POLICY BRIEF

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CALIFORNIA POLICY LAB

Benioff Homelessness and Housing Initiative

UCSF

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766 San Francisco Residents may be Eligible for Referral to CARE Court

MARIA RAVEN, JENNIFER EVANS, DALLAS AUGUSTINE, KAITLIN DEWILDE, JAMILA HENDERSON, HEMAL KANZARIA, STEPHEN PAOLILLO, KENNETH PEREZ, LISA PRATT, ALISSA SKOG, AND JOHANNA LACOE

In 2022, California passed the CARE Court Law. Eight of California's 58 counties, including San Francisco and Los Angeles, are working to implement the law in 2023, with the remaining counties following in subsequent years. This brief estimates how many people in San Francisco may be eligible for referral to the CARE Court, based on an analysis of people who are already receiving urgent and emergent care services. This brief uses data from San Francisco's Coordinated Case Management System (CCMS) linked to data from the San Francisco Sheriff's Office and San Francisco District Attorney's Office.

KEY FINDINGS:

There are 1,700 San Franciscans with psychotic spectrum disorders who used the urgent and emergent care systems due to their serious mental illness in FY 2020. We estimate that 766 of these individuals may be eligible for referral to CARE Court based on them having had four or more urgent or emergent visits for serious mental illness in FY 2020.

Among the 766 people projected to be eligible for a referral to CARE Court:

1) 83% reported they were homeless in the past year.

2) Substance use disorders are common: over 76% have diagnoses for methamphetamine and other stimulant use disorder, and many have diagnoses for alcohol use disorder (51%) and cocaine use disorder (39%).

3) Conservatorship has not been widely used as a strategy to provide care for this group (only 17%).

4) Over one quarter of this group had an arrest within the last year.

5) The rate of one type of care - intensive case management – for this group is low, with only 27% of the potentially eligible population receiving it in FY2020. (Intensive case management programs focus on patients with serious mental illness and provide high-touch services to relatively small caseloads.)

INTRODUCTION

The state of California passed the California Community Assistance, Recovery, and Empowerment (CARE) Court[1] law in 2022 to provide behavioral health and housing services to individuals with psychotic spectrum and schizophrenia disorders who are deemed unable to care for themselves. Referred individuals who are deemed to be eligible will enter into a voluntary CARE agreement with the county behavioral health agency. While the care agreement is voluntary, those who decline to participate will be given a court-mandated CARE plan. This policy brief estimates how many San Franciscans in a database of individuals who have contact with the urgent and emergent care system may be eligible for referral to the CARE Court and what their services needs are.

The CARE court model derives from problem-solving courts, and other civil processes such as assisted outpatient treatment (AOT)[2] and LPS conservatorship[3] that have evolved for substance use, mental health, and domestic violence, among other specific problems, over the past 30–40 years. Funded primarily by local or state governments and housed within the legal system, problem-solving courts provide alternative solutions for people with chronic health and social challenges including homelessness, substance use, and domestic violence.[4] The success of these courts has typically been measured by the proportion of eligible individuals who are diverted from the criminal legal and carceral systems without re-offending.[5]

However, there are important differences between the problem-solving courts model and the current implementation plan for the CARE Court. First, while problem-solving courts only serve individuals after an arrest, many individuals will likely become involved in CARE Court despite never having been arrested. For example, a person with psychosis believed to be at risk of hurting themselves or others could be referred by a concerned family member to CARE Court for resources to support their mental health — even before any engagement with the legal system.[6]

Second, problem-solving courts traditionally focus on addressing specific areas of need such as housing, substance use, or mental illness — for example, mandating substance use treatment to divert people away from the criminal legal system and jail incarceration.[7] However, individuals' needs are often more complex, and frequently co-occurring such as other substance use and mental health disorders, as well as homelessness. The CARE Court model focuses primarily on psychosis due to schizophrenia and other psychotic spectrum disorders, but proposes to manage referrals under an integrated care or "client-centered" approach, addressing an individual's needs in a tailored fashion.

This brief identifies and describes a population of 1,700 people in San Francisco with schizophrenia or other psychotic spectrum disorders - unrelated to substance use - based on having at least two instances of a psychosis diagnosis recorded in the CCMS and the use of the urgent/emergent care system related to their serious mental illness (SMI). It then focuses on a subgroup of 766 especially high risk individuals who may be eligible for a referral to CARE Court. While all of those we identify in our analysis may not ultimately qualify for referral to CARE Court or may not be found by the court to meet the eligibility criteria, our aim is to help San Francisco and other California counties adequately plan and budget for CARE Court implementation based on this analysis of individuals' diagnoses, housing histories, and patterns of acute health service use.

