



California Health and Human Services Agency  
Community Assistance, Recovery & Empowerment

(CARE) Act  
Working Group Meeting Minutes  
February 11, 2026

**Working Group Members in Attendance:**

- **Amber Irvine** – San Diego County Behavioral Health
- **Beau Hennemann** – Anthem Blue Cross
- **Bill Stewart** – San Diego County Behavioral Health Advisory Board
- **Brenda Grealish** – Commission for Behavioral Health
- **Dr. Brian Hurley** – Substance Abuse Prevention and Control (SAPC), Los Angeles Department of Public Health
- **Cassie McTaggart**, for Sarah Davis – Judicial Council of California
- **Ian Kemmer** – Orange County Health Care Agency
- **Jenny Bayardo** – California Behavioral Health Planning Council
- **Jodi Nerell** – Sutter Health
- **Dr. Katherine Warburton** – Department of State Hospitals
- **Keris Jän Myrick** – Person with Lived Experience of Schizophrenia Diagnosis
- **Khatera Tamplen** – Alameda County Behavioral Health
- **Lauren Rettagliata** – Family Member
- **Mark Salazar** – Mental Health Association of San Francisco
- **Meagan Subers** – California Professional Firefighters
- **Monica Porter Gilbert** – Disability Rights California
- **Nichole Zaragoza-Smith** – California Department of Housing and Community Development
- **Hon. Scott Herin** – Superior Court of Los Angeles County
- **Stephanie Regular** – Alameda County Public Defender Office
- **Stephanie Welch** – California Health and Human Services Agency
- **Susan Holt** – Fresno County Behavioral Health

**Working Group Members in Attendance Online:**

- **Ivan Bhardwaj** – California Department of Health Care Services, Behavioral Health
- **James Kwon** – Los Angeles County Department of Mental Health, Office of the Public Guardian
- **Jennifer Bender** – Riverside County Public Defender Office
- **Ketra Carter** – Homelessness Strategies and Solutions Department, City of San Diego
- **Ruben Imperial** – Stanislaus County
- **Ruqayya Ahmad** – California Pan-Ethnic Health Network

## Working Group Members Not in Attendance:

- Dr. Clayton Chau– National Healthcare & Housing Advisors
- Harold Turner – NAMI Urban Los Angeles
- Herb Hatanaka – Special Services for Groups
- Jerry May – San Jose Fire Department, Local 230
- Kent Boes – Colusa County Board of Supervisors
- Monica Morales – Yolo County Behavioral Health Services
- Roberto Herrera – California Department of Veterans Affairs
- Tim Lutz – Sacramento County Health Services

## 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 went over the day's agenda.

Linkins introduced new Working Group member James Kwon, LA County Department of Mental Health Office of the Public Guardian. All members present in person and online went around and introduced themselves.

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.

Linkins provided a brief recap of the November 19th Working Group meeting, which consisted of the following agenda items:

- Panel discussion of the role of the courts in CARE
- Overview of California Mental Health Courts
- Presentation from Martin Jones and Linda Boyd about CARE Act implementation in Los Angeles County
- Presentation from Tyler Shill about recent legislative changes to CARE (Senate Bill No. 27)
- Discussion of recent CARE activities (CARE convenings, Beyond the Bench CARE pre-conference event, oversight hearing, and most recent petition data)

Linkins introduced Stephanie Welch, Deputy Secretary of Behavioral Health at CalHHS, who welcomed the Working Group members.

Deputy Secretary Welch emphasized that as the first meeting of 2026, the day's meeting is the first of the final four statutorily required meetings for the Working Group. She expressed appreciation to counties that hosted recent site visits for state partners, including Los Angeles County, Kern County, and Fresno County, with upcoming visits to San Bernardino County, Riverside County, San Francisco County and Ventura County, noting these visits have helped partners from CalHHS, DHCS, and the Judicial Council better understand implementation, improve technical assistance, and identify best practices.

Deputy Secretary Welch discussed the importance of learning directly from counties implementing the CARE Act. She shared that as of September 2025, more than 4,000 individuals have been diverted into services outside the CARE process, over 3,500 CARE petitions have been filed statewide, 815 CARE agreements reached, and 30 CARE plans approved, marking progress toward the estimated 7,000–12,000 participants expected at full

implementation. Deputy Secretary Welch noted significant variability across counties and emphasized the role of the state and of the Working Group in supporting counties, sharing lessons learned, and improving outcomes.

Deputy Secretary Welch also stressed that CARE is one piece of the broader project of behavioral health transformation, and its success relies upon a suite of active system improvement efforts, including standing up new facilities, permanent supportive housing, and bridge housing. Counties are developing integrated plans under the BHSA, alongside initiatives like BH-CONNECT to expand evidence-based services and federal reimbursement. Draft BHSA plans are due March 31, with final plans submitted to DHCS by July 1, 2026.

## San Diego Implementation Update: Data, Outcomes, and Best Practices

Amber Irvine, LMFT, Assistant Medical Services Administrator, San Diego Behavioral Health Services

Melody Culhane, LMFT, CARE Program Coordinator, San Diego Behavioral Health Services

Amber Irvine expressed excitement about sharing real-time data and stories of on-the-ground progress in San Diego County. She noted many judicial and public defender partners were unavailable to participate in the presentation due to CARE Court being in session that day.

Irvine reviewed San Diego's planning and early implementation process:

- San Diego County was part of Cohort 1, launching CARE in October 2023.
- Their planning process began in late 2022, establishing strong collaboration across partners to operationalize CARE.
- Early work focused on developing court forms and integrating clinical and data reporting.
- The team used HMA trainings and built their staffing model based on higher initial caseload projections, resulting in a robust team able to provide intensive, wraparound services.
- The county also expanded capacity by adding an ACT team with a direct referral system to ensure timely access to care.
- While they have developed effective engagement strategies, engaging individuals who are chronically homeless, severely mentally ill, and often distrustful remains a central challenge.

Irvine shared the latest data from San Diego:

- As of early February 2026 in San Diego County, there have been 505 petitions received, with 16% filed by BHS.
- To date, there have been 173 CARE agreements, no CARE plans, and 31 total graduates.
- Nine individuals self-petitioned, most of whom were initially petitioned by others but not ready at the time.
- 23% of respondents were experiencing homelessness at the time of filing, with an additional 32% at imminent risk of homelessness.
- 91% of participants are now stably housed. Housing remains an ongoing process, often requiring multiple placements and adjustments based on readiness and support needs.

