



California Health and Human Services Agency Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes August 9, 2023

Working Group Members in Attendance:

- **Al Rowlett**, Chief Executive Officer, Turning Point Community Programs; Commissioner, MHSOAC
- **Anthony Ruffin**, Community Center Director 1, LA DMH Concierge Outreach Team
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Charlene Depner**, Director, Center for Families, Children & The Courts, Judicial Council of California
- **Chevon Kothari**, Deputy County Executive, Sacramento County
- **Dr. Fadi Nicholas**, Chief Medical Officer at Sharp HealthCare in San Diego
- **Dr. Veronica Kelley**, Chief of Mental Health and Recovery Service, Orange County
- **Hon. Maria Hernandez**, Assistant Presiding Judge, Superior Court of Orange County
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Khatera Aslami Tamplen**, Consumer Empowerment Manager, Alameda County Behavioral Health Care Services; Commissioner, MHSOAC
- **Kiran Savage-Sangwan**, Executive Director, California Pan-Ethnic Health Network
- **Lorin Kline**, Director of Advocacy, Legal Aid Association of California
- **Matt Tuttle**, President, San Jose Firefighters Union Local 230
- **Tyler Sadwith**, Deputy Director of Behavioral Health, DHCS
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tomiquia Moss**, Founder & CEO, All Home CA
- **Tracie Riggs**, County Administrator, Tuolumne County
- **Zach Friend**, County Supervisor, Santa Cruz County
- **Zach Olmstead**, Chief Deputy Director, Department of Housing and Community Development

Working Group Members Not in attendance:

- *Vitka Eisen, CEO, HealthRIGHT 360*
- *Sarah Jarman, Director of Homelessness Strategies and Solutions, City of San Diego*
- *Dhakshike Wickrema, Deputy Secretary of Homelessness, Cal BCSH*
- *Eric Harris, Director of Public Policy, Disability Rights California*
- *Harold Turner, Executive Director, NAMI Urban Los Angeles*
- *Herb Hatanaka, Executive Director, Special Services for Groups*
- *Xóchitl Rodríguez Murillo, Deputy Secretary, Minority Veterans Affairs, CalVet*

1. Welcome and Introductions

Karen Linkins, Principal, Desert Vista Consulting, welcomed the CARE Act Working Group (WG) members and members of the public and briefly reviewed details of the meeting agenda and space. Karen Linkins reviewed WG meeting logistics and the virtual meeting guidelines for both WG members and members of the public, including the following details:

- The meeting is being recorded on Zoom (Note: Recording started midway through the meeting)
- ASL interpretation is available in the pinned video feed and a link for live captioning is provided in the chat
- WG members on Zoom should remain on camera, if possible, and stay on mute unless speaking. The “raise hand” feature should be used to indicate a question or comment.
- A chat transcript will be part of the meeting record
- Members of the public will be invited to share during public comment
- The WG will not meet more than quarterly and will not end later than December 31, 2026.
- Meetings may be a mix of in person and virtual, with in person meetings being held primarily in Sacramento, though potentially in other locations. A virtual attendance option will remain available even when an in-person quorum is required.
- WG members must attend 75% of meetings annually and have the option of sending a delegate to meetings they cannot attend
- All WG meetings will be open to the public and subject to Bagley Keene requirements
- The WG is not an oversight or voting group, but rather a body tasked with generating ideas and solutions
- WG members must understand and respect Cal HHS’ duty to implement the CARE Act. They must also be respectful of other members’ expertise and differing opinions.

Karen Linkins reviewed the WG objective of generating ideas and solutions aimed at successful implementation of the CARE Act and reminded members of the expectation of respecting differences of experience and opinion within the group. She announced that the next meeting will be in the same location on November 8, 2023.

Deputy Secretary Stephanie Welch encouraged decorum and respect from WG members and from members of the public in attendance.

2. CARE Act Implementation Update

Leaders from the three key State entities involved in supporting CARE Act Implementation provided overviews of the roles and activities of their respective agencies.

California Health and Human Services Agency (CalHHS):

Deputy Secretary Welch reviewed the following information from previous meetings on the role and activities of CalHHS:

- Leads coordination efforts with and between JC and DHCS
- Engages with cross sector partners at city and county levels and coordinates with diverse stakeholders via regular meetings
- Supports DHCS’ training, TA, and evaluation work, as well as implementation of Behavioral Health Bridge Housing
- Supports communication through managing a CARE Act website, responding to inquiries, and doing proactive outreach to media and community. She emphasized that accurate public communication is highly important.

- Coordinates the WG, which serves as an essential mechanism to receive feedback, achieve successful implementation, and spread accurate information to the public.
- Requires feedback from the many diverse perspectives represented in the WG on how to achieve successful implementation, including the details of the annual report and evaluation plan, TA/training for a range of stakeholders, county implementation progress, housing access, and other emerging issues. All expertise that group members bring is relevant to these concerns.

Deputy Secretary Welch shared a slide detailing the publicly available communication tools that are available on the CalHHS CARE Act website, which can be used to disseminate information on the local level. She said that the quarterly reports that CalHHS publishes are being refined with counties' communications needs in mind so they can distribute them to stakeholders. She said that they are published in both English and Spanish and they are working on adding more languages.

Deputy Secretary Welch said that the agenda for today's meeting reflects feedback received from Working Group members at the last meeting. She shared that there will be an update on implementation status later in the meeting from WG members who represent Cohort 1 counties but provided a brief update on the state of planning activities, including the current priority to work with and assist counties with local level communications. Additionally, Deputy Secretary Welch gave an overview of some recent accomplishments from implementation planning across Cohort 1 counties, such as hiring treatment staff, hosting information sessions, and expanding housing supplies.