DATA & DEFINITIONS

To identify individuals who may be eligible for referral to the CARE Court system, this brief uses linked healthcare and criminal legal system data from the City and County of San Francisco from FY19–20 (July 1, 2019 to June 30, 2020) (see definitions on page 3) and is guided by eligibility definitions provided in the CARE Court legislation (see Appendix A).

Per the legislation, an eligible individual is: "a person with untreated schizophrenia spectrum or other psychotic disorders" who "must be either unlikely to survive safely without supervision or be a threat to themselves or others without support."[8] In addition to meeting eligibility criteria, the petition to CARE Court requires either 1) an affidavit from a licensed behavioral health professional that the individual meets diagnostic criteria, or 2) evidence that the individual has been detained on two 5250 holds, with the most recent occurring in the past 60 days.

As described below, limitations in our data preclude us from being able to identify individuals with a recent history of two 5250s. However, we use several factors to identify individuals that may be eligible for referral to the CARE Court system based on other qualifying criteria outlined in the legislation under the affidavit pathway, understanding that all referrals may not ultimately qualify for services.

DEFINITIONS

5150 hold	72 hour involuntary hold based on being deemed a danger to oneself, another person, or being gravely disabled.
5250 hold	A 5250 hold is a 14-day extension of a 5150 hold. If a person has been placed on a 5150 hold, the attending psychiatrist can file a 5250 certification, attesting the person still meets one of the three criteria of the 5150 hold.
Serious Mental Illness (SMI) urgent/ emergent visit	The ICD-10 codes included in our definition of SMI are: F20, F22–F25, F29, F30–F34, F39–F45, F48, F50, F54, F60, F68–F73, F79, F90. These codes exclude visits coded as substance-use induced psychosis. We identified above ICD-10 codes pertaining to SMI from visits to emergency departments, psychiatric emergency services at ZSFG, inpatient psychiatric hospital stays at ZSFG, and Dore psychiatric urgent care clinic.

To create an approximation of the population who may be eligible for referral to CARE Courts, we first identify all individuals who had at least two instances of a psychosis diagnosis during FY 2020 recorded in CCMS and we exclude individuals with psychosis due to underlying substance use disorder (SUD). Next, we identify two subgroups-one with a history of at least one involuntary 5150 hold in FY2020, and a second subgroup of people with four or more urgent visits for Serious Mental Illness (SMI) in FY2020. We chose a threshold of 4 or more visits in FY 2020 as an indicator of frequent visits, as this is a threshold in the frequent ED user literature.[9] If a person met these criteria, we included them in our analysis.

While involuntary holds may be the best proxy measure of the inability to care for oneself among those with psychotic spectrum disorder (and thus eligibility for CARE Court referral), our data undercount the number of involuntary 5150 and 5250 psychiatric holds because the dataset only captures these holds when they are placed in the psychiatric emergency services unit at Zuckerberg San Francisco General Hospital (ZSFG). Recent data show that in FY 2020, only 20% of all mental health holds in San Francisco occurred at ZSFG[10], and most holds were placed in other settings including EDs and other designated psychiatric facilities throughout the city.

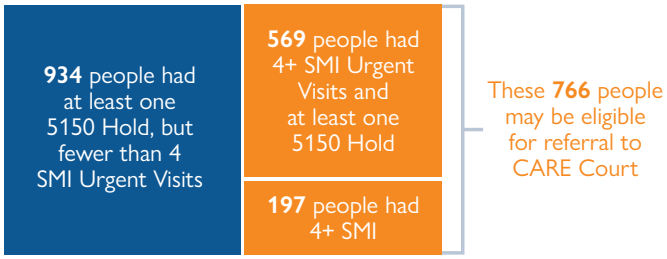
Because we are unable to fully capture the holds data, we use four or more urgent/emergent visits for SMI (during the year) as an additional proxy indicating an individual may be struggling to care for themselves as these individuals could be eligible for referral under the CARE Court affidavit pathway.[11]

To provide the most complete picture of individuals who may be struggling to care for themselves — even those who may not be eligible for a referral to CARE Court — we provide information on all 1,700 individuals with some use of the urgent/emergent system in our analysis (either at least one 5150 hold, 4+ SMI visits, or a combination) in this brief.

Given our data limitations regarding involuntary holds, we then narrow our focus to the subgroup of individuals with 4+ SMI visits as the group most likely to be eligible for CARE Court referral (Figure 1). Most individuals in this subgroup also have at least one 5150 hold documented in our dataset (see Methodology note).