- 96% of individuals with CARE agreements are taking psychotropic medications and 52% are on long-acting injectables, without any court-ordered medication, highlighting the impact of relationship-building and engagement.

Irvine discussed patterns in the cases that have been dismissed:

- The most common reason for dismissal in San Diego is ineligibility.
- About 14% are elective clients who declined court oversight but accepted treatment, such as ACT services.
- 12% of dismissals were due to respondents being unable to be located, despite extensive efforts.
- While 27% of individuals ultimately refused services despite extensive outreach, engagement efforts continued after dismissal, reflecting continued persistence by BHS beyond the court process and contributing to some later self-petitions.
- Additionally, about 8% of dismissals involved individuals referred for both CARE and LPS conservatorship, where conservatorship was determined to be the more appropriate pathway for the individual.

Irvine addressed challenges with sustaining participant engagement:

- Only 9% of participants with CARE agreements are currently disengaged from services, which are lower than expected.
- Disengaged individuals are referred back to outreach teams for continued engagement while treatment teams focus on active participants.

Culhane described outreach as relentless engagement, balancing persistence with respect for individual preferences.

- Outreach teams are spending an average of 57 days building rapport.
- Teams locate individuals with minimal information, meet basic needs, and use a person-centered approach that builds trust and avoids overwhelming legal or clinical language.
- Public defenders delay involvement to allow rapport-building first, acknowledging many individuals' prior negative system experiences.
- Family and support networks are engaged when appropriate, with resources such as NAMI family support groups.

Culhane continued by outlining best practices for CARE agreements, emphasizing collaboration, participant-centered planning, and a supportive court process.

- A staged introduction to the public defender supports engagement, with collaboration among the clinician, participant, defender, supporters, and peer staff to develop the CARE agreement.
- Agreements are individualized and strength-based, presented as a menu of services aligned with participant goals such as housing, employment, or family reunification.
- Motivational interviewing is used to support engagement and develop a roadmap toward recovery and long-term goals.
- Peer support is incorporated early to enhance connection and engagement.

- The court environment is non-punitive, reinforcing participation and shared accountability across the participant and service providers.

Irvine continued by highlighting specific practices that support a smooth court process:

- Respondents are offered flexible court options, in person, virtual, or waived through their Public Defender, and their preference is always honored.
- Staff provide transportation for in-person hearings when needed and offer on-site support for virtual appearances, ensuring participants feel comfortable, supported, and able to share their perspectives.
- The CARE Judge holds weekly pre-hearing roundtables with Public Defenders, BHS, and County Counsel to stay aligned, share relevant updates, and provide helpful context in advance, (i.e. recognizing sobriety and addressing medication compliance).
- All partners promote a unified, team-based approach, keeping the environment collaborative, avoiding conflict in court, and centering the participant as the priority.

Irvine highlighted several strategies San Diego implemented to reduce barriers, streamline the process, and better support both petitioners and participants throughout the CARE process.

- Reduce petitioner burden by directly contacting them when their case is called; allow quick virtual appearance or waived appearance, with BHS stepping in as successor petitioner.
- Increase system partner participation with hospitals, PERT, detention, state hospitals, by simplifying appearances and offering flexible options.
- Require treatment providers, including ACT programs, to attend hearings for real-time coordination and continuity of care.
- Allow supportive individuals to attend hearings even if not formally designated, ensuring participants still feel supported.
- Provide culturally competent, trauma-informed support, including interpreters, ASL, tribal coordination, and on-site clinical and peer staff.
- Triage and adjust hearing schedules based on participant needs to reduce stress and improve engagement.
- Consolidate hearings whenever possible by preparing CARE agreements in advance, often resolving multiple steps in one hearing and connecting participants to services more quickly.

Culhane continued by emphasizing that housing is a critical foundation in CARE, closely aligned with the housing-first model and essential to stabilizing individuals before other services can be effective. She outlined the following strategies used in San Diego to support successful housing outcomes:

- Prioritize housing as a basic need, especially for individuals who are unhoused or at risk of homelessness.
- Utilize Bridge Housing, which can be used up to 270 days, often paired with coordinated releases from incarceration to ensure individuals have placement upon reentry.
- Leverage housing as a key rapport builder, increasing engagement and trust early in the process.

- Apply motivational interviewing to respect autonomy, even when individuals initially decline housing, while continuing engagement.
- Offer a range of housing options like SROs, board and care, independent living, master lease units, to align with participant preferences.
- Expand master lease independent living, providing high levels of ACT support, on-site services, and built-in community connection.
- Integrate peer support early to strengthen engagement, provide unique insight, and support resource linkage.
- Utilize peers throughout the process, including hospital outreach, housing support, psychiatric advance directives, and connection to essential resources like furniture, clothing, and treatment.

Culhane discussed graduation planning as an ongoing, intentional process within CARE, emphasizing continuity, autonomy, and celebrating long-term recovery beyond the court's involvement. She said most participants opt to continue in CARE up to two years, with clear pathways to step down to other ACT programs or strength-based case management at the time of graduation. She highlighted the following strategies related to graduation planning:

- Introduce graduation planning early, reinforcing that recovery is lifelong and CARE is one step in that journey.
- Normalize concerns about transition by preparing participants throughout the process and emphasizing continuity of care beyond court involvement.
- Complete psychiatric advance directives when appropriate, centering individual preferences and future care planning.
- Maintain stability planning, including preferred hospitals and supports, in case of future needs.
- Celebrate progress through flexible graduation options, individual or group ceremonies, honoring participant choice.
- Recognize achievements with meaningful ceremonies, personalized touches, and opportunities for participants and families to reflect on growth.
- Highlight strong outcomes, including reduced justice involvement, housing stability, employment, family reunification, and participants becoming leaders in recovery.

Culhane continued by highlighting alternative pathways into CARE, emphasizing the importance of expanding access beyond the traditional petition process to reach more individuals in need. She discussed several key strategies:

- Expand entry points into CARE beyond petitions, including conservatorship step-downs, court referrals, hospitals, and detention settings.
- Leverage internal petitions, notably from conservatorship transitions, to streamline access and reduce system burden.
- Utilize outreach teams to persistently engage individuals, even after dismissal or initial decline, to reconnect them to CARE.
- Establish a dedicated hospital liaison to build partnerships, provide education including on new legislation, and increase referrals.

