California Health and Human Services Agency
Community Assistance, Recovery & Empowerment (CARE) Act
Working Group Meeting Minutes
Wednesday, November 6, 2024 10:00 a.m. - 3:00 p.m.

Physical Meeting Information:
1215 O Street, Sacramento, CA 95814
Allenby Conference Room 110A[B]

Virtual Meeting Information: Zoom Webinar
Dial In: +1 669 254 5252 (Meeting ID: 160 352 7173)

Working Group Members in Attendance:

- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem Blue Cross
- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control (SAPC), Los Angeles Dept of Public Health
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jerry May,** San Jose Fire Department, Local 230
- **Dr. Katherine Warburton,** Chief Medical Officer, California Department of State Hospitals
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Hon. Maria Hernandez**, Assistant Presiding Judge, Superior Court of Orange County
- **Meagan Subers,** California Professional Firefighters
- **Monica Morales,** Office of Second District Supervisor for Santa Cruz County
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tim Lutz**, Director of Health Services, Sacramento County
- **Ashley Love,** Chief Community Assisted Treatment Section, Community and Crisis Care Programs Branch, DHCS standing in for Ivan Bhardwaj, Division Chief, Medi-Cal Behavioral Health – Policy Division, DHCS

Working Group Members in Attendance Online:

- **Amber Irvine,** San Diego County Behavioral Health
- **Charlene Depner,** Director, Center for Families, Children & The Courts, Judicial Council of California
- **Dr. Clayton Chau**, National Healthcare and Housing Advisors
- **Deb Roth**, Disability Rights California
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, California Business, Consumer Services and Housing
- **Jodi Nerell,** Director of Local Mental Health Engagement, Sutter Health (greater Sacramento)

- **Lorin Kline,** Director of Advocacy, Legal Aid Association of California
- **Ruqayya Ahmad**, Policy Manager, California Pan-Ethnic Health Network
- **Tracie Riggs**, County Administrator, Tuolumne County
- **Xóchitl Rodriguez Murillo**, Deputy Secretary, Minority Veterans Affairs, CalVet
- **Zachary Olmstead**, Chief Deputy Director, Department of Housing and Community Development

Working Group Members not in attendance:

- **Al Rowlett**, Chief Executive Officer, Turning Point Community Programs; Commissioner, MHSOAC
- **Anthony Ruffin**, Community Center Director 1, LA DMH Concierge Outreach Team
- **Dr. Veronica Kelley**, Director, Orange County Health Care Agency
- **Ketra Carter**, Homelessness Strategies and Solutions Department, City of San Diego

1. Welcome and Introductions

Karen Linkins, Principal, Desert Vista Consulting, welcomed the CARE Act Working Group (WG) members, both those present in person and those who joined online.

Linkins asked all members to introduce themselves briefly, beginning with new members: Jerry May, President, Local 230 San Jose Firefighters; Meagan Subers, California Professional Firefighters; and Amber Irvine, CARE Program Coordinator, San Diego Behavioral Health.

Deputy Secretary Stephanie Welch spoke to the importance of the perspective these new members are bringing to the group as people who are working in the field.

Linkins reminded the group to speak slowly for the ASL interpreters. She reviewed virtual meeting guidelines for the members who joined via Zoom and members of the public. She also reviewed essential operations information for the Working Group. She shared the 2025 meeting dates and encouraged members to submit agenda item suggestions for future meetings.

Linkins advised that there would not be an Ad Hoc report out by co-chairs, and shared updates on their behalf.

The Training, Technical Assistance, and Communications groups, along with the Services and Supports groups, met in September.

- They received updates from the Judicial Council on past and upcoming Training and Technical Assistance (TTA) activities for Cohorts 1 and 2, as well as services provided by self-help centers to potential petitioners.
- Discussions included essential petition pathways, identifying additional TTA needs for Cohort 2 and system partners, and strategies for engaging system partners in the CARE process.
- Jodi Nerell also updated the Services and Supports Working Group on Sutter's CARE pilot program at one of their facilities.

The Data Group did not meet in September but convened in October.

- They discussed essential petition pathways, received updates from the Judicial Council on data collection requirements for the courts, and heard from HMA about the upcoming early implementation report and reviewed new data requirements introduced in SB 42 and SB 1400.

In October, the Services and Supports and TTA Communications groups held a joint meeting.

- They heard from HMA about recent legislative changes introduced by SB 42 and SB 1400 and discussed the opportunities and impacts these changes would have on various components of the CARE process.

2. Keynote: CARE for People with Co-Occurring Disorders

Brian Hurley, MD, MBA, FAPA, DFASAM, Medical Director, Substance Abuse Prevention and Control, County of Los Angeles, Dept of Public Health

Linkins introduced Dr. Brian Hurley.