The healthcare data are from the San Francisco Department of Public Health Coordinated Care Management System

FIGURE 1. Among 1,700 San Francisco residents diagnosed with psychotic spectrum disorder in FY 2020, a subgroup of 766 may be eligible for referral to CARE Court



Note: Of the 3,798 individuals in the CCMS data who had at least two psychosis diagnoses in FY2020, 2,098 had neither a 5150 hold or 4+ SMI urgent visits.
4+ SMI urgent/emergent visit group: 766 people who had 4+ SMI visits, of which 197 had no 5150 holds, and 569 had at least one 5150 hold.

(CCMS).[12] The data comprise records of nine urgent and emergent physical health, mental health, and substance use disorder services provided by San Francisco healthcare centers: emergency services, medical inpatient hospitalization, medical urgent care, psychiatric emergency services, psychiatric inpatient hospitalization, psychiatric urgent care, sobering center, medical withdrawal management, and social withdrawal management.

The criminal legal system data are from the San Francisco Sheriff's Office (SFSO) and San Francisco District Attorney's Office (SFDA), and include data on county jail bookings and arrests referred to the SFDA's office for prosecution. Data from both sources include general demographic information for each individual and are linked via a common identifier and anonymized for analysis.

RESULTS

Our analysis identified 1,700 individuals in San Francisco in 2019–20 with psychotic spectrum disorders who are frequent users of the urgent and emergent care system due to their serious mental illness.

Demographics

As shown in Table 1A, this population identified as mostly male (70.9%), White (35.0%) or African-American/Black (31.8%), and aged 26 to 45 (55.8%).

Behavioral health and physical health needs and services

This population of 1,700 individuals has high rates of physical and other behavioral health comorbidities. Over one-third (35.3%) were diagnosed with alcohol use disorder (AUD) in the past year, while 25.7% had diagnoses for cocaine use disorder and 21.3% for opioid use disorder, including Fentanyl. Because of the eligibility criteria in the legislation, we exclude substance use-induced psychosis diagnoses from our analysis because stimulant use can result in psychosis in the absence of underlying severe mental illness. However, over half (60.8%) have an underlying diagnosis of stimulant use disorder (e.g., methamphetamine and amphetamine), indicating a high degree of co-morbid SMI diagnosis and stimulant use. Among other health comorbidities, this population has especially high rates of depression (47.2%), and notable rates of hypertension (20.1%), cardiac arrhythmias (15.7%), chronic pulmonary disease (15.5%), and liver disease (10.9%).

This population had high rates of acute care service utilization, with a median of two psychiatric emergency services (PES). Over one-quarter (27.3%) had six or more emergency department (ED) visits, and 7.6% utilized an urgent or emergent substance use service (e.g. residential social and medically supported detoxification and rehabilitation services including the SF sobering center) in the past year. Less than 20% were enrolled in intensive case management during FY 2020.[13] It is important to note there are non-intensive case management services and outpatient treatment services for substance use and mental illness that are not captured in our data, which patients could have been receiving. However, given the characteristics of this population, many would benefit from the level of service provided by intensive case management programs.

Conservatorship

Within this group, 13.7% had a history of conservatorship. Our data include both temporary and permanent conservatorships, but because temporary conservatorships are more common, the actual percentage of individuals in our report who have been permanently conserved is likely much lower.

Housing needs and services

During the past year, a majority of individuals in this group indicated that they were currently homeless during an urgent/emergent care visit (1,201 people, or 70.7%), and 22.1% spent at least one day in a shelter (Table 1C). Almost half (48.0%) had been assessed for Coordinated Entry Priority Status, based on the barriers to housing, experiences of homelessness, and vulnerability assessed by the SF Department of Homelessness and Supportive Housing (HSH). Of those, 32.0% were not prioritized for housing within HSH's Homelessness Response System following their assessment, while 8.8% were prioritized and had an active housing referral through HSH, and 7.2% had a deactivated housing referral. We do not observe reasons in the data for prioritization or lack thereof. Referrals can be deactivated for multiple reasons, including if a client is lost to follow-up or doesn't accept a housing referral. Only 53 individuals (3.1%) were housed in permanent supportive housing (PSH).

Criminal legal system contact

Over one quarter of this population had criminal legal involvement in the past year: 456 were arrested at least once

in San Francisco and 136 were convicted. There was a median of two arrests for this group, and the highest number was 12. Almost half of the population had a history of arrest in the 10 years prior to 2020, and one quarter had a previous conviction in San Francisco (Table 1C).