- Respond quickly to hospital referrals, often within two days, with clinicians and peer support to enhance engagement and screening.
- Serve as a bridge between hospitals and CARE, supporting discharge planning and preventing individuals from being lost to follow-up.
- Offer CARE as an alternative to conservatorship or formal petitions, helping providers identify the most appropriate level of care.
- Increase successful internal petitions through strong hospital collaboration, improving continuity into community-based services.

Culhane shared the first page of their CARE referral form, noting that it is concise, colorful, and far less cumbersome than the full petition. The form captures the essential information needed to engage participants, confirm diagnosis, and verify treatment history. She shared additional information on referrals:

- Most referrals meet CARE criteria, though about 24% may initially lack information on past holds or qualifying diagnoses.
- A small portion of referred individuals, 6%, declined services, while 3% are temporarily unlocatable possibly due to weekend discharges; outreach teams work to engage them and often file internal petitions later.
- Some referrals are denied because individuals are voluntarily engaged with another ACT program; CARE can be pursued later if needed.
- The referral process provides flexibility, streamlines engagement, and ensures vital information is collected efficiently without creating barriers for participants.

Irvine shared that, building on the success of the CARE hospital liaison, the team is piloting a similar approach with detention facilities to reach participants with criminal justice involvement.

- About 74% of petitioned participants have a history of criminal justice involvement, highlighting the need to engage individuals in detention.
- BHS developed a Memorandum of Understanding with local detention facilities to increase collaboration and communication under strict operational guidelines. They also created a CARE jail liaison position to accept referrals, conduct screenings, and file internal petitions on-site, reducing administrative burden for detention staff.
- Early results are promising: all initial referrals received have been appropriate, demonstrating potential to connect eligible individuals to CARE and reduce gaps in service delivery.

Culhane explained the process for stepping down participants from public conservatorship into CARE, highlighting the county's collaborative and preventive approach:

- Step-downs begin with a consult request from the Public Conservator's Office, often initiated by a public defender, investigator, or case manager assessing readiness for lower-level care.
- Review focuses on participant understanding and willingness, agreement from current case manager, and appropriateness of CARE services. A clinical review committee evaluates each case to determine whether CARE is suitable.

- When appropriate, BHS internal petitions are filed, and participants can terminate conservatorship and enter CARE in a streamlined, same-day process.
- This approach prevents cyclical conservatorship, supports reintegration into the community, restores participant rights, and provides a safety net while promoting long-term stability.
- Early outcomes indicate step-downs into CARE may reduce the need for future conservatorships.

Irvine discussed operational challenges with Incompetent to Stand Trial (IST) referrals and Senate Bill (SB) 27 implementation:

- IST referrals often come from minute orders with minimal information, sometimes only the individual's name, leaving clinicians to gather eligibility details.
- Clinicians conduct investigations and file internal petitions when referred individuals are eligible and willing, but many refuse to engage, limiting successful petitioning.
- SB 27 adds complexity, as current referrals lack the elements of a full CARE petition, making it difficult for the judge to establish prima facie eligibility.
- The Public Defender's office is piloting a quick screening tool to confirm diagnostic criteria and willingness, improving referral quality.
- Video conferences with detention facilities are being explored to increase engagement with respondents who cannot meet in person.
- 147 IST referrals have been received, only 12% of which have resulted in petitions so far.
- Continuous collaboration with partners is underway to streamline the process, improve referral quality, and better utilize resources while remaining responsive to the court's requests.

Irvine shared insights on Department of State Hospital (DSH) petitions, highlighting successes and challenges with coordination:

- The DSH pilot has been successful for referrals made pre-discharge, with strong communication and helpful documentation packets.
- Once individuals return to local custody, coordination becomes more difficult due to logistical issues and concerns from criminal public defenders about CARE investigations affecting ongoing cases.
- Sudden releases or dismissals limit time for planning coordinated transitions into CARE.
- Some returning individuals are sentenced to longer incarceration terms, making them temporarily CARE ineligible and requiring dismissal until reengagement is possible.
- Quick releases and limited communication between criminal and civil courts create additional challenges for timely CARE engagement.
- Only ~15% of DSH referrals have resulted in CARE agreements, often due to acuity of symptoms or ongoing criminal charges, with others referred to conservatorship or alternate services.

Deputy Secretary Welch asked for clarification on the distinction between IST referrals and the individuals referred from DSH.

- Irvine clarified that IST referrals occur before state hospital placement to restore competency locally, while DSH referrals involve individuals returning to local custody after state hospital treatment.

Irvine addressed how the media has portrayed CARE and provided context on its effectiveness and reach.

- Media critiques suggest CARE may offer limited improvements in housing and treatment outcomes.
- Public doubt about the effectiveness of CARE persists, particularly because the program does not force treatment, which can limit its reach.
- Approximately 27% of individuals continue to refuse participation in CARE, but the remaining 73% are actively participating and benefiting from CARE services.

Irvine highlighted the positive impact of CARE in San Diego:

- CARE is delivering life-changing services, people are recovering, achieving their goals, and stabilizing in the community.
- The program fosters a hopeful environment, emphasizing empowerment as a core principle in San Diego.
- Outreach and engagement are key components, with significant effort invested in each individual to bridge gaps in care.

Culhane emphasized the importance of CARE's voluntary and empowering approach:

- The voluntary nature of CARE allows participants to choose their treatment, respecting autonomy and supporting long-term recovery.
- Recovery is not linear. Participants may have ups and downs, and ongoing support is essential throughout the process.
- Accountability is maintained by BHS and contracted providers, with close oversight.
- Contractors are monitored closely through twice weekly meetings.
- A public defender tracker flags concerns immediately, ensuring each participant's needs are reviewed and addressed.

Irvine noted that the success of CARE depends heavily on strong therapeutic relationships and thoughtful engagement. While challenges remain, the past two years show what works and why patience is important as the program evolves.

- Recovery outcomes improve when participants are engaged rather than forced; outreach and relationship-building have reduced refusals to 27%.
- Stimulant use disorder is common among CARE-eligible individuals, and contingency management is effective.
- Assertive Community Treatment and WRAP support recovery and social connectedness.
- Collaboration across public defenders, courts, jails, and hospitals is essential and requires flexibility and shared understanding.
- CARE is a complex program that needs time to stabilize. Stepping back may reveal that current processes are already working well.