Deputy Secretary Welch announced that a new Subject Matter Expert, Dr. Vinson, has been engaged to support the CARE implementation process on such topics as the overdiagnosis of schizophrenia among men of color and effective treatment modalities.

Department of Health Care Services (DHCS):

Tyler Sadwith, DHCS Deputy Director for Behavioral Health, presented updates on DHCS' training and technical assistance efforts.

Deputy Director Sadwith reviewed the role and responsibilities of DHCS related to CARE Act implementation, with a primary role of partnering closely with WG members and a range of stakeholders to achieve successful implementation. He noted several concrete DHCS deliverables throughout the CARE timeline for both the public and the legislature, including:

- Technical assistance, consultation, and management of a digital resource library to support CARE Act implementation through their contracted vendor, Health Management Associates (HMA).
- An annual report that focuses on analyzing the scope and impact of CARE model through specific performance indicators with attention to demographic information to support disparity reduction efforts
- An independent evaluation with two parts—one due 3 years after act is implemented and one due 5 years after act is implemented. DHCS is currently in the process of identifying an evaluation contractor.
- Issuing guidance to counties regarding the circumstances under which it is appropriate to delay implementation.
- Administering funds (startup, accountability, and ongoing).

Deputy Director Sadwith shared recent updates from DHCS activities:

- HMA continues to partner closely with Cohort 1 counties to assist them with TA and training needs, as well as helping to address any local concerns.

- HMA has developed some communication materials for counties and is in the process of developing more. These materials cover topics such as the CARE process, legal roles, and the role of the volunteer supporter. He asked for feedback from the WG members on the materials that were distributed to them today.
- DHCS created a draft of the data dictionary in June and held informational sessions with Cohort 1 counties about data reporting requirements. The purpose of the data dictionary is to ensure data is recorded and reported in a consistent manner across counties and aligned with the requirements of the statute. This draft is currently in the process of being finalized.
- DHCS held several trainings and open forum discussions on topics such as housing and community supports, serious mental illness and evidence-based care, and data requirements. There are more trainings under development and they are working with counties to tailor trainings to their specific needs.
- DHCS released a large amount of funding, including Behavioral Health Bridge Housing funding, to counties.

Deputy Director Sadwith provided an overview of upcoming DHCS activities over the next several months:

- Contract with an independent evaluator
- Issue formal guidance on the data collection and reporting process
- Continue to offer trainings, including trauma-informed care and racial bias. There will also be trainings and materials tailored to constituencies, such as providers, peers, and families.
- Continue to offer technical assistance to counties, including psychiatric advanced directives

Judicial Council of California (JC):

JC Director Charlene Depner presented an update on the progress being made by the Judicial Council of California (JC) on CARE Act implementation:

- Currently distributing funding to counties as laid out in the Budget Act, notably to qualified legal services providers, Public Defenders, and Los Angeles County. This process will be complete by the end of the month.
- Approved final CARE Act Rules and Forms in May. Efforts to improve readability of forms and increase ease-of-use are underway. All Rules and Forms have been added to the Self Help Guide.
- Working on training and technical assistance in collaboration with CalHHS's consultant. All trainings are recorded and posted on the JC CARE website. Trainings for judges and court staff are active and trainings for people with other roles in the court process are coming shortly.
- Working on data collection and reporting, which is a challenge due to overlapping legislation on data requirements. Currently meeting with counties to plan for effective data collection.
- Site visits to Self Help Centers are underway to ensure readiness, with a focus on information about representation and helping them build a bridge to Public Defenders offices. Public Defenders will take on most cases as only two legal services providers, both in San Francisco, will provide representation.
- Disseminating communications, including through a ListServ and JC's online resource library, to provide information to courts.

Questions and Discussion:

Karen Linkins invited questions from Working Group members on the presentations from CalHHS, DHCS, and JC.

- A WG member asked Deputy Director Sadwith if the racial bias trainings that he mentioned will be required for counties.
 - Tyler Sadwith responded that trainings are not required in the legislation and therefore the department is unable to make them compulsory, but they are highly encouraged.
- Kiran Savage-Sangwan said they are happy to see that a process flowchart has been created but would love to see more information from the perspective of the respondent, such as how they are being engaged between the initial petition filing and the initial appearance.
 - Stephanie Welch replied that there is a section on today's agenda to discuss the draft materials, including the flowchart. She said that it was a great suggestion and something that could be worked on in the ad hoc groups.
- Keris Myrick asked Tyler Sadwith if a supporter is no longer a volunteer role if a respondent selects a peer support specialist, who can bill Medicaid, to be their supporter.
 - Tyler Sadwith responded that a peer and a supporter are not the same role. Peer groups currently are being collaborated with in the development of trainings and technical assistance. For peers who are selected by respondents and do decide to participate as supporters, these materials being developed will support successful participation. Serving as a supporter would count as covered support services under Medi-Cal if they are serving in a peer support role, though it falls outside of the typical elements of peer support services. A peer could provide either type of service.
 - Stephanie Welch said that the role of the voluntary supporter has been adapted from the developmental disability community and they are currently figuring out how to apply it to the CARE process. She welcomed feedback and suggestions from members and anyone active in the peer support community. She said questions about the supporter can be tackled in ad hoc groups, but there is lots of value in the role and it will allow loved ones to provide support as well if they are serving as the supporter.
- Keris Myrick said that there was recently a training in LA County that was not consistent with other messaging. She asked how it will be ensured that all constituencies receive accurate information. She said that at the LA training it was said that the CARE process is not voluntary, which does not seem consistent with other communications.
 - Stephanie Welch requested the date of the training, acknowledged the need to ensure that all information is accurate and expressed appreciation for the issue being raised.