Dr. Hurley began with a brief disclaimer related to the medications mentioned in his presentation, then presented the following information on his learnings from his work in Los Angeles County:

- In the County Behavioral Health System, mental health and substance use disorder (SUD) have traditionally been addressed separately, with distinct funding and regulatory structures for specialty mental health services (SMS) and SUD services. Many individuals are served by both programs, including some who meet CARE eligibility criteria.
- Rather than prioritizing one diagnosis over the other—such as schizophrenia versus methamphetamine use disorder—it is more effective to recognize that these conditions coexist. As an addiction psychiatrist, determining a "primary" diagnosis based solely on evaluation is often impossible.
- For individuals with chronic psychotic conditions who also use substances, integrated care provides the best outcomes for addressing complex needs.
- The most commonly used substance among individuals with serious mental illness is methamphetamine, followed by cocaine, based on National Survey of Drug Use and Health data.
- In 2018, the County Department of Mental Health and the RAND Corporation evaluated how well the system of care addressed co-occurring disorders. About 8% of individuals with co-occurring disorders receive treatment for both conditions, leaving 91.7% untreated for one or both. This represents a significant treatment gap and an immense opportunity to improve care.
- Access to specialty care is a significant barrier, as evidenced by long waiting lists. Beyond access, many individuals are reluctant to seek treatment in separate programs due to stigmas, logistical barriers, and challenges in service coordination.
- County Department of Mental Health (DMH) data shows that while 20% of clients screened positive for heavy drinking, few were diagnosed or treated for alcohol use disorder (AUD). Addressing substance use greatly enhances recovery outcomes for individuals with chronic psychotic conditions.

- County behavioral health must offer a continuum of interventions in community-based settings designed for treating co-occurring disorders. Care should be brought directly to individuals rather than expecting them to seek it out.
- The Surgeon General highlights the need for integrated care across addiction treatment, primary care, community health, medical hospitals, and social services.
- ASAM and the American Academy of Addiction Psychiatry developed the *Management of Stimulant Use Disorder* clinical practice guideline that shows evidence that Contingency Management (CM) is the most effective approach for treating stimulant use. Medi-Cal funds CM programs, and details are available on the DHCS website.
- Dr. Hurley emphasized the critical importance of treating opioid use with medication.
- A toolkit, *How to Integrate Substance Use Disorder Care at Your Mental Health Clinic*, developed by the RAND Corporation and Dr. Hurley, provides guidance for co-occurring disorder care. It includes screening tools, workflows, and protocols, all of which are available online.

Q&A:

Dr. Hurley opened the floor for comments and questions.

Hon. Maria Hernandez asked Dr. Hurley about youth fentanyl use and intervention.

- Dr. Hurley responded that youth fentanyl use has increased overdoses, as fentanyl has replaced less lethal substances. Though the rate of youth substance use is down, the key to prevention is supporting families with the resources they need. He suggested addiction medications should be available in all youth programs, especially for fentanyl use disorder.

Bill Stewart thanked Dr. Hurley for his presentation and inquired on where there are opportunities within CARE to amplify integrated services.

- Dr. Hurley responded that CARE offers a full range of clinical interventions to be included in CARE agreements, such as contingency management, counseling, and other essential components. LA County is leveraging drug Medi-Cal to its fullest extent, focusing on practitioner prescribing rates, counseling, and care coordination.

Keris Myrick highlighted the persistent misunderstanding of 42 CFR Part 2 as a barrier for providers that often leads to reluctance or uncertainty in sharing information. Myrick also inquired on the trauma-informed approaches in co-occurring disorder and substance use treatment. Myrick also suggested that Housing First is the appropriate approach, as individuals often can be removed from housing due to continued substance use.

- Dr. Hurley emphasized that Housing First is a core component of CARE. He highlighted the need for a greater continuum of housing that meets individuals where they are, including designated spaces for supervised use and options for early abstinent housing. In response to Myrick's question about trauma-informed approaches, Dr. Hurley stressed that trauma must be treated as the rule, not the exception, in both SUD and chronic psychotis services. Seeking Safety is an excellent example of a flexible, trauma-informed approach that can be designed for individuals with co-occurring trauma and substance use. He added that 42 CFR Part 2 applies only if a provider or agency is explicitly holding itself out as a substance use treatment program. Integrated care for co-

occurring disorders—such as counseling, medication, and support—can often be provided without Part 2 encumbrances, as long as the services are not categorized under specialized SUD treatment.

Deputy Secretary Stephanie Welch noted concerns about individuals using stimulants being excluded from residential services due to perceived disruptive behavior. She highlighted the high prevalence of co-occurring substance use disorders, particularly methamphetamine use, in the CARE population. She asked for suggestions for addressing these challenges and combating related stigma within the system.

- Dr. Hurley emphasized the importance of dispelling the false narrative that individuals using methamphetamine cannot be helped and highlighted specific evidence-based practices. For patients with co-occurring mental health and methamphetamine use disorders, he stressed the need for frequent engagement and relationship-building through regular check-ins.

Amber Irvine inquired about any research or clinical trials exploring the efficacy of prescription stimulant medications in treating methamphetamine use disorder.

- Dr. Hurley confirmed that clinical trials are exploring the use of psychostimulant medications treating stimulant use disorders. Though not conclusive, the available evidence supports cautious use in appropriate cases.

Myrick emphasized the need to disaggregate data to better understand the demographics of the population served and stressed the value of a diverse workforce that reflects the community.

- Dr. Hurley highlighted that minoritized populations face disproportionate risks of chronic psychotic and substance use disorder diagnoses and that these same disparities exist for rates of substance use and overdose. He called for building a pipeline that fosters a workforce reflecting the diverse communities being served.

Myrick emphasized the importance of providers understanding when and how to disclose their lived experience appropriately, noting that such disclosure can foster trust and relatability.

- Dr. Hurley emphasized the importance of intentionality in disclosure to ensure it serves the patient's needs effectively.

Dr. Warburton noted that despite decades of discussions about integrating mental health and substance use disorder (SUD) services, significant gaps remain. She asked what Dr. Hurley has observed about the barriers to this integration.

Susan Holt also inquired about opportunities to advocate for increased SUD treatment training within general mental health professions.

