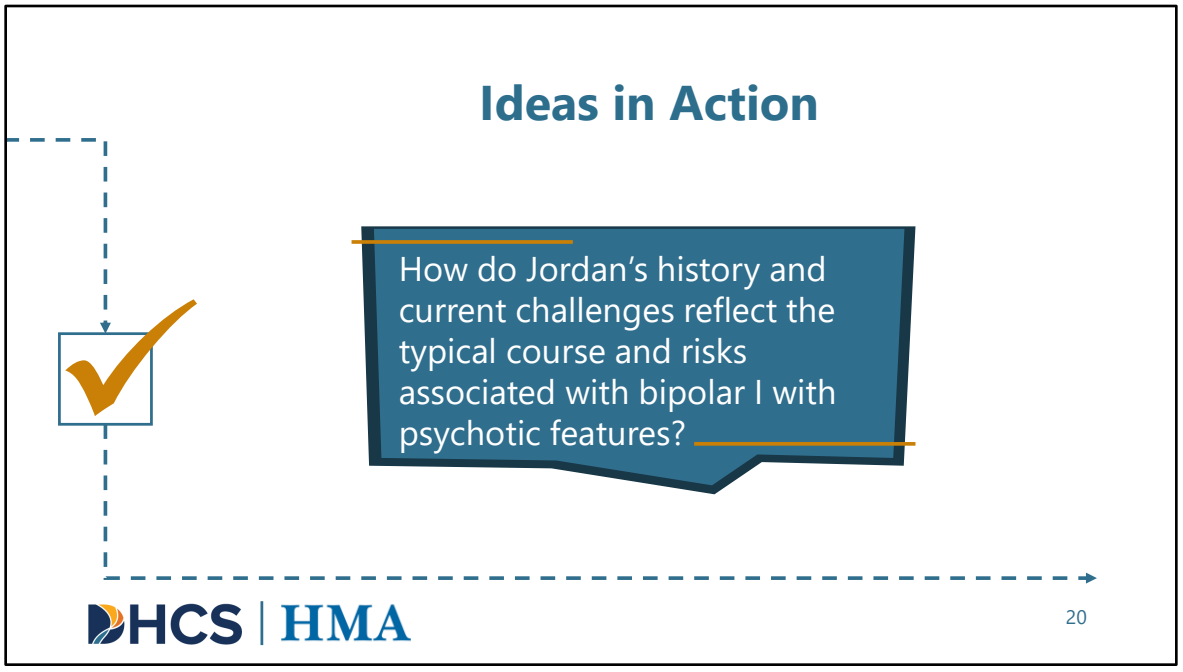
[Slide Image Description: This slide has information about the impact of treatment and support services for bipolar I disorder and an image of someone with a pencil and pad in hand facing a young woman and a young man seated in chairs in a room.]

However, the impact of support and treatment services on long-term outcomes is very positive. Early and sustained intervention with mood-stabilizing medication greatly reduces the frequency and severity of mood episodes, which in turn lowers the risk of hospitalization, suicide, and psychosocial decline.

Psychotherapy and community support services can improve medication adherence and teach coping skills, leading to better functional recovery. In many cases, bipolar I disorder with psychotic features can be managed to the point that individuals have only rare relapses and can lead a life of sustained recovery.



[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.]

How do Jordan's history and current challenges reflect the typical course and risks associated with bipolar I with psychotic features?

Jordan's experience closely mirrors the usual onset and episodic course of bipolar I disorder. His first manic episode occurred in early adulthood, which is a common age of onset, and since then he has had recurrent manic and depressive episodes with periods of partial remission in between. During the most severe phases, Jordan has developed psychotic symptoms such as grandiose and paranoid delusions, which is consistent with the way psychosis emerges at the height of mood episodes and resolves when the mood stabilizes.

The impact of untreated episodes is evident in Jordan's life. Discontinuing medication and disengaging from treatment has led to:

- Prolonged manic phases
- Public disturbances
- Difficulty maintaining employment.

These disruptions highlight the risks of untreated bipolar I disorder, including impaired judgment, social and occupational instability, and involvement with law enforcement. At the same time, Jordan's situation underscores the potential benefits of consistent treatment and support—mood-stabilizing medication and community services could reduce the severity of episodes, lower the risk of psychosis, and help him regain baseline functioning, including stability in work and relationships.