Eligibility for CARE Court Referral: Focusing on Subgroup with 4+ Urgent Visits for SMI

Our data do not provide reliable estimates of involuntary 5150 and 5250 holds, and we are not able to provide an estimate of eligibility for referral to CARE Court based on the 5250 pathway outlined in the legislation. As outlined in our methods, we use high visit rates for serious mental illness to provide a narrower estimate of CARE Court referral eligibility.

We identify a subgroup of 766 individuals with at least four urgent/emergent visits for a SMI. Most of these individuals (569) also have at least one 5150 hold documented in our data, and it is likely that this subgroup actually has a higher number of both 5150 and 5250 holds than is reflected in our data. Understanding the needs and service histories of this group may help target services more effectively. (Table 1).

Behavioral health and physical health needs and services

Because the 4+ SMI Urgent Visits subgroup is defined based on their higher visit numbers, service utilization is higher in all categories relative to the overall group. Over one quarter of the 4+ SMI Urgent Visits Group was enrolled in intensive case management in FY2020 (Figure 2). The subgroup also has higher rates of all physical and mental health comorbidities, including for all SUD diagnoses. Some particularly notable differences include methamphetamine or other non-

FIGURE 2. Share of entire sample and of 4+ urgent visits for SMI subgroup receiving Intensive Case Management in FY2020

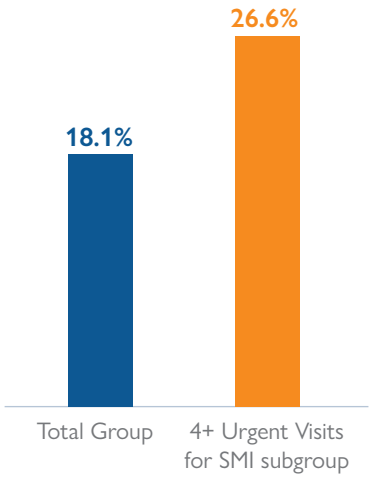


FIGURE 3. Most frequent behavioral health and physical health diagnoses among entire sample and among 4+ urgent visits for SMI subgroup in FY 2020

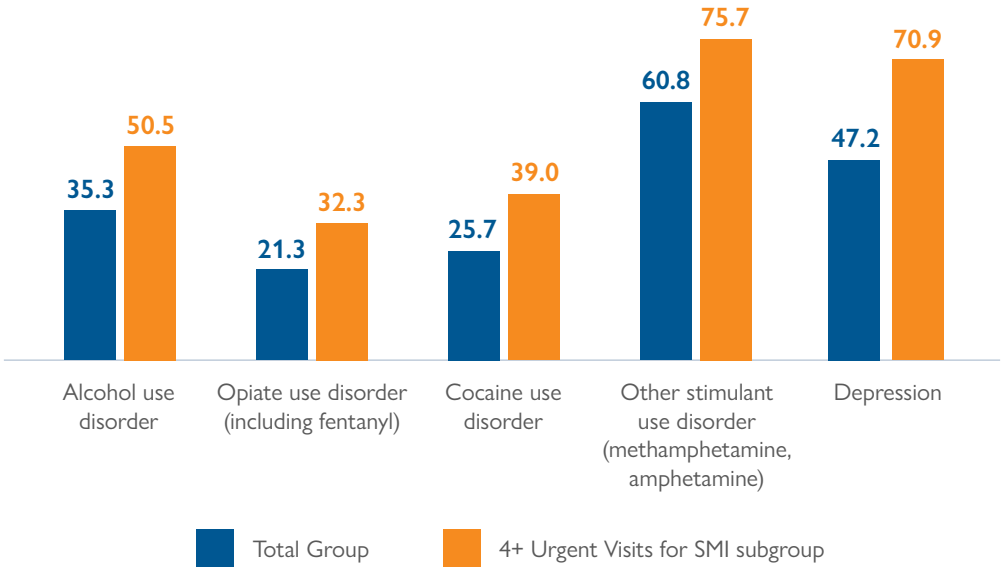


TABLE 1A. Demographics and service utilization for entire sample and for 4+ SMI urgent visits subgroup in FY 2020