3. Updates on Cohort 1 County Implementation

Tracie Riggs, County Administrator for Tuolumne County, and Dr. Veronica Kelley, Chief of Mental Health and Recovery Services for Orange County, shared implementation planning updates from their respective counties and from Cohort 1, as a whole. Dr. Veronica Kelley, joined by Hon. Maria Hernandez of Orange County, shared updates first:

- Actively collaborating and communicating with the county Public Defender, peer community, family community, the local NAMI, and county counsel. Peers have taken an active role in messaging and material development.

- Referring to CARE Act as CARE, as the word “court” is not landing well in the community.
- Managing expectations about what CARE is and is not, as most people think it is just about homelessness and/or think it is much broader in scope.
- Responding to questions – mostly clinical and some legal, so it has been very important to have all partners present at information sessions so questions can be best answered. Many of the legal questions are concerns about the mental health declaration and requirements for evidence.
- Developed a process flow diagram to help people understand all elements of the CARE process.
- Clarifying some confusion in the community about how CARE differs from AOT.
- The Judge leading CARE is eager to ensure that private insurers pay for services.
- Developed communication materials that are available in seven threshold languages.
- Actively hiring for both behavioral health and the court as they have now secured the funding for the new positions. They are also moving some people to CARE from other collaborative courts.
- Training public defender and the court in LEAP (listen – empathize – agree – partner), an evidence-based practice.
- Recognizing that effective engagement of this population will take substantial time and visits, they estimate 40 engagement attempts to build sufficient trust, which the court has said they will grant the time for.
- Providing additional trainings to staff and the community on schizophrenia and best practices.
- Actively meeting with a range of city and county partners, including the Sheriff, hospital system, and community-based organizations.
- Given all these activities, they are ready to go and are hopeful. There are still blind spots and new questions that come up that they are sorting out and CARE will not provide an overnight transformation, but they are engaged and ready.

Tracie Riggs shared updates from Tuolumne County:

- Tuolumne County is much smaller and more rural than Orange County and thus is navigating a much different landscape, but they have a robust team from the county and the court working together to plan.
- Successfully filled two vacancies with help from the state, but are struggling with filling other positions, such as for clinicians.
- The Board of Supervisors just approved a Navigation Center with capacity for up to 50 individuals to use up to six months each. This will provide an opportunity for engagement and assessing and addressing respondents’ individual needs. After staying in the Navigation Center, respondents will be moved into long-term supportive housing, which they are currently working to expand the supply of by purchasing a hotel. There is no psychiatric residential care in the county, so they are looking for other options.
- Conducting a series of community engagement events to get information out, both online and in person.
- Restructured court staffing to support CARE.
- The landscape of overlapping behavioral health legislation feels like a perfect storm, so all Cohort 1 counties are trying to sort through it.
- The Board of Supervisors believes the scope of CARE is broader and somewhat misunderstands the purpose, so they are working on correcting those assumptions.
- Working to do all they can to get individuals engaged in services voluntarily.

- Funding for the Public Defender is not sufficient to cover all elements of representation for all clients who may be referred, so that is a concern. They also have funding concerns about not being able to bill for non-clinical services, such as time sitting in court.
- Some concerns about law enforcement engaging with people in crisis and considering training needs to address this.
- Short supply of affordable housing for both potential CARE participants and for staff, which contributes to the hiring challenges.
- Overall, Cohort 1 counties are excited to start the process and figure out how to address issues as they arise.

4. CARE Act Data Collection, Reporting and Evaluation Approach

Karen Linkins introduced the keynote presenter Dr. Sarah Vinson, who is a forensic psychiatrist, Professor of Pediatrics and Psychiatry, and the Chair of Psychiatry and Behavioral Sciences at the Morehouse School of Medicine, in addition to managing her own clinical practice and consultation company through which she has consulted on cases nationwide. The following provides highlights of Dr. Vinson's presentation:

- Presentation Goal: Provide social and cultural context related to the issues CARE is addressing and the challenges it is raising.
- Courts and clinicians define mental health through focusing on illness and diagnoses, though the WHO defines it more as holistic emotional wellbeing and how someone is living and operating, not about a diagnosis or medication adherence.
- The experiences of people from marginalized communities and the experience of decisionmakers who impact policy implementation are often disparate. People in positions of authority generally come from middle- or upper-class backgrounds who systems have worked well for. This is very different from the experiences of people who will be CARE respondents, who systems have not worked for and who are impacted by housing insecurity. In conversations about implementation and more broadly, it is important to be aware of that difference.
- For respondents, the CARE process might be seen as something that will increase their oppression. Oppression is multi-faceted and includes exploitation and cultural imperialism, which accepts dominant cultures as standard. The healthcare system and court system often participate in these forms of oppression.
- It is important to consider the social determinants of mental health, such as where people live, work and play, as these things can determine if illness appears and how and they tend to break down along lines of marginalization. Biological explanations are insufficient to understand someone's health. Screening for these social determinants often comes too late.
- Dr. Vinson played a video showing a recreation the Clark doll experiment of young children being asked to associate positive and negative traits with a Black doll or a white doll. The children associated the negative traits with the Black doll and the positive traits with the white doll. She said that this video displays how people understand and internalize social hierarchies from a young age. Everyone who is part of CARE in any position has been exposed to these same societal inputs. This conditions people making diagnoses to carry this bias into their diagnostic and treatment process.
- Marginalization is based not only on race, but also on disability, gender presentation, if someone is housed, and other factors.
- The overdiagnosis of Black men can be viewed as the most stigmatized diagnosis being assigned to the most stigmatized group of people.