We'll now pivot to talk more about treatment recommendations for bipolar I disorder with psychotic features.

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

Treatment of bipolar I disorder with psychotic features should be guided by evidence-based practices, as outlined by the American Psychiatric Association (APA). The combination of treatments should be patient-centered, meaning they are crafted in collaboration with the individual, they respect the person's goals and cultural background, and are comprehensive (addressing medical, psychiatric, and social needs).

The APA's practice guidelines for mood disorders emphasize a combination of pharmacotherapy, psychosocial interventions, and lifestyle interventions for optimal outcomes.

Pharmacotherapy

- Mood stabilizers help reduce mania, treat depression, and support long-term stability.
- Psychotic symptoms often require antipsychotics, especially during acute episodes.
- Complex cases may need combination therapy; antipsychotics may be tapered after stabilization.
- Maintenance mood stabilizers are typically continued long-term.

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[Slide Image Description: This slide has information about pharmacotherapy and a dark blue icon of a pill beside a pill bottle over a light blue hexagon shape and a brown hexagon outline.]

Mood stabilizing medications can reduce manic symptoms, prevent suicide, and provide long-term mood stabilization. The presence of psychotic features often necessitates the use of **antipsychotic medication**. In some cases, an antipsychotic on its own can manage a manic episode, but combination therapy is often indicated for severe episodes. Antipsychotics are usually tapered down after the acute phase, if possible, with the mood stabilizer continued as maintenance.

Psychosocial Interventions

- There are also **psychosocial treatments** that improve outcomes in bipolar I disorder:
  - Cognitive-Behavioral Therapy (CBT)
  - Family Psychoeducation (Family-Focused Therapy)
- Support groups, peer support, and rehabilitative services when needed (e.g., supported employment or supportive housing) can also improve outcomes.

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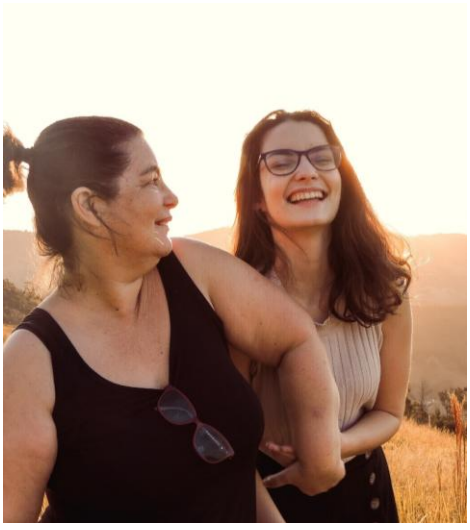
[Slide Image Description: This slide has information about psychosocial interventions and an image of someone holding a clipboard seated across from a young man and woman on a couch.]

Several **psychosocial treatments** can improve outcomes in bipolar I disorder, starting with effective case management.

Other evidence-based modalities for bipolar disorder include:

- **Cognitive-Behavioral Therapy (CBT)** to help individuals identify and manage triggers for mood swings and challenge dysfunctional thoughts.
- **Family Psychoeducation (family-focused therapy)**, which educates family members on mental illness, communication and problem-solving skills, warning signs of relapse, and the necessity of treatment adherence.

Treatment guidelines also encourage support groups or peer support, and rehabilitative services when needed (e.g., supported employment or supportive housing for those whose illness has disrupted their functioning).



Lifestyle Interventions

- Regular sleep, reduced substance use, and stress management (e.g., mindfulness, exercise) support mood stability.
- Interventions should be person-centered, trauma-informed, and culturally responsive.
- Strategies must align with the individual's goals, values, and life circumstances—not imposed norms.