	OVERALL SAMPLE (N = 1,700)		4+ SMI URGENT VISITS SUB-GROUP (N=766)[1]	
DEMOGRAPHICS	#	%	#	%
Gender				
Female	495	29.1	191	24.9
Male/Transgender/Other	1,205	70.9	575	75.1
Race and Ethnicity (self-identified)				
African-American/Black	541	31.8	273	35.6
Asian	224	13.2	79	10.3
Latino/a	230	13.5	103	13.5
White	595	35.0	269	35.1
Other	110	6.5	42	5.5
Age Group				
18–25	170	10.0	65	8.5
26–35	499	29.4	218	28.5
36–45	449	26.4	219	28.6
46–55	300	17.7	122	15.9
56–65	210	12.4	111	14.5
66+	72	4.2	31	4.1
Ever Conserved	232	13.7	130	17.0
SERVICE UTILIZATION			#	%
Median # of psychiatric emergency services (PES) visits past year	2	1-3	4	2–6
Number of emergency department (ED) visits				
0	299	17.6	52	6.8
1	379	22.3	77	10.1
2	213	12.5	77	10.1
3	167	9.8	79	10.3
4	92	5.4	52	6.8
5	86	5.1	53	6.9
6+	464	27.3	376	49.1
Any urgent/emergent substance use service in past year	129	7.6	103	13.5
Enrolled in Intensive Case Management (ICM)	307	18.1	204	26.6

[1] Number of SMI (Serious Mental Illness) visits is defined as the sum of ED visits with an SMI diagnosis, PES visits, and urgent care or inpatient mental health visits in the fiscal year.

TABLE 1B. Comorbidities for entire sample and for 4+ SMI urgent visits subgroup in FY 2020

	OVERALL SAMPLE (N = 1,700)		4+ SMI URGENT VISITS SUB-GROUP (N=766)[1]	
ELIXHAUSER COMORBIDITIES DIAGNOSED IN PAST YEAR	**#**	**%**	**#**	**%**
Alcohol use disorder	600	35.3	387	50.5
Opiate use disorder	362	21.3	247	32.3
Cocaine use disorder	437	25.7	299	39.0
Other stimulant use disorder (methamphetamine, amphetamine)	1034	60.8	580	75.7
Renal Failure	23	1.4	15	2.0
Peripheral Vascular Disease	18	1.1	12	1.6
Other Neurological Disorders	119	7.0	73	9.5
Obesity	58	3.4	35	4.6
Depression	803	47.2	543	70.9
Liver Disease	185	10.9	114	14.9
Hypothyroidism	46	2.7	32	4.2
Hypertension	342	20.1	208	27.2
Diabetes	159	9.4	87	11.4
Deficiency Anemia	52	3.1	30	3.9
Congestive Heart Failure	38	2.2	22	2.9
Coagulopathy	26	1.5	15	2.0
Chronic Pulmonary Disease	263	15.5	182	23.8
AIDS/HIV	108	6.4	65	8.5
Cardiac Arrhythmias	266	15.7	172	22.5
Fluid and Electrolyte Disorders	116	6.8	74	9.7

[1] Number of SMI (Serious Mental Illness) visits is defined as the sum of ED visits with an SMI diagnosis, PES visits, and urgent care or inpatient mental health visits in the fiscal year.

TABLE 1C. Homelessness, shelter days, housing supports and criminal justice involvement for entire sample and for 4+ SMI urgent visits subgroup, FY 2020

	OVERALL SAMPLE (N = 1,700)		4+ SMI URGENT VISITS SUB-GROUP (N=766)[1]	
	#	%	#	%
HOMELESSNESS/SHELTER DAYS				
Homeless in past year	1,201	70.7	637	83.2
Any days in shelter in past year	375	22.1	262	34.2
HOUSING SUPPORTS				
Coordinated Entry Priority Status (among currently homeless)				
Not assessed	625	52.0	264	41.4
Assessed, not prioritized	384	32.0	242	38.0
Housing referral active	106	8.8	73	11.5
Housing referral deactivated	86	7.2	58	9.1
Currently in permanent supportive housing (PSH)	53	3.1	30	3.9
CRIMINAL JUSTICE INVOLVEMENT			#	%
History of arrest in San Francisco in past 10 years	815	47.9	393	51.3
History of conviction in San Francisco in past 10 years	423	24.9	214	27.9
Arrest in San Francisco in past fiscal year	465	27.3	251	26.9
Conviction in San Francisco in past fiscal year	136	8.0	71	7.6