- Despite some respondents likely being privately insured, CARE exists within the public mental health system. This system will be faced with all of its usual challenges, such as funding challenges, plus new ones, such as additional administrative burdens.
- CARE is discussed as a way of reducing and preventing institutionalization. A lot of the elements of institutionalization invoke hierarchies.
- Mental health diagnoses are not only about the individual, but about the entire societal context, which policies play a large role in, as the ability to sustain healthy communities is a large part of mental health. In this way, policies about education, housing, and the economy are all mental health policies. Even when looking at individual circumstances such as someone's childhood foundation, it is crucial to think about how those things are influenced by larger structures. Currently, the mental health system does not take this view and is instead highly individualized.
- CARE respondents are people who have likely experienced structural trauma, so their trust of systems will likely be low. This stems from people seeing systems do harm instead of act in accordance with their stated purpose. This challenges the idea that certain groups do not engage as much with services because of some innate difference. Additionally, it is largely a lack of access that keeps people out of services.
- The prevailing idea that many judges have that if someone gets into treatment, their problems will be solved, misses a large piece of the puzzle. The majority of physicians come from wealth and many do not understand the contexts that their patients live within.
- Regarding limited access as a driving cause of untreated illness, the majority of Black and Latinx adults with mental illness receive no treatment. Cost has been found to be the highest barrier to seeking care, far more than stigma.
- When people without private insurance are able to get seen by a provider, the diagnostic assessment is far too short to gather and weigh all relevant information, which is made worse for people who have trauma with systems and do not want to disclose highly personal details in the first conversation with a provider. Reconsiderations of diagnoses are rare. These constraints are not the fault of providers but of the system design itself that prioritizes productivity.
- An example of how the same health challenges can be interpreted and treated differently depending on the population experiencing them is the differing responses to the opioid and cocaine epidemics. This can be seen in narratives about the two epidemics but also in funding streams and training requirements.
- Not surprisingly, the word "court" is not landing well with in all communities as people may have negative personal associations with courts. The same is true for other language such as "involuntary hospitalization."
- It is useful to reframe ideas about cultural mistrust, which point to an idea that certain groups are inherently paranoid, to an understanding of this mistrust as experience-based fear. For example, resistance to call the police often stems from justified fears of police violence.
- Especially for marginalized groups, symptoms of trauma often are misinterpreted, particularly for Black men. For example, flashbacks get read as hallucinations and hypervigilance gets read as paranoia. Dr. Vinson shared that she worked in the juvenile justice system for years and changed a lot of schizophrenia diagnoses to PTSD diagnoses and changed their treatment plan accordingly, which resulted in recovery for patients who were considered treatment refractory.
- Dr. Vinson showed a video of a young boy playing basketball in his driveway and hiding behind a car when a police car drives by. She said he later told his dad that he was afraid because they killed George Floyd when his father asked why he was hiding. She

said she showed this because his behavior might look paranoid or guilty, but it is entirely changed once you know the context of what was going on in his mind. Racial and structural trauma are not considered in the DSM despite their large influence on health. Especially when it comes to marginalized populations, the diagnosis of schizophrenia is not always bulletproof.

- When judges and providers look at records that do not tell a person's full story, it may be the system rather than the person that is recovery resistant. She encouraged WG members to consider how social and systemic marginalization have impacted the CARE eligible population. For those directly involved in implementation, she encouraged them to be aware of the personal bias that we all have, to leverage their privilege to advocate for meaningful representation among decisionmakers, and to track outcomes and be responsive to them. Even though conversations about antiracism have increased, the data has generally not followed suit to examine patterns like who police take to jail versus to a treatment facility. She encouraged WG members to advocate for systems change, as these issues come down to systems rather than individual players. As racism is present in the court and mental health systems, creating a race neutral program within those systems will produce a racist program. She encouraged continued thought and conversation about protective factors and social determinants of health and said that everyone at the table has a degree of power to make a positive impact rather than reproduce inequities.

Questions and Discussion:

Karen Linkins thanked Dr. Vinson for her presentation and welcomed questions from WG members:

- Bill Stewart thanked Dr. Vinson for the information she covered and said it was very enlightening for his experience on the WG.
- Anthony Ruffin thanked Dr. Vinson and shared that he works on Skid Row in Los Angeles. He said the topic of CARE came up while he was doing outreach and people were expressing fear that they would all be sent to jail. He explained that CARE will not send them to jail but it was a tough conversation.
 - Dr. Vinson replied that for a lot of people, courts are the site of some of their worst memories and where they may have previously been sent to prison or jail.
- Al Rowlett thanked Dr. Vinson and said that it seems from her data that some of the individuals who will be referred to CARE and have schizophrenia diagnoses may not have that diagnosis or be referred to CARE if they had received more comprehensive treatment. He said that he is troubled by this and thanked her for charging them to do something about it.
- Keris Myrick said that this presentation was challenging to listen to because the points Dr. Vinson raised were raised as concerns throughout the time that the CARE legislation was being considered. She said it saddens her that CARE is reverting to the courts and that we have not instead addressed structural barriers and found some other path outside the courts.
 - Dr. Vinson said she appreciated the comment and that it is difficult to make people feel as though courts are not coercive, because their nature is coercive. She added that upstream interventions are needed and courts are not upstream.
- Hon. Maria Hernandez thanked Dr. Vinson for her presentation and said that she believes she is the only judge on the WG. She said she appreciates the comments by other members and the presentation and said that she has seen firsthand that everyone interacting with the court system has trauma and upstream interventions are needed. She also said that at present, despite opposition, CARE is being implemented and she

does not want people to feel that the court system is inherently coercive. She shared that she works in collaborative treatment courts and that there is lots of room for the court system to improve but that judges are not inherently coercive. She said that she has worked with many young men of color in her courts who say upon graduating from the program that they did not believe it would be a team effort and they would get their felonies wiped but they did with significant time and rapport building. She said her and other judicial officers want to implement CARE in a way that provides dignity to people.