Culhane and Irvine emphasized the importance of gaining more input from counties before legislative changes. They outlined the following needs related to ongoing implementation:

- Education on conservatorship processes to ensure rights are respected.
- Increased supports for families affected by psychosis and serious mental illness.
- Continued enhancement of system referrals, noting that family petitions remain the most common.
- Addressing the need for additional resources, staffing, and housing.
- Recognizing the challenges of staff turnover and burnout, particularly for ACT program teams who carry a heavy workload.
- A study of 600 San Diegans found 53% knew nothing about CARE, showing the need for ongoing community education.
- Mobile crisis teams provide faster support than the outdated 5200 evaluations; increasing funding for these teams may be more effective.

Irvine concluded the presentation.

Linkins thanked Irvine and Culhane for their presentation, noting it provided a deeper understanding of county CARE processes and highlighted best practices to share more broadly. She emphasized the importance of having data and insights for process improvement, as well as the need for county updates to be a regular agenda item for the Working Group. She then opened the floor for questions.

## Q&A

Dr. Brian Hurley highlighted many successes in San Diego's approach. The presentation noted that individuals with chronic psychotic conditions are at disproportionate risk for stimulant use disorder. He asked whether any specialty mental health providers might pursue Drug Medi-Cal and AOD certification for nonresidential programs, or whether San Diego might use non-Medi-Cal funding sources to implement contingency management.

- Irvine noted that there is limited availability of contingency management programs in San Diego. While most ACT programs do not currently provide these services, some ACT programs are also DMC-ODS certified, which could be an avenue to explore. Many contingency management programs remain in the pilot stage, and Irvine emphasized the need to think creatively about integrating these services into ACT teams.
- Deputy Secretary Welch asked for clarification on whether contingency management is being offered by DMC-ODS contractors and why those services are not integrated with ACT teams as part of the CARE model.
- Irvine clarified that San Diego has only three contingency management providers, all linked to outpatient clinics. ACT participants cannot also enroll in outpatient programs, creating a duplication-of-services issue. While CARE can provide extensive support, systemic barriers often prevent individuals with psychotic and stimulant use disorders on ACT teams from accessing contingency management.
- Dr. Hurley noted that implementing contingency management within FSP programs involves several components. The CM waiver creates a narrowly defined program, requiring time to clarify site requirements, administrative processes, and staffing.

- Deputy Secretary Welch noted that CARE was established to reduce barriers for this population. While some topics do not need to be discussed in this group, they require attention to support CARE's overall success.

Lauren Rettagliata thanked the presenters and introduced the option of using 5200 evaluations, which provide a comprehensive assessment addressing psychiatric, medical, social, housing, financial, and legal needs. She noted that across California, 5200 evaluations are largely inaccessible, no counties reported active workflows, and families requesting evaluations are often redirected to mobile crisis or law enforcement, which contributes to repeated emergency visits, untreated psychosis, incarceration, and deterioration. While voluntary care is preferable, involuntary care through 5200 may be necessary in cases of severe psychosis or anosognosia. Rettagliata stressed that families, clinicians, and first responders need more points of access, and that failing to implement 5200 carries significant human and financial costs.

Susan Holt raised concerns about the complexity and delays in licensing and certification, which hinder the expansion of DMC-ODS providers and integration with specialty mental health services. She highlighted the Behavioral Health Bridge Housing program and the upcoming funding cliff, stressing the need to sustain housing interventions and transitional rent support. She also named mobile crisis teams as a critical resource that need more funding. Holt noted challenges arising from first responders' reluctance to engage in involuntary detainment when no crime is occurring, which limits the behavioral health system's ability to connect individuals with care safely.

Keris Myrick thanked the presenters and emphasized the importance of funded outreach and engagement, noting that the power of peers is supported by research and that peers help participants connect and remain in treatment. She expressed interest in the role of family peers, who can be certified and compensated to support their relatives. Myrick encouraged a focus beyond community stabilization toward helping participants live full lives, reinforcing the importance of social connection and therapeutic relationships. She also suggested clarifying terminology for jail programs, recommending that "jail" be used instead of "detention" unless a broader term is needed.

Beau Hennemann thanked the presenters and noted the need for more detail on housing services. He highlighted reliance on bridge housing and independent arrangements and expressed interest in understanding other housing resources, current gaps, and barriers. Hennemann also emphasized the importance of service coordination beyond mental health, including physical health and social determinants of health such as financial support, transportation, and food access.

- Culhane emphasized the importance of incorporating different types of housing, noting that availability is limited. CARE connects participants to independent living, board and care, transitional rent, Section 8, and SROs, aiming to honor individual preferences. She praised contracted agencies for their resourcefulness in helping participants secure housing. Culhane also highlighted attention to medical needs within CARE agreements, ensuring participants see primary care providers and manage conditions like diabetes.
- Irvine added that CARE agreements include legal support alongside medical and social services. CARE aims to support individuals as whole, complex persons, addressing a wide range of needs.

Linkins closed the discussion, thanking the presenters for their time.

## CARE Act Communication Strategies – Presentation and Discussion

Linkins introduced Sarah Hutchinson, President of Neimand Collaborative

Hutchinson thanked the group and provided a brief overview of the current CARE communications strategy, including recapping 2025 efforts, previewing 2026 plans, and sharing ways for partners to stay engaged.

- In 2025, the team simplified the California Health and Human Services Agency CARE website to improve accessibility; since its October relaunch, it has generated over 6,600 sessions from more than 5,000 users.
- They prioritized showing CARE in action through 40+ video interviews across multiple counties, helping translate complex work into relatable stories.
- A central goal was to build confidence and reduce uncertainty, recognizing that unclear messaging can slow engagement and action.
- Communications targeted key audiences including judges, families, first responders, and system partners.
- Efforts also aimed to shape local perceptions by normalizing CARE as a viable pathway, while helping audiences understand how it fits within broader systems.

Hutchinson shared two short videos highlighting CARE successes.

- The vertical video format is designed for short, mobile-friendly social media clips to share quick, accessible snapshots of what CARE looks like in practice.
- The goal is to translate complex policy into moments highlighting lived experience, helping people understand what CARE looks like in action after two years of implementation.
- Storytelling is being used to reduce confusion, address misinformation, and lessen resistance.
- By highlighting real experiences, the effort helps people see themselves in the CARE process and supports shared learning across counties.

Hutchinson outlined that in 2026, the communications strategy will build on growing momentum in storytelling to highlight real progress and create stronger emotional connection to the work.