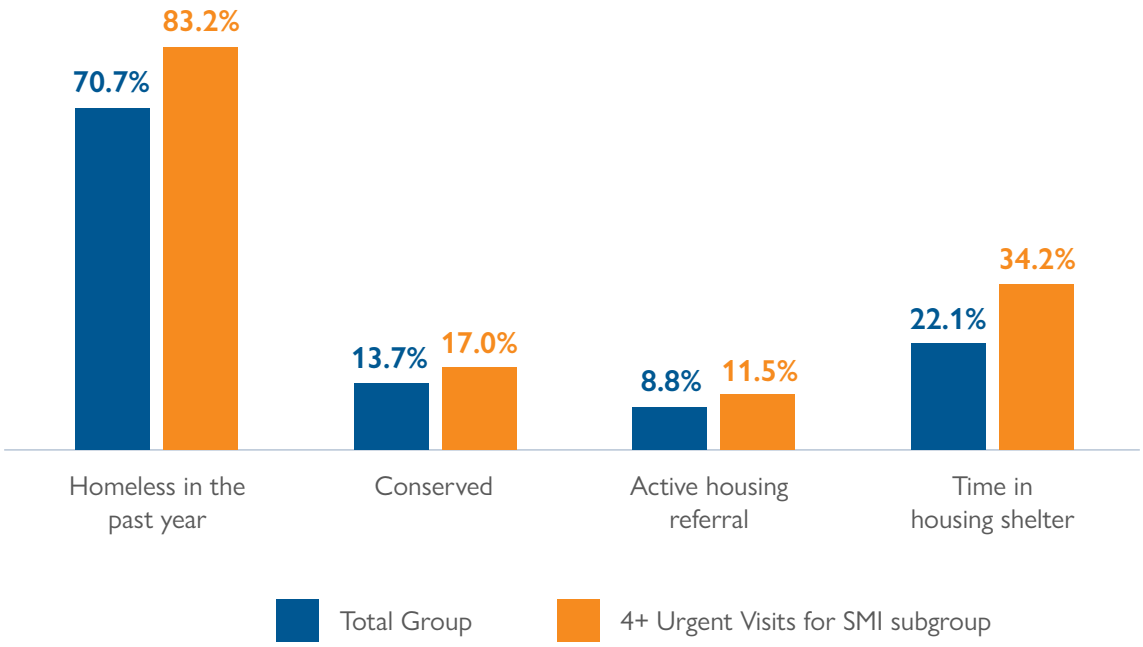
[1] Number of SMI (Serious Mental Illness) visits is defined as the sum of ED visits with an SMI diagnosis, PES visits, and urgent care or inpatient mental health visits in the fiscal year.

cocaine stimulant use disorder (75.7%) and alcohol use disorder (50.5%). This subgroup also has a high prevalence of depression diagnoses (70.9%). Of note, those already connected to an intensive case management service may not be eligible for CARE Court services if they are actively engaged in behavioral health treatment.

Housing needs and services and legal involvement

While the overall group of 1,700 individuals has high rates of homelessness, the 4+ SMI visits subgroup has a higher prevalence of homelessness (83%), and they are more likely to have been conserved (17%) (Figure 4). More members of this group have active HSH housing referrals (11.5%), and have spent time in shelters in the past year (34.2%). This may be due to their more frequent contact with acute care systems that result in more opportunities for connections to case management and other services. While the subgroup differs substantially from the overall group in most other domains, there are no notable differences in criminal legal involvement.

FIGURE 4. Share of total group and 4+ SMI urgent visits subgroup by housing and conservatorship status, FY 2020



POLICY AND SERVICE IMPLICATIONS

High needs, low engagement

Our analyses identifies 1,700 people with extremely high needs, striking rates of homelessness, criminal legal involvement, urgent/emergent service utilization, substance use disorders, and physical and mental health problems. Of these, 766 people may be eligible for referral to CARE Court. Despite these needs, only a small proportion of this population was enrolled in intensive case management and few individuals had been assessed for housing. These low rates of intensive case management and assessments may be indicative of the lack of service availability and/or the challenges around engaging a population without stable housing. The low engagement rates may indicate that those who are potentially eligible for a referral to CARE Court may be difficult to engage in their mandated CARE plans. Compared to the general SF population, both groups are comprised disproportionately of individuals who self-identify as African American/Black. This likely relates to systemic racism that has contributed to poverty, poor health, and homelessness among Black residents in San Francisco and throughout the country.

Lack of conservatorship resources

If an individual fails to complete their CARE Court-mandated care plan, that may be used as evidence in support of conservatorship, and we anticipate some individuals may

require conservatorship. However, San Francisco (and likely most other jurisdictions) does not have the resources to conserve these individuals, nor does it have sufficient non-carceral spaces to place them. The CARE Court is intended to divert these individuals away from conservatorship, jail, or to prevent contact with the criminal legal system entirely. However, there are currently not enough alternatives for placement. This is especially problematic given the high rates of homelessness among this population, who, without alternative spaces available, will likely return to homelessness and exposure to arrest.