- Dr. Vinson responded that it is important to start with the acknowledgement that courts have not helped in the past when interacting with someone and have that conversation, rather than starting by trying to convince them they will help this time.
- Khatera Aslami Tamplen shared that she really appreciated the content of the presentation, which has been part of the advocacy peers have been doing throughout this process. She said it is important to be honest about the impacts of the legislation and to focus on how to get people the supports they need.

Deputy Secretary Welch thanked Dr. Vinson and said that she is here to be a resource as they continue to tackle equity and other related issues. She said they are committed to paying attention and looking at the data, and recognizes this will be a long term discussion as the WG will be meeting for three years. She said that this issue extends far beyond CARE, as there are hundreds of thousands of Californians who need mental health and substance abuse treatment that is trauma-informed. She thanked Dr. Vinson for her time and asked the WG if they had any comments.

- A WG member asked about next steps after this discussion as it does feel as though they are putting a race neutral program in a racist system, as Dr. Vinson put it. She said to avoid that outcome they need to be intentional, but she does not see that happening as counties are currently moving quickly into implementation.
- Stephanie Welch said that next steps will be discussed in the next agenda item and it is for everyone to determine collaboratively. She said they have an opportunity to work with subject matter experts in the ad hoc groups, such as Dr. Vinson. She also acknowledged there will be many more conversations and the topic is of high priority, in addition to the related topics of appropriate housing and engagement. They are unable to dive into details in this group, but that's what the ad hoc groups will be for. She asked if anyone else had any takeaways to share.
- A WG member shared that they took the idea of balance out of the presentation, as CARE touches so many different structures. He said that improvement for some people is still improvement and any help they can provide to people is a good step.
- A WG member said that their takeaway was thinking more deeply about how CARE communications should be crafted for minority communities. They shared that a concrete action could be thinking about if all new materials that are generated are culturally aligned and if not, revising them so they are appropriate to the audience. For example, language about evidence-based practices is misleading because they are often not evidence-based for communities of color. It is important to ensure that services laid out in the CARE plan meet a respondent's cultural needs, which should be incorporated into the trainings.
- A WG member shared that in the process of implementation design, flexible and innovative processes are required that can be examined and modified in real time. Racial disparities persist even when examined, so iterative processes are crucial.
- A WG member shared that Orange County is taking certain steps to ensure an equity-centered approach and have a presentation that could be useful for the WG and other

counties to consider. Demystifying the process, as Dr. Kelley discussed, is crucial in order to build trust. He said that people of color do not trust the judicial system for valid reasons, which must be respected. He also noted that people's core needs must be addressed and strategies for meeting people's underlying needs should be taught in small and large counties. He shared that on the topic of engagement, it must be respectful and responsive, which could happen by asking for feedback from the people that counties are engaging.

5. Updates on Time Limited Ad Hoc Sub-Groups

Deputy Secretary Stephanie Welch reminded Working Group members about the discussion at the May Working Group meeting to establish three Ad Hoc Sub-Groups on: 1) Services and Supports; 2) Data and Evaluation; and 3) Training and Technical Assistance and Communications. Establishing these groups will expand the range and types of stakeholders who can participate in the Working Group process. She acknowledged that to maximize participation, it would be ideal to hold these Ad Hoc meetings virtually; however, there are some logistical considerations that need to be addressed now that the Bagley-Keene rules that allowed virtual meetings, which were established during the pandemic, have expired. She noted that there is currently a bill being considered that would eliminate the requirements for holding in-person meetings with a quorum and allow for virtual meetings again. However, until this passes, we will need to consider options to have an in-person location where a quorum could be established, which could impact the variety of stakeholders and Working Group members who could serve on the Ad Hoc Groups.

Deputy Secretary Welch asked if any members had questions or concerns about the proposed structure.

- Khatera Aslami Tamplen asked if communication materials that may be developed by the ad hoc group will come back to the main WG for review.
 - Deputy Secretary Welch replied that this would ideally be the case, though some things may have to get turned around more quickly. She said there may be a way to solicit input from the WG virtually between meetings. She said that she did not want to give a definitive answer now, in part because she is continuing to hear how urgently needed communication tools are.
- Chevon Kothari asked for clarification on why only two WG members could be part of each ad hoc group, as that differed from her understanding of Bagley Keene rules.
 - John Freeman replied that their understanding is that for a non-voting body, a virtual meeting is allowed if there is also a physical quorum in a singular location, such as today's meeting. If the meeting is entirely virtual, each member's location must be noticed and public access to each location must be provided, which would be challenging.
 - Chevon Kothari asked if it would solve the issue if there were a group of people who committed to being in person each meeting.
 - John Freeman responded that a full quorum would be required.
 - Stephanie Welch said that this may be resolved with new legislation. She said that this is the guidance they have gotten from their counsel, but they will double check its accuracy. She said it sounds like more people are interested in participating so they will try to explore other options to make that possible.
- Bill Stewart clarified that with the current proposal, they would not be able to participate in any group even if they have something to contribute.
 - Deputy Secretary Welch said that they would be able to send a designee.

- Bill Stewart asked if people he works with as part of another group will be able to participate in the ad hocs.
 - Deputy Secretary Welch replied that yes they can, which is the intended purpose of doing it this way. She said that she wants help from WG members to find the best people to sit on these groups. She said that if there is someone on a member's team who is excellent at data collection, for example, they should be nominated to the ad hoc group.

Karen Linkins asked the co-chairs of each group to introduce themselves and share initial thoughts on their group.

