CARE Court and the Specialty SUD System

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Key Considerations

- **In addition to the issues related to the lack of funding for MH or SUD services, lack of housing, and financial penalties that will only make it more difficult to provide services for CARE Court participants, some other considerations specific to DPH-SAPC services include:**
  - Prevalence of SUDs >> prevalence of psychosis
    - Unintended adverse consequences of involuntary SUD care are potentially much more significant with broad eligibility criteria that include individuals with SUD (e.g., inequities with respect to the application of court mandates and access to limited treatment capacity, patients' rights, creating more stigma related to sharing or seeking help for substance use due to concerns about being mandated into treatment, etc.).
  - Presence of medical decision-making capacity is clearer with respect to psychosis, but less clear for someone whose psychosis has cleared and who continues to use substances.
  - While extrinsic motivation associated with drug courts have evidence supporting their effectiveness, drug courts serve a narrow population and applying a broader framework to court-mandated SUD treatment outside of drug courts is an untested approach → For this reason, it is prudent to take a measured approach with the initial implementation of CARE Court with respect to individuals with SUD.

Expected Impact of CARE Court on DPH-SAPC's Specialty SUD System

- Continuum of specialty SUD treatment services would remain unchanged (Recovery Services, outpatient, Opioid Treatment Program services, intensive outpatient, residential levels 3.1/3.3/3.5 with a likely increase in residential level 3.3 services for people with co-occurring MH and SUDs, inpatient withdrawal management, Recovery Bridge Housing).
- However, we anticipate several key needs from CARE Court related to:
  - Increased lengths of stay and need for SUD beds (residential, inpatient, Recovery Bridge Housing)
  - Increased needs for SUD workforce:
    - More licensed clinicians capable of caring for people with more serious psychiatric conditions.
    - More trainings for SUD counselors on caring for people with more serious psychiatric conditions.
  - Increased Medi-Cal expenses (e.g., treatment services, care coordination)
  - Increased on-Medi-Cal expenses (e.g., local [non-federal] match obligations, room and board, Recovery Bridge Housing, navigation services, logistical time spent waiting at courthouse, etc.).
  - Increased administrative staff at DPH-SAPC to manage CARE Court process (programmatic staff, data staff, clinical staff for trainings and increased authorizations, etc.).

Recommendations

- **Overall, DPH-SAPC supports the CARE Court proposal and the eligibility criteria include both people with psychotic conditions and individuals with co-occurring SUD and psychosis.**
- **Recommendations**
  1. Specify that CARE Court eligibility criteria is only applicable when SUD is a non-primary co-occurring diagnosis and adding other language to safeguard against broadening this to primary SUD diagnoses.
  2. Clearly define medical decision-making capacity and limit the determination of medical decision-making capacity based on the presence of psychosis, as opposed to the presence of a substance use disorder even if psychosis is not present.
  3. Establish an SUD workgroup to allow for more time to thoughtfully shape the role of SUD participants in CARE Court.
  4. Recommend expansion of DMC-ODS as a fully funded State benefit.
     - Currently, DMC-ODS is considered optional and as a result, counties need to pay the local match for DMC-ODS services for newly eligible (post-ACA) clients, as opposed to it being a fully funded State benefit similar to the specialty mental health waiver where State General Fund is used to cover the local match for specialty mental health services for newly eligible clients.

Recommendations (cont'd)

5. Limit court orders to medically necessary Medi-Cal benefits.
   - If courts are allowed to mandate services that are not covered by Medi-Cal, this would essentially serve as unfunded mandated care from the perspective of counties.
6. Fully fund CARE Court activities.
7. Remove the proposed financial penalties for county behavioral health systems.
8. Ensure accountability of the managed care plans and private plans as well as county MH and SUD systems.
   - Counties are not the only entity responsible for delivering behavioral health services and thus managed care plans and private health plans must also be partners in CARE Court.

Discussion / Q&A

“The opposite of addiction is not sobriety; the opposite of addiction is connection.”

- Johann Hari