- Dr. Hurley highlighted disparities in investments, noting that while community mental health programs have received significant funding for decades, substantial investments in SUD systems, like DMC-ODS, only began in 2016. He stressed the importance of investments to enhance training, expand workforce capacity, and establish parity with community mental health systems.

Dr. Clayton Chau asked about the potential for California's direct Medi-Cal system to fund outreach initiatives to better engage communities affected by substance use disorders (SUDs). He also inquired whether the recent easing of Part 2 restrictions would make integration efforts easier.

- Dr. Hurley noted that while some improvements have been made, Part 2 is still not fully aligned with HIPAA and written authorization for information sharing is still required. He

highlighted ongoing advocacy, including by ASAM, for further alignment to streamline care. On the topic of Medi-Cal-funded community outreach, Dr. Hurley pointed to Los Angeles County's efforts to expand field-based services, noting ongoing capacity constraints.

Holt highlighted the growing disparity between private and public behavioral health sectors. Particularly in residential SUD care, private providers struggle to make public-sector rates viable. This disparity exacerbates workforce challenges, especially in recruiting and retaining Alcohol and Other Drug (AOD) counselors. Holt stressed the need for collaborative efforts across the state to incentivize and support the behavioral health workforce. She also pointed to challenges in provider enrollment, licensing, and administrative processes, suggesting that these systems be streamlined.

- Dr. Hurley replied that SUD rates are set by the state, limiting flexibility. In Los Angeles County, efforts are underway to prepare for value-based care through payment reform initiatives. These include locally developed incentive programs, such as bonuses for providers meeting specific criteria. He also discussed various challenges associated with residential SUD programs being classified as non-medical services. Dr. Hurley expressed gratitude for DHCS's collaborative efforts on this topic and stressed the importance of workforce development and accurate cost data to inform rate-setting and payment reform.

Deputy Secretary Welch expressed her appreciation for Dr. Hurley's involvement in the group, emphasizing the importance of practical, real-world input from those working in the field.

3. Representatives from California Health and Human Services Agency, Department of Health Care Services, and Judicial Council

California Health and Human Services Agency

Deputy Secretary Stephanie Welch reflected on the progress and challenges in implementing Behavioral Health Transformation, emphasizing the importance of integrating initiatives like the CARE Act into the broader vision of the administration's approach.

- Passage of key legislation during 2020/2021 helped increase efforts toward mental health parity. Despite limited resources from the original Mental Health Services Act, the Proposition 1 Behavioral Health Services Act (BHSA) bond will enable counties to increase housing options.
- By the end of her career, she hopes to see a truly integrated system that serves individuals with commercial or employer-based insurance, including those with conditions like schizophrenia. Many initiatives underway, including those in the Behavioral Health Continuum Infrastructure Program, will not fully materialize until the end of this decade.
- While work on CalAIM began before the pandemic, its significant implementation occurred during and after. The goal is to modernize the Medi-Cal system to support best practices in both care delivery and administration for behavioral health.

- FY 2022/2023 focused on creating behavioral health crisis call centers in California, aimed to strengthen the overall crisis care system, not just improve response capabilities. AB 988 - Miles Hall Lifeline Act, was signed by California legislature and Governor Newsom.
- The passage of the CARE Act introduced a new pathway for individuals with severe behavioral health needs to receive assistance first.
- Behavioral Health Connect (BH Connect) aims to create community-based, equitable care networks by focusing on delivering evidence-based practices effectively within Medi-Cal programs.
- BHSA will better equip counties to provide tiered levels of care based on acuity and need. It enables individuals to step down from intensive ACT-level care to lower levels while maintaining intensive case management and ensure flexibility and continuity of care for long-term support.
- Deputy Secretary Welch highlighted how individuals in the CARE process will benefit from the broader project of system transformation.

Deputy Secretary Welch recognized the critical work being done daily by those on the ground. She noted the current moment of transformation in behavioral health care and the potential impacts of the presidential election result. Deputy Secretary Welch expressed optimism about California's potential to lead the nation in designing a system that takes care of people and meets individuals where they are at.

Deputy Secretary Welch shared additional reflections on CARE, focusing on essential learnings in the lead up to Cohort 2 counties launching.

- Deputy Secretary Welch sees CARE as a necessary and effective pathway for some individuals. While the civil court process might feel traumatizing for some, it has also proven to be transformative and effective for others.
- Reports from professionals highlight the success of CARE in enabling radical and relentless engagement. This approach is working; people are becoming receptive and engaging with services because of CARE.
- Even if CARE isn't the right fit for an individual, filing a petition could still help ensure the individual is found and engaged in services.

In closing, Deputy Secretary Welch reminded the group that the focus of CARE is on meeting people where they are, providing multiple chances for engagement and support, and ultimately ensuring individuals receive the care they need.

Deputy Secretary Welch invited questions from Working Group members.

Herb Hatanaka expressed his appreciation and invited her to relay the message to his team.

- Deputy Secretary Welch shared that she is inspired by everyone involved in implementation, especially those in the Cohort 1 counties doing direct service work.

Holt expressed support for the emphasis on outreach and engagement, noting that practice-based evidence shows it's crucial.

Tim Lutz echoed Holt's comments. He highlighted the frustration of the numerous touches required for engagement, which can be difficult to explain to community groups or elected leaders. Lutz emphasized the importance of seeing CARE as an essential tool within the system. He also pointed out a gap in local efforts, particularly in direct engagement with city partners, and suggested working with cities to leverage CARE more effectively.