Need for additional long-term solutions

One role of CARE Court may be to facilitate the allocation of, and draw attention to, the urgent need for additional psychiatric, long-term housing/placements, and other relevant services. In order to succeed, CARE Court must be adequately resourced from the start. Currently, resources are expected to be derived from existing funding and housing services including Mental Health Services Act, federal funds, and the proposed $1.5 billion for behavioral health bridge housing and other anticipated placements under Governor Newsom's $12 billion homelessness investments that began in 2021.[14]

Among those who are potentially eligible for a referral to CARE Court who have prior criminal legal involvement (e.g., arrest or conviction), CARE Court may prevent future incarceration; however, this possibility relies on the availability of adequate and appropriate health and social services and the willingness of people to participate in them. San Francisco is a city/county with relatively well-funded services and lower barriers to accessing those services, so these potential challenges could be even greater for jurisdictions that are less prepared or less well-resourced.

Serving individuals with private insurance

The Court will be working with a population that is extremely high need. Identifying and characterizing potentially eligible individuals using integrated county data (such as CCMS) may facilitate clearer estimates about the resources needed, and highlight the need for additional funding to support these resources. Participating counties may also see a small increase in privately insured individuals utilizing CARE Court who do not otherwise receive county-funded care and are therefore less likely to be in databases like CCMS.[15] Providing mandated care for these individuals (and billing their private insurers for that care) may require counties to develop systems to bill private insurers if they don't already have them.

Collaboration with CalAIM and CARE Court

To the extent that individuals eligible for CARE Court are enrolled in or eligible for Medi-Cal, CalAIM may provide some of the supports that are needed via its Enhanced Care Management and Community Supports. The Providing Access and Transforming Health (PATH) program is designed to expand access to such supports. PATH allows counties to apply for funding to build capacity among community-based organizations, public hospitals, county agencies, and others, allowing these entities to contract with Medi-Cal managed care organizations to increase capacity. In addition, PATH should support the Justice-Involved Capacity Building Program, that will support the ability of individuals who are incarcerated to access Medi-Cal services during their 90 days prior to release. Collaborative planning between those who are implementing CalAIM and CARE Court will be important to assure the most efficient allocation of new and existing resources, and to prevent duplication.

Evaluation of new CARE Court Model

Under the legislation, an independent evaluation of the effectiveness of the CARE Act is required. This evaluation should help determine if the program is effective at improving client health, housing, and wellness outcomes and worth additional resource allocation. It will be important for the evaluation to account for unintended consequences of the program, such as increasing the risk of criminalization of individuals with SMI, regardless of any potential health benefits.

In addition, providing preliminary analyses of the impact of the CARE Court model in San Francisco and other pilot counties could inform how it is implemented state-wide. San Francisco's existing linked cross-system data could be especially helpful for providing these insights.

LIMITATIONS

As we have outlined, our data are not comprehensive. The sample includes only users of publicly funded services, most of whom are insured by Medi-Cal, does not include city-wide data regarding any involuntary holds (i.e., 5150s and 5250s), and does not include reliable data on non-intensive case management programs. The CARE Act legislation allows a recent history of two 5250s to obviate the need for an affidavit from a behavioral health professional on a CARE Court petition. Counties with comprehensive 5250 data may consider using these markers to identify individuals who may be eligible for CARE Court. However, many individuals will likely be referred via affidavit

if they meet other criteria, so that 5250 data alone will underestimate the eligible population. Finally, some individuals who are completely disengaged from services may also be eligible for CARE Court referral, but are not captured in our data. We found high rates of co-occurring SUD in this at-risk population, including amphetamine use. It can be difficult to distinguish substance-use induced psychosis from psychosis due to psychiatric disease such as schizophrenia. It is possible that despite our effort to exclude SUD-induced psychosis, some diagnoses in our dataset were in fact due to substance use, which could lead to an overestimate of the population who may be eligible for referral, as some of those individuals may not be eligible for referral to CARE Court if there is no co-occurring SMI.

Our data encompass the first four months of the initial COVID lockdown (March 2020–June 2020). It is possible that the response to COVID-19 may have reduced the availability of services this population may have otherwise visited, including outpatient behavioral health services and shelters. This may have temporarily reduced access and service use, resulting in some individuals who would have otherwise frequently used these services from being included in this analysis. ED visits also dropped significantly during the lockdown, but some research shows that ED visits among people experiencing homelessness and those with behavioral health complaints did not decrease at the same rate as the general public, so the impact of this on our results is unclear.