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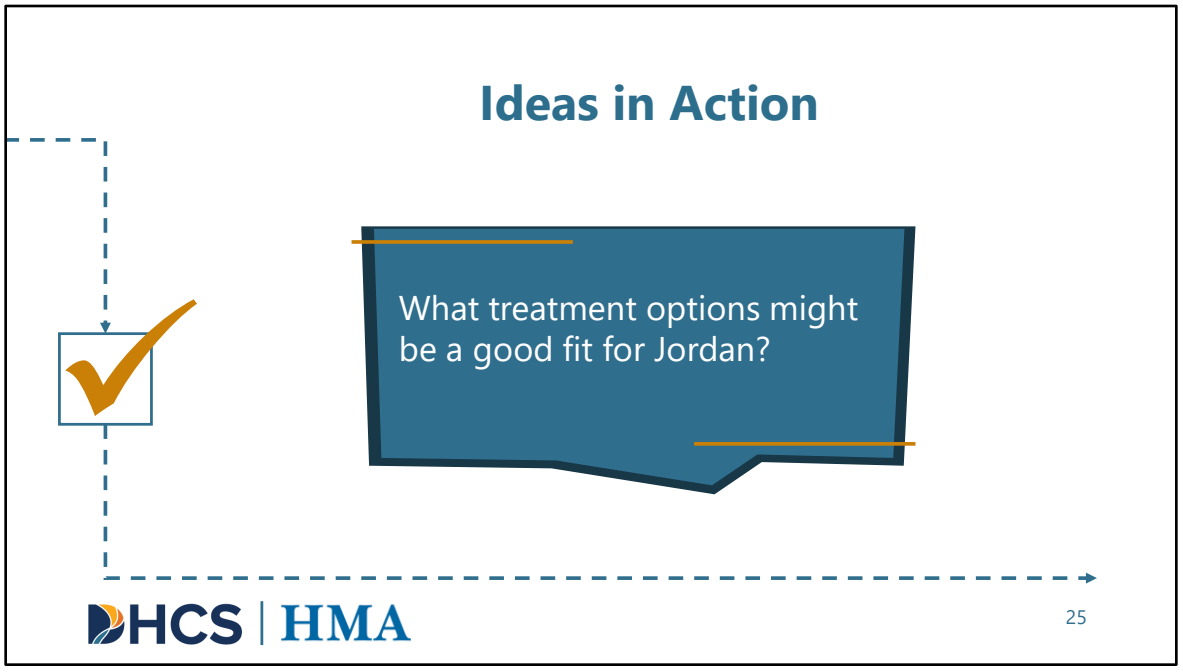
[Slide Image Description: This slide has information about lifestyle interventions and an image of a middle-aged woman and a younger woman outside together smiling, perhaps a mother and a daughter.]

Lifestyle interventions are advised as part of a holistic treatment plan. Maintaining regular sleep-wake cycles is crucial, as sleep deprivation can lead to an episode of mania. Individuals are counseled to minimize alcohol or drug use, since substances can destabilize mood or interact with medications. Managing stress through techniques such as mindfulness or regular exercise can also be beneficial.

These interventions should follow a person-centered, trauma-informed, and motivational interviewing approach to identify strategies that align with the individual's goals, cultural practices, and life circumstances.



[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 treatment options might be a good fit for Jordan?

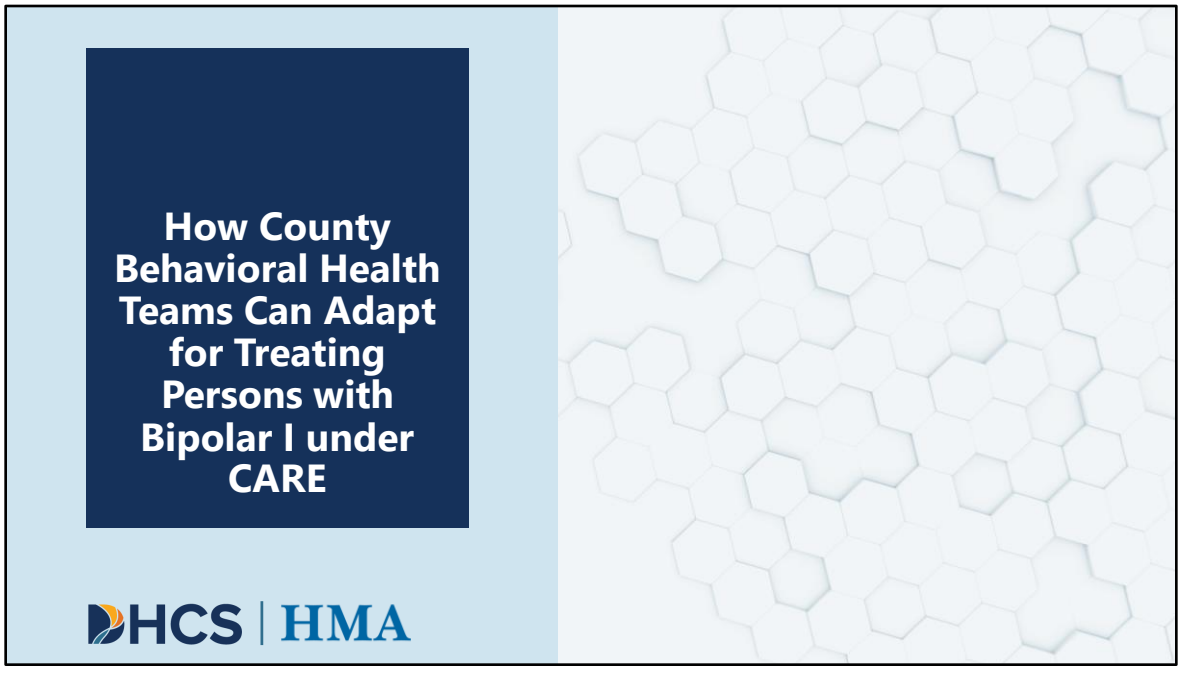
Given Jordan's history of recurrent manic and depressive episodes, psychotic features during severe phases, and challenges with treatment adherence, a comprehensive, patient-centered plan would be most appropriate.