Lauren Rettagliata expressed that as a resident of a Cohort 2 county, she has noticed CARE implementation already improving existing programs, as the county has expanded assertive community treatment (ACT) capacity. She also highlighted how the CARE Act empowers loved ones by giving them a formal way to articulate the challenges they face and the needs of their family members who are not receiving care.

Stewart shared a personal perspective as a direct consumer, highlighting the positive impact of the CARE Act. He acknowledged that while the program is still in its early stages, it is making a significant difference by connecting individuals with resources and support they otherwise wouldn't have had.

Department of Health Care Services

Linkins introduced Ashley Love, Chief, Community Assisted Treatment Section, Medi-Cal Behavioral Health – Policy Division, to present updates from DHCS.

- DHCS' primary responsibilities regarding CARE implementation include providing training and technical assistance, developing materials and offering consultation to state partners, counties, and other stakeholders, and issuing guidance.
- DHCS is also tasked with: Administering startup funds, the accountability fund, and ongoing costs related to CARE, developing and publishing the annual report and supporting the independent evaluation of CARE.
- Two bills (SB-42 and SB-1400) have been signed that include modifications to data collection/reporting requirements and changes to the CARE process.
- SB-42 requires County Behavioral Health to accept referrals from LPS-designated facilities and file petitions for eligible referred individuals who do not engage voluntarily.
- Other updates implemented through the new legislation include: Clarifications on what evidence can support a CARE petition, changes to enable communication between CARE courts and referring courts, requirements for CARE to be considered as an alternative in temporary conservatorship proceedings, an extension to the timeline for counties to file investigative reports, and a mandate that courts provide ongoing notice of proceedings to the petitioner.
- These changes are crucial to improving the CARE process and the services and supports offered.

Deputy Secretary Welch emphasized that, in response to feedback from counties, more time is needed for engaging with clients. She reminded the group that through CARE, counties receive reimbursement for this outreach.

Love continued her presentation:

- Legislative updates expand the scope of data collection to include outreach and engagement activities, services offered before petition filing, CARE inquiries made to

counties, system referrals, and early CARE process stages, including reasons for petition dismissals.
- The aim of these changes is to monitor pathways into CARE, determine if individuals are connected to services, and identify the specific services they receive. Later in the day, HMA will provide an overview of training, technical assistance, and updates to the data dictionary to reflect these legislative changes.
- DHCS's upcoming milestones through 2024 and into 2025 include publishing the Early Implementation Report in the coming weeks, collecting stakeholder feedback on the Revised Guidance for Data Collection and Reporting, publishing the Draft Revised Data Dictionary in early 2025 for stakeholder comment, and issuing guidance on referral forms and procedures for facilities and county behavioral health agencies based on SB-42 requirements.
- DHCS is engaged in ongoing collaboration with HMA and state partners to define key performance indicators for the CARE Act's annual report. HMA is drafting this report, which will be published on the DHCS website by July 1, 2025.
- DHCS continues to collaborate with the RAND Corporation to support the independent evaluation of the CARE Act.

Love invited questions and comments.

Deputy Secretary Welch asked Love to elaborate on what stakeholders can expect from the early implementation report. She underscored the importance of viewing the report as an early snapshot rather than a comprehensive analysis, acknowledging the ongoing nature of the evaluation process.

- Love explained that the early implementation report will focus on aggregated trial court data reported to DHCS via the Judicial Council. The report will cover key metrics such as the number of petitions submitted, dismissals, CARE participants, and court hearings during the first nine months of implementation, from October 1, 2023, to June 30, 2024. She emphasized that this early report will not delve into specific client outcomes or participant data on services and supports, which will be included in the annual report.

Myrick inquired about funding for outreach and engagement efforts.

- Love confirmed that counties can claim reimbursement for administrative activities, including outreach and engagement efforts.

Myrick expressed the need for California to prioritize outreach and engagement for individuals outside of the CARE process, as people often fall through cracks due to gaps in services. Myrick also questioned how California could leverage Medi-Cal to provide preventive services and outreach earlier in the process, ultimately aiming to reduce the need for crisis-level interventions like those under the CARE Act.

- Deputy Secretary Welch acknowledged that addressing outreach and engagement for individuals not currently in CARE is a critical issue. She emphasized the importance of learning from the CARE model and said that throughout the behavioral health system, outreach and engagement must be proactive and ongoing. Initiatives like CalAIM, Behavioral Health Connect (BH Connect), and the Behavioral Health Services Act offer opportunities to strengthen these efforts. She invited Beau Hennemann to comment, as he has expertise with managed care plans and their initiatives.
- Hennemann responded, emphasizing that outreach and engagement are already happening across various programs. The challenge is to connect these efforts to create an integrated approach, particularly through CalAIM, community health workers, health plans, and enhanced case management.

- Deputy Secretary Welch emphasized that the partnership between managed care plans and behavioral health services is crucial for a holistic approach. Welch also mentioned the role of Prop 1 planning locally, stressing that if all parties involved are supported in their roles, the overall system can more effectively meet individuals' needs.
- Holt acknowledged value of Enhanced Care Management (ECM) but pointed out that it is still in the early stages in her county. She emphasized that the current reimbursement rates for outreach and engagement in her community are not sufficient to meet the needs of those she serves.

Monica Morales highlighted the challenges her county faces in balancing multiple responsibilities with limited resources, including a significant staff vacancy rate and reduced reimbursement rates under CalAIM. Morales expressed that while they share the goal of serving the community, the current policy structure is making it difficult to achieve those objectives.

Hennemann acknowledged the challenges of leveraging new opportunities like ECM, Community Health Worker benefits, and street medicine, noting that these programs are still in development. Hennemann also highlighted the issue of blended funding streams, which can create administrative burdens for community-based providers.