METHODOLOGY APPENDIX

We examine the following data elements contained in the CCMS dataset: demographic information, service utilization, diagnoses, and housing factors. Demographics included client age, self-identified gender, and race. We base homelessness in the past 12 months on housing status recorded in the medical chart or provided by the San Francisco Department of Homelessness and Supportive Housing (HSH). History of conservatorship is defined as ever having been conserved. It is important to note that our data include temporary conservatorships, and not only the permanent conservatorships that would be more applicable for this population, and cannot be separated for the purposes of this report. Annual service utilization measures include the number of psychiatric emergency service (PES) visits, number of acute mental health visits per the SMI visit definition above, number of emergency department visits, and having any urgent or emergent visit for a substance use service. Recorded diagnoses are based on the Elixhauser Comorbidity Index.[16] We also examine whether patients were enrolled in intensive case management. Housing factors include Coordinated Entry Priority Status, currently residing in permanent supportive housing (PSH), and any nights in an emergency shelter in the past year. Coordinated Entry Priority Status are categorized as not assessed, assessed but not prioritized, or having an active or deactivated housing referral.

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Endnotes

1 "CA SB1338 - BillTrack50." **https://www.billtrack50.com/billdetail/1460095**.Accessed 19 Jun. 2022.
2 **https://www.sfdph.org/dph/comupg/oservices/mentalHlth/AOT/default.asp**
3 **https://www.scscourt.org/self_help/probate/conservatorship/conservatorship_lps.shtml#what**
4 "Problem-Solving Courts: A Brief Primer - Berman - Wiley Online ...." 16 Dec. 2002. **https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-9930.00107**. Accessed 19 Jun. 2022.
5 "What Makes a Court Problem- Solving?" **https://www.courtinnovation.org/sites/default/files/What_Makes_A_Court_P_S.pdf**. Accessed 3 Jul. 2022.
6 "Newsom's CARE Court a fix for broken mental health system." 11 Jul. 2022, **https://www.latimes.com/california/story/2022-07-11/california-mental-health-newsom-care-courts**. Accessed 11 Jul. 2022.
7 Paolillo, S., Cawley, C., Henderson, J., Kanzaria, H., Lacoe, J., Perez, K., ... & Skog, A. (2022, November). **Signals of Distress: High Utilization of Criminal Legal and Urgent and Emergent Health Services in San Francisco**. Berkeley, CA: California Policy Lab
8 **https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1338**
9 "Persistent Frequent Emergency Department Use: Core Group Exhibits Extreme Levels Of Use For More Than A Decade" Oct. 2017. **https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0658.** Accessed 12 February 2023.
10 " 'A ticket to nowhere': Thousands are brought to S.F. hospitals involuntarily. Then what happens?" 9 Feb. 2023. **https://www.sfchronicle.com/sf/article/mental-illness-san-francisco-hospitals-homeless-17772797.php.** Accessed 10 Feb. 2023.
11 Data encompasses all medical services for San Francisco Health Plan members at any San Francisco ED.
12 CCMS compiles information about complex, high-needs patients across multiple service domains by integrating data from several county agencies and the San Francisco Health Plan (SFHP), San Francisco County's primary Medicaid managed care plan. The database includes out-of-network medical services use for SFHP beneficiaries.
13 CCMS does not consistently record non-intensive case management and therefore statistics on this type of case management are not reported here.
14 **https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf**
15 California Health Benefits Review Program (CHBRP). Abbreviated Analysis: California Senate Bill 1338: Community Assistance, Recovery, and Empowerment (CARE) Court Program. Berkeley, CA: CHBRP; 2022. **https://www.chbrp.org/sites/default/files/bill-documents/SB1338/sb1338-AbbreviatedAnalysis.pdf.** Accessed 23 Feb. 2023.
16 Elixhauser comorbidities include alcohol use disorder, opiate use disorder, cocaine use disorder, other stimulant use disorder, renal failure, peripheral vascular disease, other neurological disorders, obesity, depression, liver disease, hypothyroidism, hypertension, diabetes, deficiency anemia, congestive heart failure, coagulopathy, chronic pulmonary disease, AIDS and HIV, cardiac arrhythmias, and fluid and electrolyte disorders.
17 **https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1338**

APPENDIX A: CARE COURT ELIGIBILITY CRITERIA AND PETITION REQUIREMENTS

An individual shall qualify for the CARE process only if all of the following criteria are met:

(a) The person is 18 years of age or older.

(b) The person is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for the CARE process.

(c) The person is not clinically stabilized in on-going voluntary treatment.

(d) At least one of the following is true:

(1) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

(2) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

(e) Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

(f) It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

And the petition requires:

(d) Either of the following:

(1) An affidavit of a licensed behavioral health professional, stating that the licensed behavioral health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent to submit to an examination, within 60 days of the petition, and that the licensed behavioral health professional had determined that the respondent meets, or has reason to believe, explained with specificity in the affidavit, that the respondent meets the diagnostic criteria for CARE proceedings.

(2) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to Article 4 (commencing with Section 5250) of Chapter 2 of Part 1, the most recent one within the previous 60 days.[17]