- **Pharmacotherapy** would be central. Mood stabilizers could help reduce the intensity of manic symptoms and provide long-term stability, while antipsychotic medication may be necessary during acute episodes with delusions, such as Jordan's recent paranoid episode. Because Jordan has discontinued medications in the past, careful monitoring, education about the importance of maintenance therapy, and collaborative decision-making would be essential to support adherence.
- **Psychosocial interventions** would also be a good fit. Cognitive-Behavioral Therapy (CBT) could help Jordan identify triggers for mood episodes and develop coping strategies. Family-focused therapy or psychoeducation could improve communication and help Jordan's support system recognize early warning signs of relapse. Given Jordan's difficulty maintaining employment and schooling,

rehabilitative services such as supported employment programs could provide practical assistance in stabilizing daily life.

- **Lifestyle interventions** would round out the plan. Establishing regular sleep routines, minimizing substance use, and incorporating stress management strategies like mindfulness or exercise could reduce relapse risk. Since Jordan has struggled with voluntary engagement in care, a trauma-informed and motivational interviewing approach would be important to align treatment with his personal goals and cultural background, increasing the likelihood of sustained participation.

Altogether, combining medication, therapy, community supports, and lifestyle strategies offers Jordan the best chance of reducing relapse, managing psychotic features, and regaining stability in work, education, and relationships.



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

With the inclusion of bipolar I disorder with psychotic features under CARE eligibility, county BH teams may need to adjust their practices to ensure appropriate identification, engagement, and support. The following strategies can help teams prepare for and respond to the unique needs of individuals with bipolar I disorder in both acute and long-term phases of care.

Preparing Teams and Systems

- **Train county BH staff** on bipolar I with psychotic features—diagnosis, treatment, and recovery.
- **Update screening tools** to reflect new CARE eligibility.
- **Ensure providers have experience** with mood disorders and relevant therapies.
- **Reconnect with clients** who may now qualify under SB 27.

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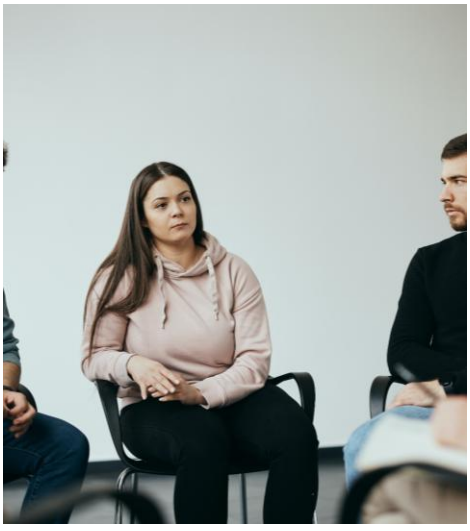
[Slide Image Description: This slide has information about preparing teams and systems for the inclusion of the bipolar I disorder diagnosis as a criteria for eligibility in CARE with an image of people putting their hands together in a circle.]