Hon. Hernandez expressed concerns about resource challenges, particularly in light of Prop 36, which mandates counties to provide treatment. She noted that the populations discussed in the CARE Act could overlap with those affected by Prop 36, especially those who end up incarcerated. As both justice partners and treatment providers, she asked how this would be addressed moving forward.

Holt related the long-term nature of the work to her experience as a distance runner, sharing that the fastest way to the finish line is through teamwork. She expressed gratitude for the opportunity to be part of conversations like this one and hoped that, alongside Deputy Secretary Welch and state colleagues, expert voices would continue to shape policy decisions.

Additional Background on Legislative Changes

Deputy Secretary Welch reflected on the lessons learned during the first year of CARE Act implementation, noting the initially low petition volume from system partners, such as conservators, public guardians, and behavioral health directors. Deputy Secretary Welch noted that one of the criteria for CARE is multiple 5250s (involuntary holds), meaning that eligible individuals are coming into contact with various systems that could initiate a CARE petition.

She shared that one of the motives of CARE is to offer a less restrictive alternative to conservatorship, potentially serving as a stepping stone from conservatorship to a community-based housing setting. She highlighted the importance of engaging public guardians and to identify individuals who might benefit from CARE as an off-ramp.

Deputy Secretary Welch explained that she had expected to see more petitions coming from behavioral health providers working with individuals who frequently cycle through institutional settings but do not engage in long-term care. She shared data on the volume of 5150 and 5250 holds, emphasizing that there is a significant opportunity to engage these individuals, particularly those who are stable or could be stabilized with ongoing support.

She also highlighted that people who are stable upon discharge from jail could benefit from a CARE petition to ensure they continue to receive necessary support. Additionally, she emphasized the opportunity CARE provides for first responders, who work closely with behavioral health professionals and encounter individuals in crisis.

Deputy Secretary Welch continued by addressing efforts to improve the petition process for system partners. To address this, state partners have worked on creating simple videos to help

first responders and staff at LPS-designated facilities understand the petition process. Additionally, they have been working with mental health service providers in jails to educate them on petition filing. This is part of a broader effort to educate counties, especially Cohort 2 counties, about the lessons learned and the importance of using CARE as a tool for high utilizers of services, such as those frequently hospitalized or incarcerated, to address their ongoing care needs.

Deputy Secretary Welch introduced Frank Congine, Assistant Deputy Director for Forensics at Orange County Health Care Agency, to update the group on their efforts to partner with the jail system.

Congine provided updates, emphasizing the importance of refining and simplifying processes for a smooth transition from incarceration to community care. He highlighted the collaborative efforts of various departments, including Custody Health Services, Probation, and the Mental Health Collaborative Courts. Their Jail to Community Reentry Program (JCRP) has integrated outreach and engagement teams to avoid information overload and reduce redundancy. The county held a large training session for around 80-100 team members, including outreach and engagement workers, JCRP team members, and jail partners, to ensure everyone was aligned on how CARE can be used to help individuals leaving jail without stable treatment. Congine highlighted the support of judges, public defenders, and county council, which helps ensure individuals are stabilized in treatment before petitions are dismissed, with the option to reopen cases without re-filing.

Hon. Hernandez asked how many petitions have been filed in Orange County by the jail system.

Congine mentioned that while he didn't have the exact count of petitions at hand, he has noticed a recent uptick and Orange County submits this data weekly. He echoed Deputy Secretary Welch's approach of encouraging people to think of CARE as a primary tool. Congine also touched on the clinical challenges in assessing stability for individuals whose environmental circumstances are shifting, underscoring CARE's role in ensuring continuity of care.

4. Lunch

5. Feedback on Statewide Communications Tools and Telling the Story of CARE

Representatives from San Diego County

Linkins introduced Amber Irvine, Behavioral Health Program Coordinator, and Melody Culhane, Behavioral Health Program Manager, both leading the CARE Program in San Diego. They presented their process for transitioning individuals from conservatorship to CARE and shared a 60-second video highlighting the program's first graduation.

Irvine shared that when the CARE legislation was signed in September 2022, San Diego County immediately identified it as an opportunity to step individuals down from restrictive conservatorships to community-based programs offering intensive supports. The goal was to prevent the common cycle of decompensation and re-conservatorship. To achieve this, San Diego built its CARE program under the umbrella of the Public Conservator’s Office to facilitate diversions during LPS assessments or step-down transitions to community care.

Culhane noted that many individuals, while stable enough to leave restrictive environments, lack the necessary resources to succeed in the community. CARE provides the additional oversight and support needed to prevent relapse and hospitalization.

Linkins inquired about the respondent's role during step-down meetings.

Culhane responded that before discussing a step-down, the Public Conservator's office engages the conservatee directly to gauge their interest and understand their recovery goals. The focus shifts from simply maintaining stability under conservatorship to exploring how they can move forward in their recovery. Forensic psychologists involved in re-establishment evaluations are encouraged to have similar conversations with conservatees to determine readiness for a step-down. Culhane emphasized that collaboration with the conservatee is crucial before filing a CARE petition.

Linkins asked Irvine and Culhane what advice they would give to Cohort 2 counties.

Culhane highlighted three critical elements for a successful transition from conservatorship to CARE:

- Voluntary Participation: The program's voluntary nature encourages individuals to actively engage in their recovery, which is key to their success.
- Support System Communication: Maintaining communication with family, case management, and other support systems ensures stability.
- Collaboration: Close collaboration with community partners and public defenders helps facilitate a smooth and successful transition.