- Continue expanding storytelling by partnering with counties to share real experiences that show what's possible through CARE.
- Provide tools and resources to make it easier for partners to tell the CARE story locally.
- Shift to a more proactive approach, including paid and earned media, to increase awareness and address misinformation.
- Launch a CARE Champion effort, targeting 10–15 participants to help amplify messaging.
- Host quarterly roundtables, beginning in Riverside, to highlight successes and increase visibility with media.
- Continue producing short-form and social media content to broaden reach and engagement.

Hutchinson shared details of the new paid media strategy for 2026 focused on awareness and petition filing.

- Digital campaign targeting decision-makers, system partners, and potential petitioners.
- Focused on key counties including Los Angeles County, Orange County, and San Bernardino County.
- Ads across Meta platforms, LinkedIn, YouTube, Google, and streaming services.

Hutchinson outlined ways to get involved in communications efforts.

- Get involved by becoming or nominating a CARE Champion, sharing local progress stories, or contributing op-eds to help shape the narrative.
- CARE Champions will serve as trusted, credible messengers with firsthand experience, helping educate the public and decision-makers.
- The role may include media interviews, events, and outreach, with training, tools, and ongoing support provided.
- Overall, the goal is to amplify real experiences, improve understanding, and proactively tell the CARE story.

Hutchinson emphasized the continued need for partners to help identify and share stories from the field.

- Ongoing support is needed to surface stories that reflect real, imperfect, and nonlinear progress, not just ideal outcomes.
- Stories should highlight impact on petitioners and families, illustrate coordination across systems, and help address expectations and common misperceptions.
- A major goal is to include voices with lived experience, alongside behavioral health staff and local leaders.

Deputy Secretary Welch clarified that this communications effort is focused on educating the public about CARE, correcting misinformation, and highlighting its purpose and impact for the target population, rather than addressing broader behavioral health system issues or related press topics.

## Q&A

Hutchinson invited feedback and reflections from the group on where the greatest opportunities lie to proactively share stories about CARE's impact.

Bill Stewart noted that streaming and sharing links will reach more people, especially younger audiences who stream frequently.

Khatera Tamplen emphasized the importance of avoiding stigmatizing messages when sharing CARE stories, suggesting collaboration with peer-run organizations and careful review of talking points to ensure individuals are portrayed respectfully.

Keris Myrick highlighted the need to avoid insider or stigmatizing language and to clarify that CARE does not work for everyone, emphasizing the importance of setting realistic expectations and countering myths perpetuated by media.

Stewart noted the effectiveness of short-form videos on TikTok for reaching younger audiences.

- Hutchinson replied that TikTok is under consideration, but Twitter is less feasible. The team is currently working on very short six-second video clips.

Deputy Secretary Welch noted the value of allowing local adaptations of media assets, such as adding county-specific labels or contact information, so communities can use the materials while tailoring them to local CARE resources.

- Hutchinson confirmed that co-branding is possible, as done in Alameda, with some guardrails, and emphasized that counties will have access to created assets to use and adapt as needed.

Lauren Rettagliata noted that while social media is useful to disseminate information, many people don't have access to smart phones. She highlighted public libraries as a key touchpoint, where people use shared computers, reaching both potential respondents and petitioners. She also suggested printed materials or physical handouts placed in accessible locations so people can pick them up or read them on site.

- Hutchinson responded that outreach will include standard digital platforms, so library users can access materials online. She said that printed distribution is not currently planned but agreed it could be valuable for any county to implement.

Susan Holt expressed excitement about the campaign and suggested creating a local media toolkit for cross-sector partners to maintain a consistent narrative. She emphasized the importance of moving beyond a focus on petition numbers, noting that reporters often focus narrowly on metrics rather than the broader story, and recommended equipping counties with strategies to redirect conversations to meaningful progress and impact.

- Hutchinson agreed, highlighting that the CARE Champion toolkit is designed to be leveraged broadly, not just by Champions, and welcomed feedback to ensure it effectively supports local media engagement and storytelling.

Myrick expressed confusion about whether the goal is solely to address misinformation in the media or also to raise public awareness that CARE is an option.

- Hutchinson clarified that it's both, as well as ensuring decision-makers are not misled by inaccurate narratives. The three priorities are raising awareness of CARE as a resource, combating misinformation, and making sure decision-makers hear an accurate story grounded in on-the-ground reality.

Irvine highlighted the power of showing progress through individual stories but noted that confidentiality laws and client protections create barriers to using identifiable images or information. She suggested that graduation events might offer opportunities to share stories with participant consent.

- Hutchinson agreed, emphasizing sensitivity and realistic expectations, noting that human stories can still be compelling and relatable even without showing identifiable individuals, allowing the impact of CARE to be effectively communicated.

Linkins thanked Hutchinson and the group and closed the presentation.

## Featured Topic: Recommended Framework from Psychiatry Subject Matter Experts on CARE Agreements/Plans

Stephanie Welch, Deputy Secretary, California Health and Human Services Agency  
Dr. Kate Warburton, Special Advisor, California Health and Human Services Agency;  
Statewide Medical Director, California Department of State Hospitals

Deputy Secretary Welch reflected on the concept of the three-legged stool of housing, medication, and wraparound mental health treatment. She noted that while the concept was helpful in early conversations, it is insufficient in capturing the complexity and full scope of treatment and recovery needs. She emphasized how ongoing collaboration and direct observation of CARE proceedings during county site visits have significantly deepened her understanding of the crucial role of human connection in the CARE process. The focus of CARE extends beyond stabilization to whole-person care and outcomes, supporting participants to meet their own personal goals, such as returning to school, reconnecting with family, and building meaningful lives. Core services such as housing, medication, and wraparound supports are essential components of treatment through the CARE process but serve as the foundation to help individuals achieve their broader goals. She highlighted the need to better integrate purpose and belonging throughout the CARE process, including as part of graduation planning, while ensuring systems are aligned to support participant-defined success.

Deputy Secretary Welch transitioned the discussion to Dr. Kate Warburton, highlighting the work of experts who are committed to defining the full range of supports needed to help individuals move beyond stabilization and engage in deeper conversations about their future and what they want to accomplish, building the foundation for long-term recovery.

Dr. Warburton reflected on the importance of purpose and belonging and emphasized that CARE is translating theoretical concepts into practice, aligning with expert recommendations and clinician insights, and addressing the needs of California's most vulnerable populations.

Dr. Warburton described the CARE Act population, and the complex needs CARE is designed to address, emphasizing that CARE-eligible individuals experience persistent psychosis and face multiple barriers to effective treatment.