Here are some ways CARE teams can help prepare teams and systems:

- Provide ongoing training for behavioral health staff on the unique features of bipolar I with psychotic features, including diagnosis, treatment, and recovery trajectories.
- Update internal eligibility screening tools to include bipolar I with psychotic features.
- Ensure clinical team members and contracted providers have experience treating mood disorders, including therapies and medications specific to treating bipolar I disorder.
- Proactively reach out to clients who may now be eligible for CARE, including those whose cases were previously dismissed because bipolar I was not an eligible diagnosis.



Clinical Planning and Service Delivery

- **Equip teams to manage both acute episodes and long-term stabilization**, adjusting service intensity as needed.
- **Integrate evidence-based therapies** into CARE agreements and CARE plans.
- **Frequently ask** about sleep, substance use, and stress.
- **Prepare for rapid intervention** during mood episodes, including suicide risk and impulsivity protocols.

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[Slide Image Description: This slide has information about clinical planning and service delivery within CARE with an image of people sitting in a circle.]

Here are some things that CARE teams can consider adapting in their clinical planning and service delivery:

- Ensure teams are equipped to address the symptoms of bipolar I disorder and to tailor services as the CARE participant's needs change.
- Discuss how to integrate the consideration of therapies proven effective for bipolar I disorder into CARE agreement or CARE plans.
- Routinely check-in with the individual regarding maintaining regular sleep-wake cycles and managing substance use and stress levels.
- Prepare for rapid intervention during manic or depressive episodes, with protocols for suicide risk assessment and management of impulsive behaviors.

Safety, Support, and Recovery

- **Develop safety plans** that address high-risk activities common in mania; include in psychiatric advance directive (PAD) development.
- **Offer peer support, psychoeducation, and rehabilitative services** as needed.

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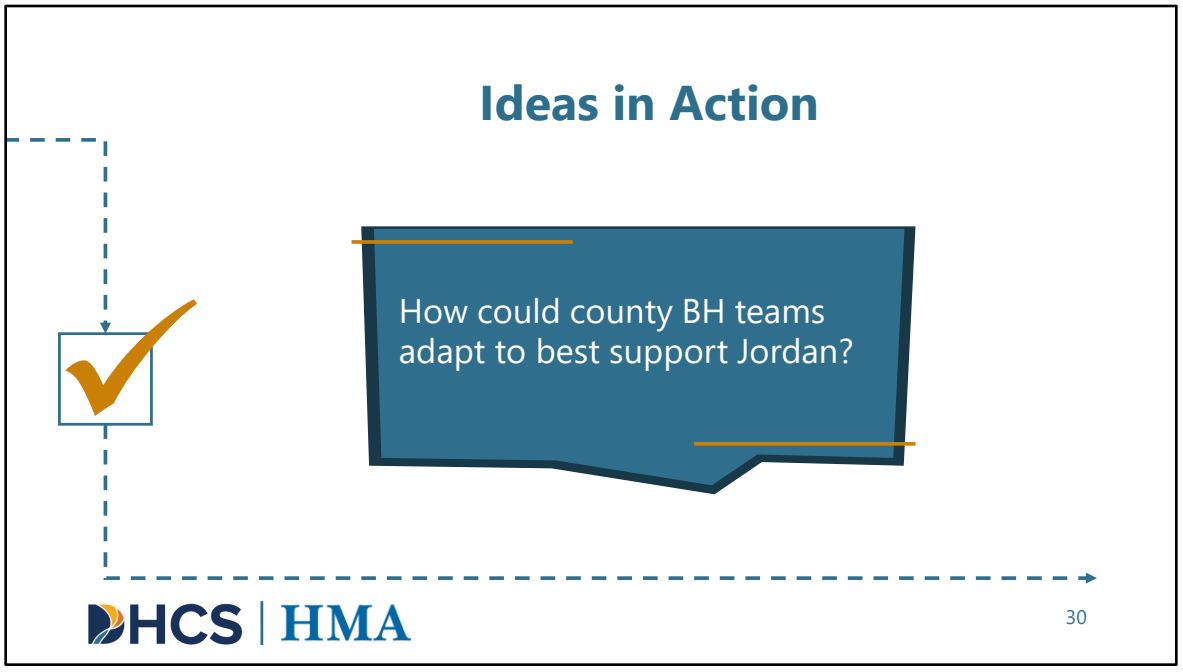
[Slide Image Description: This slide has information about safety, support, and recovery with an image of holding hands.]