Linkins asked how San Diego communicates with clients about what CARE is through a trauma-informed lens.

Culhane said she explains the difference in the environment between CARE court and conservatorship hearings. She emphasized that CARE focuses on empowering individuals by discussing their goals, such as family reunification, community engagement, or personal milestones. The goal is to provide support for every individual's specific objectives.

Culhane acknowledged that smaller counties might face challenges building similar infrastructure. To support continued growth, San Diego is focusing on leveraging partnerships like the Mobile Crisis Response Team (MCRT) for more referrals.

Irvine explained that to address concerns about the administrative burden and uncertainty around the petitioner's role, they've streamlined the process. For example, a simple text or call informs petitioners when a hearing is approaching, allowing Behavioral Health Services (BHS) to replace them and complete the process virtually in under a minute. Additionally, Irvine mentioned exploring the potential for a hospital liaison within the CARE team, particularly for psychiatric hospitals, to ease petition filing and connect more eligible individuals to CARE.

Culhane and Irvine invited questions.

Rettagliata asked for clarification about the specifics of the process for individuals under LPS conservatorship transitioning to CARE.

- Culhane explained that the process is collaborative, with the public conservator's office filing the internal petition, which makes BHS the designated petitioner. BHS staff meet with individuals to explain CARE, addressing concerns and clarifying that the court element is about county accountability. They also communicate with the individual's family, with permission, to ensure everyone involved understands the process.

Rettagliata expressed optimism about the potential positive impact of CARE, particularly in light of the challenges that individuals often face after being released from conservatorship.

Linkins asked Irvine about recent reports of outcome data from San Diego.

- Irvine shared data showing significant improvements in crisis service utilization data as well as promising data related to participants accepting medications. Irvine emphasized that these results challenge misconceptions about people with psychotic disorders being unwilling to engage in their own treatment.

Morales inquired about how the CARE program is supporting unhoused individuals and how the referral process to housing is working in San Diego.

- Irvine shared that 35% of CARE respondents were unhoused at the time their petition was filed, with an additional 11% incarcerated and at risk of being unhoused upon release. After engagement in CARE, 83% of participants have achieved stable housing. In San Diego, CARE participants are prioritized for short-term bridge housing through contracts with independent living facilities.

Culhane emphasized that the CARE program is proactive in providing support to individuals, even before they formally enter into an agreement. The team works to connect participants with services, such as residential treatment programs, even if their eligibility for the program is still being determined.

CARE Success Stories

Linkins highlighted the importance of sharing CARE success stories at both the individual and system level. Neimand Collaborative has been engaged to help tell these stories. Linkins introduced Rich Neimand and Erin Hart, who are leading efforts in collaboration with San Diego to start capturing and sharing impactful CARE stories.

Deputy Secretary Welch emphasized the importance of sharing real, comprehensive stories about individuals navigating the CARE process. The goal is to highlight both the experiences of the individuals and the efforts of professionals actively working on the ground. Deputy Secretary Welch also pointed out that misconceptions about CARE create misinformation and stigma and stressed the need to correct these narratives. The stories Neimand Collaborative wants to tell focus on dispelling myths and showing how CARE helps individuals access local services.

Rich Neimand expressed gratitude for being part of the discussion, highlighting the collaborative energy present in the room. He emphasized the goal of capturing and sharing stories, fostering connections between stakeholders to improve outcomes for underserved populations.

Neimand explained that Neimand Collaborative is a social impact marketing firm with extensive experience in public health, health systems, and collaborations across the nation. Their approach uses both informal and formal methods to ensure effective communication and culturally aligned care. Neimand introduced his team, mentioning that Erin Hart was attending in person, while Karolyn Cooper, Vice President of Research to Impact, and Tracy Zimmerman, Vice President of Strategic Communications, were joining virtually.

Hart highlighted the importance of capturing individual stories to convey the nuances of the CARE process. Hart stressed that telling a range of individual stories allows people to understand how CARE works on a personal level, demonstrating its power and impact.

Linkins invited Irvine to share the specific story being developed as a case study by Neimand Collaborative.

Irvine shared a story about a CARE participant who was petitioned by her husband. The participant had young children and experienced her first episode of psychosis shortly after giving birth, leaving her unable to care for herself or her child. Initially resistant to help, she eventually entered treatment after months of outreach and engagement. She has now entered

into a CARE agreement and agreed to a long-acting injectable, and has become an active, present mother, and is now seeking employment. Irvine highlighted this story as one of many illustrating CARE's transformative effects on participants.

Working Group Discussion

Linkins thanked Irvine and transitioned to an open discussion, asking members which audiences the story might resonate with and how these stories can effectively demystify CARE at the local level and broaden its impact and reach.

Stewart expressed a concern about ensuring balance in the narratives being shared. He suggested highlighting diverse nuances in the experiences of individuals diagnosed with schizophrenia would make the stories resonate with a wider group of people.

- Hart asked Stewart for specific elements he believed should be emphasized in stories, inviting suggestions on aspects that could resonate or provide greater clarity for audiences. She noted that public health work often involves incremental progress with occasional setbacks, and agreed with Stewart that stories that highlight this reality are more reflective of the true nature of the work.

May shared his perspective, emphasizing the importance of focusing on the beginning of the CARE process, which often starts with a 911 call. He highlighted the critical role of first responders, including firefighters and police officers, who frequently encounter individuals in crisis. May advocated for greater collaboration, particularly with those on the front lines.