- **Services and Supports:** Jodi Nerell and Tracie Riggs introduced themselves and said they have met one time together to discuss potential focus areas, though they still have questions about the mechanics of the group. Potential activities in the group could include creating a visual representation of the existing continuum of care and use it to identify and address barriers and weaknesses in the system. They hope for a diverse group to help achieve this. They will also be focusing on housing and the challenges faced in this area, particularly in rural counties. They will work on developing effective, honest messaging informed by Dr. Vinson's presentation and make sure they process is made very clear in materials.
- **Training, Technical Assistance and Communications:** Susan Holt and Anthony Ruffin introduced themselves and said that they have met once to lay groundwork. They acknowledged that Cohort 1 and LA are already well on the path to implementation, so their needs will be different than those of Cohort 2. They will look at best practices and are very open to suggestions from other WG members for focus areas.
- **Data Collection, Reporting and Evaluation:** Beau Hennemann and Keris Myrick introduced themselves and said they have met once but are very excited about focusing about data, even if it doesn't excite everybody. They said they will likely work with the independent evaluator to influence the evaluation and work with HMA on the data dictionary. They will look at privacy issues and work to identify and work around data sharing issues. Evaluation encompasses more than just data, so they will look at how to capture other types of learnings from Cohort 1. Keris shared her love for data and said that they have an opportunity to fill in the gaps in what is required for the evaluation and data collection. They want to find ways to look at how people's lives are changing ways that may not be recorded during their time in CARE.

Deputy Secretary Stephanie Welch said she expects that the Data group may be the one that is not time limited, especially when the annual reports come out. She shared her takeaway that there is interest among the WG members to participate, so they will work to try to find a solution to enable that. She also said they will put together a tool for people to submit nominations of members for the ad hoc groups. She encouraged members to tap their networks to bring the best people to this process.

- Chevon Kothari asked if there will be a way to nominate a type of perspective to be incorporated, like a representative from a managed care plan, rather than a specific name.
 - Karen Linkins replied that these suggestions can be emailed directly to her.
 - Deputy Secretary Welch reminded the group of all perspectives that should be represented.

6. Supported Decision-Making, Psychiatric Directives, and the Role of the Supporter

Karen Linkins introduced **Christopher Schneiders** and **Rayshell Chambers** to present on supported decision-making, psychiatric advanced directives (PADs), and the role of the supporter. Christopher Schneiders is the former Director of the Saks Institute at the University of Southern California, helped launch the California MHS-OAC, and is the CEO of Schneiders and Co. Consultants. Rayshell Chambers is the co-founder of Painted Brain, a mental health tech nonprofit that provides peer-based services and technology, and an independent consultant for small nonprofits that serve communities of color. Christopher Schneiders presented first:

- Shared about his experience and work with Elyn Saks, who founded the Saks Institute
- Supported Decision Making (SDM) and Psychiatric Advanced Directives (PADs) are written into the CARE Act, but he is sharing broader information about the concepts
- SDM and PADs are tools to increase autonomy and self-determination in a system that often neglects people's preferences in a mental health crisis
- SDM is a model in which people choose trusted supporters that help them make life decisions, but do not make decisions for them. These agreements can be formal or informal. More information is available through the National Resource Center for Supported Decision-Making's website.
- Many people have referred to SDM as "supportive decision making" or "shared decision making," which are not the same thing. It is very significant that SDM is written into the CARE Act for people who have advocated for the use of it for years.
- SDM is relatively new in the United States, but it was adopted as a right by the United Nations in 2006 at the Convention on the Rights of Persons with Disabilities. The United States was not a signatory on this declaration, but the declaration said that states must recognize the legal capacities of persons with disabilities and should be provided with the supports necessary to exercise those capacities. This language is similar to the ADA of 1990.
- In 2016, the Saks Institute in collaboration with the Burton Blatt Institute began work on an SDM pilot program for people with schizophrenia and other experiences of psychosis. The researchers partnered with participants to create written SDM plans identifying what types of decisions they wanted decision making support with, including who would provide that support and how. In their process, the researchers interviewed people and organizations with experience with SDM, including the ACLU and others, and learned from the efforts of the IDD/DD community. The pilot resulted in a collection of tools, materials, and study protocols. Their final report is being written right now for publication.
- A Psychiatric Advanced Directive (PAD) is a legal rights documents that indicates a person's preferences while they are competent for future mental health treatment and allows a chosen proxy to interpret those preferences during crisis. More information is available at the National Resource Center on Psychiatric Advance Directives' website, run out of Duke University.
- The CARE Act says that a PAD will have the force of law, which is the first time that PADs as well as SDM have appeared in California law.
- There is a recent French study that proved the cost-effectiveness and general effectiveness of PADs facilitated by peer workers.
- Beginning in 2019, the Saks Institute collaborated with California's Mental Health Services Oversight and Accountability Commission (MHSOAC) to create a pilot program in multiple counties for assessing the feasibility of using PADs within the SDM paradigm. The Saks Institute helped launch this project, which is the first of its kind in California, but are not involved in the implementation. The goal of the project is to improve

community mental health services for people at risk of involuntary care and institutionalization.