County BH teams can consider ways to increase safety, support, and recovery for individuals with bipolar I with psychotic features:

- Develop safety plans that address high-risk activities common in mania. Consider including these plans in a psychiatric advance directive (PAD).
- Offer peer support, psychoeducation, and rehabilitative services as needed.



[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.]

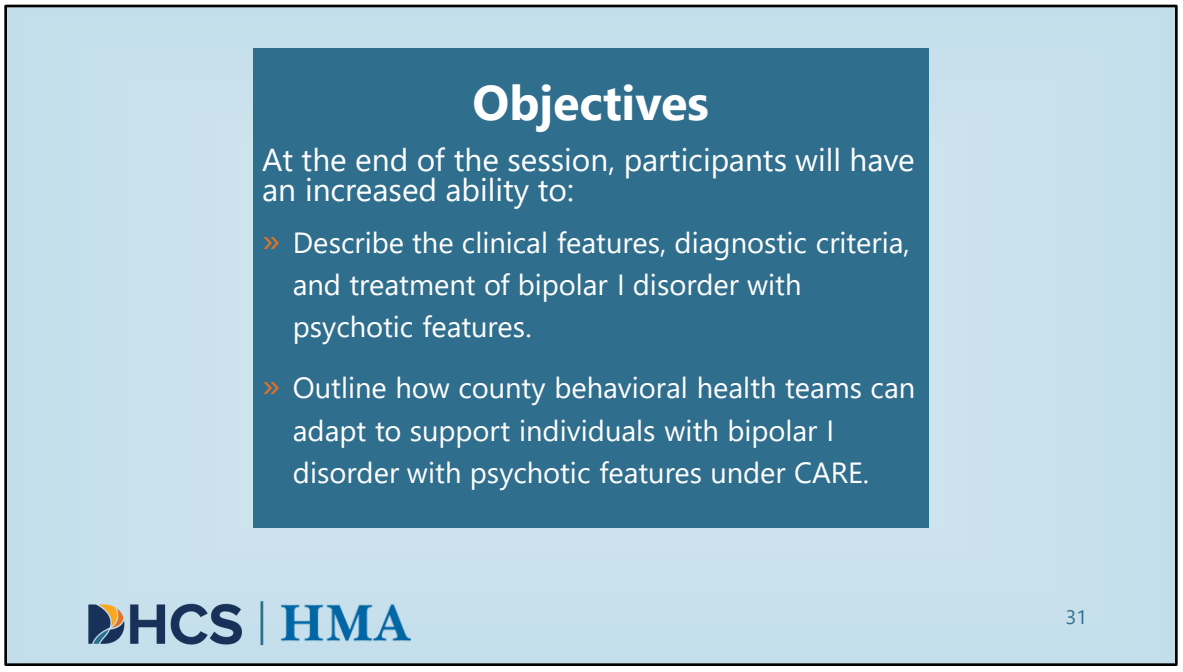
How could county BH teams adapt to best support Jordan?

By adapting systems to recognize bipolar I disorder with psychotic features, training staff, and delivering flexible, evidence-based supports, county BH teams could help Jordan stabilize, reduce the risk of future crises, and regain functioning in work, school, and community life.

- Preparing Teams and Systems
    - Update screening tools to reflect new CARE eligibility criteria.
    - Train county BH staff on bipolar I disorder with psychotic features, including diagnosis, treatment, and recovery.
    - Reconnect with clients who may now qualify under SB 27.
- Clinical Planning and Service Delivery
    - Equip teams to manage both acute episodes and long-term stabilization, adjusting service intensity as needed.
    - Prepare protocols for rapid intervention during mood episodes, including

suicide risk and impulsivity management.

- Safety, Support, and Recovery
  - Develop safety plans for high-risk behaviors common in mania and include them in psychiatric advance directives (PADs).
  - Provide peer support and psychoeducation to strengthen engagement and understanding of bipolar I disorder with psychotic features.



[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:

- Describe the clinical features, diagnostic criteria, and treatment of bipolar I disorder with psychotic features.
- Outline how county behavioral health teams can adapt to support individuals with bipolar I disorder with psychotic features under 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.**