Myrick emphasized the importance of trust-building and therapeutic alliance, highlighting that trust, not medication or court orders, is the key to fostering treatment engagement. She raised concerns about stories focusing on medication as the central solution. Myrick stressed the importance of respecting "no" and addressing life aspirations alongside treatment.

- Linkins expressed gratitude to Myrick for consistently reminding the group that CARE is about helping people as whole individuals, not just focusing on their diagnosis.
- Neimand thanked Myrick for highlighting the importance of seeing individuals beyond their diagnoses, which helps the team tell more authentic stories.

Linkins transitioned to a discussion about the challenges with the CARE petition process, highlighting gaps in local knowledge about petition pathways, particularly for first responders and hospital partners. She introduced Dr. Deborah Rose from HMA who led the creation of a five-minute video to demystify the petition process. The video can be viewed here: Community Assistance, Recovery, and Empowerment Act: Petitioning at a Glance.

Linkins stated that the idea for the petitioning video originated from the TTA ad hoc group.

Holt expressed appreciation for the video and shared details about Fresno's communication strategies leading up to implementation.

Deputy Secretary Welch asked what measures are being taken to ensure the video on the petition process reaches the right people and is effectively shared.

- Amanda Ternan shared various strategies that HMA is using to disseminate information and resources, including the petitioning video.

Holt was asked if the video will be converted to other languages.

- Laura Collins shared that there are a variety of petitioning resources available, including those in other languages, though the new video has not been translated.
- Dr. Chau suggested considering funding to duplicate the video into various languages, such as Korean, Chinese, and Spanish, and airing it on different language media outlets.

6. Break

7. Update on Recent and Upcoming Training and Technical Assistance Activities

Representatives from Health Management Associates (HMA)

Linkins introduced representatives from HMA to give an update on their recent and upcoming activities. Laura Collins led the presentation, joined by Amanda Ternan, Patricia Doxie, and Dr. Rose. She shared the following information on TTA for petitioners:

- Petitioning is now a key TTA focus, driven by stakeholder feedback. HMA has developed multiple trainings that cover petition basics, form completion, documentation tips, and referrals. HMA is also offering office hours for ongoing assistance for petitioners. The petitioner's training series will conclude at the end of the year.
- A dedicated petitioner's page is now live on the CARE Act Resource Center, featuring detailed overviews of forms and specialized resources for various petitioner types.
- HMA is engaging in ongoing efforts to reach all eligible petitioner groups and system partners with targeted trainings on petitioning, tailored to the needs of each audience.
- To ensure widespread participation, outreach is underway to eligible petitioner types, including leveraging listservs and community connections.

Collins outlined recent resources developed to support counties with implementation:

- A billing guide tailored for commercial payers is now available, developed in response to requests from counties. This guide has already been piloted with select counties to ensure accuracy and usability.
- Trainings specific to the needs of rural and frontier counties have been developed, complemented by regular TA calls, where counties collaborate and share strategies.
- Additional resources available include briefs on SB-42 and SB-1400, office hours focused on data, reporting, petitioning, and implementation, and targeted support as counties prepare for go-live.

Ternan provided additional information on HMA's ongoing implementation support efforts:

- Each county is supported by one of 12 HMA liaisons. Liaisons triage requests, connect counties with relevant resources, and facilitate collaboration between counties or with other stakeholders, such as courts.
- The implementation resource guide has recently been updated with additional guidance on topics like billing, court coordination, and public defender engagement.
- HMA is actively supporting counties with data collection and reporting, with dedicated resources, training, and assistance for file transfer applications.
- HMA developed a communications toolkit for counties, offering templates for newsletters and stakeholder events.
- TTA is tailored to each county based on their responses to the quarterly Implementation Status Survey.

Ternan outlined the contents and learnings of the recent Q3 Implementation Status Survey:

- The survey tracked counties' readiness for CARE Act implementation and was completed by all 50 Cohort 2 counties.
- 46 counties (92%) reported being completely on track to implement by December 1.

- The survey also tracked counties' progress on key CARE Act implementation activities from Q1 to Q3, with marked increases in areas such as workflow development, communications planning, stakeholder training, and data collection support.
- Targeted TTA is being provided to assist counties lagging in specific areas.

Ternan briefly reviewed the resources available through the CARE Act Resource Center:

- The CARE Act Resource Center offers a range of tools and information, including an overview video to guide users through features like search functions, multilingual support (23 languages), and resource pages for families, volunteer supporters, and petitioners.
- Key offerings include upcoming training schedules and FAQs (currently over 50).
- HMA representatives are available for one-on-one Resource Center tutorials.

Collins wrapped up by discussing HMA's plans for 2025:

- Focus areas for 2025 include enhancing referral pathways for petitioning (formal and informal), supporting CARE-specific assessment and treatment planning tied to agreements and plans, and addressing the role of volunteer supporters.
- The team will continue the schizophrenia spectrum disorders series with topics such as stigma, disparities, motivational interviewing, and co-occurring disorders.
- Efforts will also center on housing needs, leveraging surveys and expert input to align housing workflows with the CARE process.
- The approach remains hands-on, responding to counties' evolving needs.

Working Group Discussion

Collins invited feedback from Working Group members.

Stewart asked about a discrepancy he noticed on page 36 of the Q3 progress report.

- Ternan explained the discrepancy and provided clarification.

Stewart asked about the challenges related to the volunteer supporter process and if the HMA team could offer any insights into the status of volunteer supporters.