- He called the group to work together and collaborate on making these tools work for CARE. A major barrier to implementing PADs is silos within each counties, which must be broken down in order for them to be effective.
- He referenced Elyn Saks, who wrote that patients not being able to make their own decisions is incredibly detrimental to their health and to their commitment to treatment

Rayshell Chambers presented on the role of the peer supporter in relation to PADs:

- She shared information about her organization, Painted Brain, which was founded in 2005 and works to create community-based solutions to mental health challenges. For the last 3 years, they have been the leading peer voice in PADs education.
- She reviewed the definition of a PAD and added that some components of a PAD can include medication information, preferences for emergency treatment, information about employment and housing, and other treatment wishes.
- She has been a consumer in the public mental health system since childhood and has had negative experiences with hospitalization that a PAD could have prevented.
- Peers are doing a lot of work in the realm of PADs and should be integrated into every continuum of care. Painted Brain co-hosts a PADS National Peer Support Network and is contracted through the PADS Innovation Project to support county efforts, including creating a standardized template. They have also recently contracted with HMA to support the development of materials for CARE related to various topics including PADs.
- Governor Newsom passed SB 803 which elevates Peer Support Specialists and assigns peer services Medi-Cal billing codes. These services include educational skill building groups, engagement support, and therapeutic activity. Painted Brain is eager to see how PADs can be incorporated into these services through Peer Support Specialists. Painted Brain is also a vendor for the Medi-Cal Peer Support Specialist training.
- PADs provide protection, including information about someone's relationships that may be relevant to assessing the credibility of a petition. For example, a PAD may state that a spouse is abusive, and their petition should not be taken in good faith. A PAD also may designate a supporter or indicate preferences for supporters, such as someone with lived experience of involuntary hospitalization.
- She shared how much peer support has helped her in her own life.

Karen Linkins thanked Rayshell Chambers and Christopher Schneiders for their presentations. She asked WG members if they had any questions or comments.

- Deputy Secretary Welch asked if the presenters can help the group think about how these concepts will operate in CARE and how they will fit together with the volunteer supporter role.
 - Rayshell Chambers responded that it is clear that the supporter will be a voluntary role, but she believes that peer supporters will be able to provide training and technical assistance for supporters. She said that peers will be needed to implement PADs. She said that in order to answer the open questions, they will need to figure out what wiggle room there is for peers in the law and if they will be able to draw down Medi-Cal.
 - Christopher Schneiders responded that he does not know a large amount about the supporter role, but it will provide an opportunity for families to be involved in their loved ones' care if they are chosen. He said that having more than one supporter is ideal because a power dynamic is created, and it is useful to bring in

multiple perspectives to ensure that it is the interests of the participant rather than the supporter.

- Khatera Aslami asked if they have ideas for how the state can help peer-run organizations be involved and secure contracts to provide their services.
 - Rayshell Chambers responded that a lot of peer run organizations do not currently bill Medi-Cal, but she is an advocate for a bootcamp of sorts to get these organizations integrated into the system. Peers should be receiving contracts, but it is unclear in the legislation and the current continuum of care where that will happen. They are currently doing some work for free because it needs to be done and they are unable to bill Medi-Cal. CalAIM tries to integrate peers into the Community Health Worker benefit, but they are not CHWs. The state needs to bring organizations to the table so they can do the work.
- Keris Myrick said that she is concerned that respondents will be deemed to not have sufficient capacity to engage in the supporter process. She said she believes that the statute says that a person can have a supporter, rather than the county shall provide a supporter. She asked how it can be ensured that an offer is always made several times to have a supporter. It often happens that clients with schizophrenia are not offered telehealth services because there is a belief that they cannot engage in it.
 - Christopher Schneiders said that this is an important point and when he went through an IRB process with the PADs study, the reviewer doubted that the participants would be able to make competent choices, which is a prevailing idea.
 - Stephanie Welch said that she can check with the counties but as she sees it, the offer to have a supporter is something that will be constant because whether or not someone wants a supporter may change over time.
- Dr. Veronica Kelley said that Orange County is part of the PADs pilot and they are working on building a technology platform that they are aiming to have ready in 2024. It is being piloted in the ACT program with people in crisis, and it needs to be accessed both by first responders and providers as well as the person with the PAD. There are lots of logistical details they are working out about the best way to do this.
- Susan Holt said that this conversation reminds her of the ongoing conversation about equity and trust in systems. She prompted the group to think about what will happen when an EMS worker shows up and touches someone who said in their PAD that this was a trigger for them. The consequences of implementing this without a robust strategy is promising something, but not delivering and then moving backwards in terms of establishing trust.
- Khatera Aslami said that in Alameda County, Painted Brain provided critical digital health literacy training to consumers. She said that access is a crucial part of implementing digital tools. She said that the evidence-based practice for wellness recovery action planning is a group process that involves peers.
- Rayshell Chambers said that she would not be here without peer support and peer supporters are as essential as psychiatrists and other providers. She said that she is looking forward to supporting implementation of PADs, because it is true that poor implementation can carry high consequences.
- Christopher Schneiders said that this is a challenging but exciting process. He said that all conversations about PADs raise the question of what to do when someone says they want the opposite of what is in their PAD while they are experiencing psychosis, which there is work being done to answer.

Karen Linkins thanked the presenters and said she looks forward to their continued engagement in this process.

7. Discussion of CARE Act Communication Tools

Karen Linkins said that they are running behind in the agenda, so rather than discussing the printed draft communication materials, WG members should send their feedback to her via email or write their notes on the papers and they will be collected. She said that there are two HMA briefs that were handed out, one on the process flow and one on the supporter role. She said that she will send out a link to a feedback form from HMA tomorrow morning and feedback should be submitted in advance of the 17th. For the other briefs, she can share Word files to let members make track changes.

Deputy Secretary Welch apologized that they ran out of time to discuss these. She said that counties shared at their last Cohort 1 meeting that they have been developing their own communication tools, so she will reach out to them. She said that she does not believe it would break any rules to ask for feedback on communication tools from WG members between meetings.