- The CARE-eligible population represents a very specific, high-need group.
- Individuals often have cognitive impairments, substance use disorders, and medical comorbidities that complicate treatment.
- Cumulative trauma from homelessness, incarceration, and institutional experiences intensifies mental health challenges.
- Many participants are unhoused when they enter the CARE process, highlighting the importance of connecting individuals with safe, stable living environments.
- Some CARE-eligible individuals do not recognize the symptoms they experience, requiring relentless outreach, motivational interviewing, and creative engagement strategies.
- Long-term untreated psychosis impairs cognition and behavior, making interventions like cognitive rehabilitation essential.
- Effective care requires a holistic approach addressing mental health, medical needs, social supports, and systemic barriers.

Dr. Warburton outlined recommendations developed by the psychiatry focus group for components of an evidence-driven CARE treatment plan for individuals with treatment-refractory psychotic spectrum disorders:

- High-Fidelity Assertive Community Treatment (ACT) is essential, though provider availability is limited.
- Socialization, functional support, and accessible housing are critical for daily life engagement.
- Integrated primary care and evidence-based substance use disorder treatment should be included.
- Psychopharmacology may need to go beyond standard approaches for complex, refractory cases.
- Contingency management should be integrated to support adherence and engagement.
- All the above elements should be included in CARE plans to provide holistic, effective care.

Dr. Warburton added that State-level support and statewide training are needed to address implementation barriers and align with reforms. She also noted that clear terminology for this high-need population is needed to guide communication and care.

Dr. Warburton concluded her presentation and opened the floor for discussion.

## Q&A

Myrick appreciated Dr. Warburton's openness to different terminology and emphasized that the CARE population is defined by very high, complex needs across multiple systems rather than just by psychosis. She sought clarification on whether CARE includes only individuals with schizophrenia and similar diagnoses or also those with bipolar disorder with psychotic features.

- Dr. Warburton clarified that the term "psychosis" is used because these perceptual disturbances uniquely impact a person's ability to perceive reality. The CARE Act specifically focuses on individuals with schizophrenia spectrum disorders and, more recently, bipolar disorder with psychotic features, though she emphasized the need for the terminology that better reflects a level of functional impairment, not just a diagnosis.

Irvine emphasized that the High-Fidelity ACT component of CARE is highly effective, highlighting the "black robe effect" as a key factor in ensuring fidelity. In San Diego, with over 360 contracted providers, CARE contracts are the most closely monitored, with twice-weekly case reviews. This intensive oversight encourages providers to deliver high-quality services.

- Dr. Warburton emphasized that contracts for High-Fidelity ACT should set clear expectations, include regular monitoring, and provide support to help providers meet fidelity standards.
- Irvine noted that San Diego's approach relies heavily on frequent, hands-on contract monitoring, requiring additional staff and time to ensure providers meet fidelity standards and deliver ACT services as planned.
- Culhane explained that with their newest contract through Telecare, being new allowed tailoring to program needs and high oversight, which providers actually appreciated. As the program expands, additional meetings are being scheduled so all providers can

share concerns and barriers rather than just receiving directives, supporting more effective care delivery. She noted that sustaining this model requires balancing intensive oversight with available staff and resources, noting that maintaining high-fidelity monitoring at scale will need careful fiscal planning.

- Irvine confirmed the Telecare model is sustainable but noted that sufficient BHS staffing is essential to maintain the intensive monitoring required.

Dr. Warburton asked county partners to identify barriers to implementing this level of care, particularly given the scale and complexity of the social systems they manage.

- Susan Holt shared that while Fresno's CARE program is functioning well, sustainability is a major concern, particularly in the context of workforce shortages. In Fresno, staffing challenges make it difficult to provide both clinical care and the intensive monitoring required for CARE. Pulling clinicians into administrative or oversight roles strains clinical capacity, and pairing administrators with clinicians adds cost. She also noted that previous investments in workforce training have often shifted to the private sector, reducing the benefit for public sector care. Holt emphasized the need for deeper, sustained investment to maintain this model over time.

Linkins asked Holt and Ian Kemmer to share their perspectives on CARE sustainability within the broader context of county BHSA planning and workforce challenges.

- Ian Kemmer emphasized that sustainability requires counties to bill Medi-Cal effectively, which adds pressure to county staff who may lack training in payment reform and program financing. He noted that integrating CARE services into BHSA planning is complex, especially with a shrinking workforce and a changing behavioral health system. Making all the pieces fit, funding, services, and staffing, remains a significant challenge for counties.
- Holt noted that focusing on the CARE Act's priority population is valuable but comes with costs and trade-offs, as resources must be intentionally allocated across the community. She suggested that in planning integrated care, it would be beneficial to involve county-based subject matter experts—including community psychiatrists, certified peer professionals, rehabilitation specialists, and case managers—so that their perspectives can help shape and refine the CARE framework and model.
- Culhane emphasized that effective ACT programs require strong leadership and support for staff, including unlicensed or less-experienced team members. She noted that retaining staff in these roles for even two years is a significant achievement due to high workloads and limited resources. Culhane recommended investing in clinical supervisors to support and retain staff, acknowledging that while higher pay would help, it's not always feasible.

Myrick raised questions about the insurance coverage and inclusion of peers in CARE Act services. She asked whether the population served is exclusively in public mental health or if some are commercially insured, noting the challenge of accessing psychiatrists for people with schizophrenia or psychosis in the commercial system. She emphasized the importance of extending training to commercial providers to prevent gaps in care. Additionally, she highlighted the potential value of integrating peers into hospital and community-based care, particularly within evidence-based treatment plans, housing supports, and physical health systems.

- Deputy Secretary Welch said that denied claims for commercial CARE participants have not been reported by counties, and she encouraged any county experiencing issues to reach out directly, noting that the state has dedicated staff, including an attorney, to address such claims.

Deputy Secretary Welch asked counties to reflect on supports that are outside the direct responsibility of behavioral health, like physical health or social welfare benefits, and whether there are opportunities for the state to provide technical assistance or strengthen system integration with Medi-Cal managed care plans, social services, or other partners, emphasizing the high level of chronic health needs among CARE participants.