- Collins shared that there are several resources available on the website to support volunteer supporters, including a series of training modules on supported decision-making and a comprehensive Volunteer Supporter Toolkit.
- Irvine shared that in San Diego County, about a third of participants have an identified volunteer supporter, primarily family members. Other supporters may include peer mentors or advocates from organizations like NAMI. Supporters are linked to HMA's training resources and supported decision-making education. The participant determines how much involvement the supporter has in the CARE process.

Deputy Secretary Welch emphasized the broader potential of supporter roles, particularly around supportive decision-making and Psychiatric Advance Directives (PADs). She expressed enthusiasm about working on this initiative in the coming year, aiming to provide more flexibility and accessibility to supporters across the system.

Myrick asked if "SMI" on the training slide refers to serious mental illness or specifically to schizophrenia and schizophrenia spectrum disorders, noting the distinction between the two.

- Collins clarified that in the training materials, the term "SMI" refers to Serious Mental Illness, although the training is specifically tailored to individuals within the schizophrenia and schizophrenia spectrum disorder population.

- Myrick clarified that the use of "SMI" often gets generalized to mean schizophrenia, even though schizophrenia is a specific condition within the broader category of Serious Mental Illness (SMI). She emphasized the importance of precise language.

Myrick asked whether the stigma addressed in the training refers to societal stigma or the stigma that may exist within systems.

- Collins responded that the training on stigma has not yet been developed, and they welcome input on what content would be most helpful to include.

Myrick raised a concern regarding the training content, noting that while it may be embedded in existing sessions, it is unclear whether cultural considerations—particularly around LGBTQ+ and disability intersectionality—are being adequately addressed.

- Collins acknowledged the concern, mentioning that a trauma-informed care series does incorporate cultural considerations. She emphasized that the goal is to infuse these concepts into all training sessions and that the HMA team welcomes feedback.

Myrick shared her frustration with the difficulty of implementing evidence-based practices, like Recovery-Oriented Cognitive Therapy (ROCT), specifically designed for people with treatment-refractory schizophrenia. She highlighted the challenge of getting these interventions to be adopted in California, despite successful implementation in other regions. Myrick also advocated for Pat Deegan's training, especially for peers. Additionally, she emphasized the value of training certifications like personal medicine and empowerment coaching, particularly for individuals who might not qualify for peer specialist roles.

8. Working Group Discussion of 2025 Activities

Linkins reminded the group of the upcoming meeting dates for February, May, August, and November, and invited input for potential topics.

Hatanaka suggested the need for more thoughtful and strategic coordination. Specifically, he pointed out that despite good intentions and a team of dedicated staff, the timing and structure of how services are offered can often be inconsistent or overly regimented. Hatanaka proposed that more guidance on strategies for varying interventions beyond just offering a set menu of resources would be helpful to improve the effectiveness of CARE.

Deputy Secretary Welch suggested bringing in a county to discuss their team structure and roles in detail.

Stewart suggested collecting data on individuals who choose to have a volunteer supporter compared to those who do not, tracking their progression through the CARE Act process.

- Linkins acknowledged Stewart’s idea and mentioned that RAND could find the suggestion useful for evaluating the impact of supporters in the CARE process.

9. Closing Thoughts

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, CalHHS

Deputy Secretary Welch shared her optimism, expressing gratitude for the insightful questions and suggestions from the group. She thanked everyone for their time, energy, and contributions, noting how these efforts improve the work they do.

10. Public Comment

Linkins shared the instructions for public comments and added that email comments and suggestions can also be emailed to CAREAct@CHHS.ca.gov.

- Elizabeth Kaino Hopper from the Sacramento region shared her gratitude for the group's efforts, expressing that she was initially fearful but found encouragement in the work being done. She recalled being at the first Working Group session, where the room was packed with family supporters and individuals doing well due to the care they received. She emphasized the importance of the group's democratic, respectful approach that listens to diverse perspectives while still finding a path forward. She acknowledged the challenges of the system, sharing her own fear of her daughter being stuck in an IST program, but now feels hopeful that the CARE process will support individuals like her daughter. She expressed continued commitment to advocating for this vital work, determined to stay involved and support the group's efforts moving forward.
- Laurel Benhamida from the Muslim American Society Social Services Foundation in Sacramento and REMHDCO (Racial and Ethnic Mental Health Disparities Coalition) expressed her appreciation for the recent updates from HMA regarding the availability of materials in 23 languages. She suggested the creation of a glossary tailored for interpreters working in the CARE court system. This would be less formal than a data dictionary, providing practical terms for those who may not work full-time in the system but are still involved in translating or interpreting. She proposed a bilingual glossary as a tool that could be developed over time, to help ensure accuracy in translation and communication. Additionally, she inquired about resources available for individuals being asked to engage in CARE, as she noticed that much of the existing content seems focused on petitioners.

11. Adjourn

Linkins thanked everyone for their participation and public comments, expressing gratitude for their engagement and for staying through the meeting. She encouraged everyone to get home safely and take care of themselves.

Appendix I: Public Zoom Chat

John Freeman:

Welcome all!

John Freeman:

Information about this and other meetings is available on the CARE Act Working Group Site: https://www.chhs.ca.gov/home/committees/care-act-working-group

Email us at CAREAct@chhs.ca.gov to join the CARE listserv to receive updates and information on future stakeholder events.

Ruby Spies:

Meeting attendees will have an opportunity to share comments during the public comment period at the end of the meeting. We ask that attendees refrain from raising your hand on Zoom until then.

John Freeman:

Training and Technical Assistance and other resources are available on the CARE Act Resource Center https://care-act.org/