8. Public Comment

Karen Linkins opened the Public Comment period and requested that participants limit their comments to 2 minutes. She explained that comments can be made verbally in person or via Zoom and in writing in the Zoom chat or via email. Deputy Secretary Stephanie Welch reminded commenters to be respectful of all people in the room and their differences of opinion.

- Lauren said that she is a family member of someone who is gravely disabled. She said she learned a lot today and thanked the counties for the work they are doing and that they are doing the LEAP principles. She said that she appreciated Dr. Vinson's presentation and that she learned that noncompliance may be a symptom of illness. She said she is concerned by SDM and PADs, because CARE is meant to provide lifesaving medical treatment, which should not be called involuntary treatment. She said there will be a time for someone to participate in SDM and PADs, but not while in psychosis. She said that as a parent she wants her son to be part of decision making, but when he is in crisis he needs treatment.
- Allison Monroe said that she sees that some people who lobbied against CARE are on the WG and some people who lobbied for it are in the audience. She said she supported CARE because it focused on the sickest people who have psychosis and are deteriorating. She said that sometimes courts are the only entity that can save people's life and she liked CARE because it had a chance to save lives. She said that based on the conversations of the WG, she is not sure anymore what CARE will do. She is afraid it will do nothing to change the current system. She said that as family members, they understand how severe this illness is and how much it interferes with decision making. She said that if a CARE participant has wishes that are not logical, they should not be implemented. She encouraged the WG to feel a sense of urgency about the people who need help from CARE.
- Elizabeth Kino-Hopper shared that she is involved in advocacy for 911 alternatives and she appreciates the work the WG is doing to find alternatives to incarceration, which is where her daughter is. She echoed the concerns of previous commenters about SDM and said that it worked well for her brother with autism but should not necessarily be taken from one community and applied to this issue. She said she is concerned by using clinical language with people in the midst of psychosis. She said that she appreciates counties that are using the LEAP method. She said she is here to represent families, many of whom are very healthy even though those examples do not get heard but should. She said families need help.

- Claire Warshaw said that she has not been following the CARE Act much because she thought it was about homelessness, but when she learned it was about certain diagnoses, she became concerned because she has a diagnosis. She is afraid that the Act will victimize people with diagnoses in a discriminatory way. She said the diagnosis itself can lead to discrimination and a lack of equality in relationships. She said that within the psychiatric system, there is no recognition of normalcy and remission. She said people can be judged for many different identities and behaviors.
- John Vanover thanked the WG members who stayed to listen. He said that the presentation by Dr. Vinson was excellent and overdue and the topics she raised should have been discussed before the legislation was passed. He said that he doubts that this group will be able to override centuries of discriminatory practices, but he appreciates the start. He pointed out that people who have distrust of the system includes everyone who will be petitioned, which are all people will severe trauma and CARE will traumatize further. He said that the state needs to try to minimize rather than ignore this trauma. He said that Christopher Schneiders said that PADs must be written when a person is competent, which may have been missed by some people. He said there needs to be an upstream outreach plan in order to put them in place sooner. He added that dropping the work “court” does not change the reality of what it is.
- Anita Fisher said she appreciates the work that is being done. She said that she is the mother of an African American son and was in tears listening to Dr. Vinson, however her son’s diagnosis of schizophrenia is correct. He has been repeatedly incarcerated rather than getting any type of care. She emphasized that family members are the ones who deal with the collateral damage of the system. She was the one visiting her son in prison and supporting him when the system failed him. She said that she is trying to remain positive because she has needed the tool of CARE for her son. She said that the voluntary system does not work for certain people, and nobody has been discussing the rights that are taken away in a jail or prison.
- Tiffany Elliott said that she hears the concern of families, but she thinks they may not understand how PADs work because they require competence in order to be valid. She said that she is a person with lived experience and understands that sometimes intervention is needed. She said it is very helpful for a person to be able to say what will help them. The unreasonable requests won’t be honored, but someone should be able to ask to be in a room alone rather than be shackled to a bed and express their preferences about medication. She encouraged people to consider what happens if all agency is taken away from someone in crisis, which is a degradation of their engagement in treatment and their trust. She shared an anecdote about helping a friend with schizophrenia get to the hospital voluntarily.
- Linda Mimms thanked the group and said she represents the Schizophrenia and Psychosis Action Alliance. She said that she wants people to understand the symptoms, including anosognosia, which affects most people in psychosis and prevents people from making rational decisions. She said that she is all for SDM but using it for this population is putting a square peg into a round hole. She said that LEAP is the best method to use. She said that each day a person is in psychosis, more brain damage occurs and makes robust recovery less likely.
- Mark Gale said that families seem to be left out of these conversations. He said that he had to hospitalize his son many different times. He has dedicated much of his life to criminal justice advocacy and keeping people out of jail. He said that when all else fails, it is the families who are still there, yet do not have a voice on this group. He said that families can petition but then are told to stay out of the way, even though full recovery is

impossible without family involvement. He said that he learned a lot today and learns from peers often, but he is against the idea that families are not going to be heard.

- John Underwood said that he wants to hear more information about the role of the supporter and all the details of how to perform that function. He works with unhoused people and wants to be in that role.
- A commenter asked if there will be guidance provided for commercial health plans, as behavioral health payors have yet to receive proper guidance which is imperative for them to be compliant and reimburse claims properly.

Karen Linkins adjourned the meeting and thanked everyone in attendance.

Appendix I: Public Zoom Chat

02:53:41 Christopher Schnieders: Thanks for the update! Didn't know my screen was gonna pop up there

04:14:12 John Freeman: Public Comment will be taken on any item on the agenda. There are 3 ways to make comments:

1. In person, please come to designated location
2. Raise hand on zoom to speak. If joining by call-in, press *9 on the phone.
3. We encourage email comment to CAREAct@chhs.ca.gov