- Irvine explained that for physical health supports and psychopharmacology, the challenge isn't providing care directly but ensuring access. Many CARE participants distrust both behavioral health and medical systems, so ACT teams focus on building relationships and using motivational interviewing to help individuals accept services and attend appointments. Under payment reform, time spent transporting or supporting clients in medical settings often isn't billable, which complicates sustaining these intensive services.
- Deputy Secretary Welch emphasized that as the state works to support counties in achieving ACT fidelity, there needs to be a conversation about how CARE participants' complex physical health needs intersect with the model. She remarked that the responsibility for addressing these needs cannot fall solely on the behavioral health system.
- Culhane shared that from her hospital experience, integrating physical and behavioral health through community resources like family health centers is highly effective. At Scripps Hospital, patients were physically guided to clinics offering psychiatry, therapy, and medical care in one location, which improved engagement and outcomes. She emphasized that connecting CARE participants to similar comprehensive community-based clinics could have a significant positive impact.

Stephanie Regular noted that another gap in CARE planning involves clients who are Regional Center consumers. She highlighted a persistent disconnect between mental health services and Regional Center supports, with no effective mechanism to coordinate or integrate Regional Center involvement into participants' treatment plans.

Linkins noted the value of FQHCs and integrated behavioral health, then concluded the Q&A.

## Looking Ahead: 2026 CARE Act Annual Report

Serene Olin, Health Management Associates

Laura Collins, Health Management Associates

Serene Olin provided an early preview of the second annual CARE Act report, noting that while specific data is not yet being shared, preliminary insights are in line with learnings shared earlier in the day by San Diego County. She explained that the report aims to build on prior learnings and reflect the evolving story of CARE implementation across the state, highlighting both system progress and areas for continued growth.

- The report’s objective is to provide an update on CARE Act implementation across courts and county behavioral health agencies, while identifying opportunities for technical assistance through coordination with DHCS, CalHHS, and other partners.
- This second annual report is intended to tell the “next chapter” of the early implementation of the CARE Act, capturing upstream efforts by counties and partners, as well as impacts on individuals engaged in CARE, with a focus on identifying service gaps, participant needs, and equitable access to supports.
- Expanded reporting requirements introduced in January 2025 now require counties to provide more comprehensive data, including on CARE inquiries, system referrals, outreach and engagement efforts (both pre- and post-petition), early-stage services, and greater detail on dismissals, allowing for a more complete picture of participant pathways and outcomes.
- The report covers the first 21 months of CARE Act implementation (October 2023–June 2025), including both Cohort 1 and Cohort 2 counties, though only a few months of Cohort 2 implementation is captured in the report period.
- Data sources include statewide judicial data and county behavioral health reporting, with the majority of analysis focused on county actions and participant-level information.
- 49 out of 58 counties reported data, representing 99% of the state population, with the most robust reporting seen in data points related to CARE petitions. However, fewer counties were able to report on newer requirements such as CARE inquiries (35 counties, 88% of the population) and system referrals (31 counties, 82%), reflecting ongoing challenges in developing workflows and data infrastructure, particularly among Cohort 2 counties.

Olin continued by addressing key data limitations shaping the second annual CARE Act report:

- Significant data limitations stem from newly introduced statutory requirements, which required counties to retrospectively report new data elements with limited preparation time, affecting overall data quality.
- Missing and “unknown” data were not randomly distributed, with greater gaps observed among individuals served outside of court jurisdiction, suggesting that court oversight plays an important role in tracking CARE participants.
- While limitations exist, early findings are still considered meaningful, and alignment with San Diego County’s data provides reassurance about broader trends.
- The report expands upstream focus on county behavioral health activities, including CARE inquiries and associated county actions, highlighting efforts to engage potentially eligible individuals and, in some cases, divert them to services without court involvement, though this remains challenging for counties to track.
- New reporting on statutory system referrals will follow individuals from referral through petition and beyond, including those diverted to services outside CARE, and will also capture reasons counties may choose not to file petitions.
- The report details court outcomes for petitioned individuals, including resolutions such as CARE agreements, dismissals, graduations, reappointments, and early exits, along with reasons for those outcomes.

- Recognizing that the CARE process takes time, the report will also describe what occurs during the period between petition filing and resolution, including outreach attempts, engagement efforts, services provided during this phase.
- Additional insights will include observed shifts in who is filing petitions, as well as analysis of potential racial disparities among respondents, with efforts to contextualize findings against county population data.

Olin concluded by previewing how the second annual CARE Act report will begin to examine early indicators of impact and county capacity:

- The report will focus on individuals with approved CARE agreements or court-ordered plans, with new analysis examining how service utilization changes over time based on length of engagement in CARE.
- It will track uptake of key services and supports over time, alongside continued reporting on psychiatric advance directives (PADs) and volunteer supporters.
- New sections will introduce early outcome indicators, including criminal justice involvement, law enforcement encounters, emergency room visits, hospitalizations, and housing outcomes, to begin assessing CARE's potential impact.
- A smaller section will examine individuals diverted to county services outside of court jurisdiction, exploring service engagement in the absence of court oversight.
- The report will also assess county capacity to meet participant needs in community-based settings, highlighting variations across counties and acknowledging differences in resources, infrastructure, and implementation experience.
- Beyond reporting data, a central goal is to identify actionable insights, support continuous improvement, and elevate promising county practices.
- Ultimately, the findings aim to inform ongoing efforts to close service gaps and improve equitable access to foundational supports for CARE participants statewide.

## Q&A

Meagan Subers asked about the timeline for release.

- Olin responded that the report is expected to be posted on the DHCS website by July 2026.

Bill Stewart expressed asked whether county-level variations include how jurisdictions, like San Diego, adjust resources and staffing to strengthen access.

- Olin clarified that the report does not collect data on county staffing ratios or resource allocation, as those decisions are determined locally. However, she noted that there is clear variation in how counties staff their CARE teams, and there is interest in highlighting examples from counties such as San Diego to showcase emerging best practices.

Deputy Secretary Welch emphasized the importance of clearly communicating the limitations of the upcoming report, noting it reflects data only through June 2025, the first 21 months of implementation, with much of the state contributing only about seven months of data. She underscored that the report will not fully capture the scope, progress, or intensity of county

efforts to date, and cautioned against misinterpretation or overreliance on early figures. Deputy Secretary Welch encouraged counties to rely on additional data sources to better represent their work and outcomes. She also highlighted the forthcoming independent evaluation by the RAND Corporation, with a preliminary report expected in December. She concluded by requesting a brief, high-level overview of what new insights the upcoming report will offer compared to the previous year.

- Olin said the upcoming report will include new upstream data on outreach and early engagement before referrals and petitions, along with a deeper analysis of racial disparities compared to county census data.

Linkins asked for a general sense of petition volume to contextualize the reporting period.

- Olin estimated that roughly 2,000 petitions captured in the report period.
- Linkins added that petition volume has accelerated over time, as counties moved past initial implementation phases and processes became more established.

Myrick, on behalf of Khatera Tamplen, asked whether there would be an opportunity to review the report prior to release and raised concerns about ensuring accurate and thoughtful language, referencing issues with the first report.

- Deputy Secretary Welch supported the idea and asked how it might align with the timeline.
- Olin responded that any pre-release review would need to be determined by DHCS, given formal approval processes, but agreed to bring the request forward and acknowledged prior feedback on language.
- Deputy Secretary Welch committed to follow up and reconvene the data ad hoc group, also noting the importance of getting a more in-depth update on the independent evaluation.
- Linkins added that updates to RAND's data collection methods, including adjustments in response to concerns from public defenders, would be important for the group to review.
- Linkins and Deputy Secretary Welch discussed timing for the next ad hoc meeting, noting some uncertainty about scheduling but confirming the topic will continue to be revisited.

### Updates on Training and Technical Assistance

Laura Collins provided an update on HMA's ongoing training and technical assistance efforts supporting counties and system partners on behalf of DHCS, noting that much of the work is aligned with SB 27 implementation and county-identified needs. She highlighted a partnership with Painted Brain to develop a peer-informed video and discussion guide on the CARE volunteer supporter role, designed to support structured conversations, onboarding, and training for staff and potential supporters. Collins emphasized the value of lived experience in conveying the purpose and impact of the volunteer supporter role.

- Myrick raised a clarification about terminology, asking whether the video featured a paid peer or unpaid volunteer supporter role. She noted that the distinction matters to avoid confusion between "peer supporter" roles, which are typically paid, and "volunteer supporter" roles, which are unpaid, cautioning that blending the terms can create conceptual and operational ambiguity.

- Collins confirmed that Tristan is a peer with lived experience and a member of Painted Brain. She clarified that while the volunteer supporter role is not a funded position, individuals can still be employed by an organization and serve in that role separately, as long as it is not compensated through CARE funding. She also noted that peer organizations and community partners can help identify and support individuals interested in serving as volunteer supporters.

Deputy Secretary Welch reflected on the history of the CARE Act's supporter role, noting that it was intentionally designed around supportive decision-making. She emphasized that implementation and models across counties have varied significantly and acknowledged that the field is still learning what works best in practice.

- Myrick added that future work should remain grounded in the evidence base for supported decision-making and the role of supporters to ensure alignment with established research and practice standards.
- Collins further noted that aspects of the model were informed by the CASA model.

Collins additional details on trainings and technical assistance related to SB 27 and continued responsiveness to county needs. She outlined how statewide resources are being revised, expanded, and delivered through multiple formats to support consistent implementation and real-time problem solving across counties.

- Training and technical assistance materials have been updated to reflect SB 27 changes, including eligibility criteria, clinician requirements, and court referral processes, along with refreshed FAQs informed by recurring county questions.
- Counties are supported through ongoing office hours, targeted technical assistance sessions, and frequent data-focused forums.
- New and expanded trainings include eligibility refreshers, psychiatric advance directives (PADs), CARE agreements and plans, graduation planning, and revised data dictionary guidance.
- Additional upcoming work includes collaborations focused on whole-person care, including coordination with managed care plans, enhanced care management, hospital and emergency department engagement, and housing-related strategies.
- Communication and implementation toolkits are continuously updated for county use, particularly to support jurisdictions with limited internal resources for outreach and messaging.
- Technical assistance also includes support for justice system coordination, CDCR-related petitions, staffing models, workflow development, and legally nuanced implementation questions.
- A centralized technical assistance model is now in place, supported by subject matter experts, with multiple access points for counties including email, request forms, newsletters, and feedback channels to ensure rapid response and support.

Collins concluded her presentation by inviting questions or comments.

## Q&A

Culhane asked for clarification on training related to hospitals and emergency departments serving as petitioners, noting that referrals are more common than petitions from those settings.

- Collins clarified that she meant referrals rather than petitioners, and the focus is on supporting hospitals and EDs to effectively use the statutory referral process, with additional engagement planned through upcoming office hours.

## Public Comment

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.

- Allison Monroe, Alameda County resident and member of FASMI, shared her experience as a mother of a child who began experiencing psychosis ten years ago. She shared that she was initially hopeful about CARE because of the role it offers family members. She also had thought CARE would include a path to conservatorship when needed to ensure someone's safety. She said that her daughter died of an overdose before CARE was implemented. She expressed the disappointment of many parents in CARE and encouraged Working Group members to read their stories. She criticized the lack of meaningful family involvement in the CARE process and the absence of a path to conservatorship, commenting that this is largely due to the positions of county behavioral health departments and CBHDA.
- Laurel Benhamida from the Muslim American Society Social Services Foundation in Sacramento and REMHDCO asked if media and social media outreach will be conducted in any languages other than English. She requested links to those materials be shared. She suggested that ethnic community-based media sources across the state could be useful resources for CARE communication efforts.
- Steve McNally introduced himself as a resident of Orange County and a father of a son with schizophrenia who has accessed many county services. He commented that the legislatively required report is a minimum requirement and encouraged the state to share more real-time data with the public. He also highlighted the presence of members of behavioral health planning commissions on the Working Group and said that the elected representatives of local boards and commissions do not receive BHINs. He suggested working through local channels to elevate information to Boards of Supervisors. He expressed some hesitance about the efficacy and reach of the videos shown during the meeting.
- Linda Mimms from San Diego County introduced herself as a public policy analyst and a family member. She thanked the day's presenters and echoed comments made by Lauren Retagliatta about the importance of the 5200 process as a tool to ensure people's safety. She suggested that the group look closely at cases in which someone was petitioned to CARE and it failed to meet their needs to identify how to adapt implementation to avoid negative future outcomes.
- Anita Fisher from San Diego County expressed appreciation for people working on CARE teams and also voiced her disappointment with the program. She said it was supposed to serve the people with the most severe needs and it is not successfully

doing that. She expressed that outcome measurement needs to take a long view of recovery and track individuals over time before claiming success.

## Adjourn

Linkins thanked all Working Group members and members of the public. She adjourned the meeting and announced that the next meeting will be held on May 13, 2026.