California Health and Human Services Agency
Community Assistance, Recovery & Empowerment (CARE) Act
Working Group Meeting Minutes
May 1, 2024

Working Group Members in Attendance:

- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Deb Roth**, Disability Rights California
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, Cal BCSH
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Dr. Katherine Warburton,** Chief Medical Officer, California Department of State Hospitals
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Ketra Carter**, Director, Homelessness Strategies and Solutions Department
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Matt Tuttle**, President, San Jose Firefighters Union Local 230
- **Monica Morales**, Office of Second District Supervisor for Santa Cruz County
- **Tim Lutz**, Director of Health Services, Sacramento County
- **Ruqayya Ahmad**, Policy Manager, CPHEN
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Tim Lutz,** Director of Health Services, Sacramento County
- **Xóchitl Rodriguez Murillo**, Deputy Secretary, Minority Veterans Affairs, CalVet
- **Ivan Bhardwaj,** Chief, Medi-Cal Behavioral Health – Policy Division, DHCS
- **Dr. Veronica Kelley**, Chief of Mental Health and Recovery Service, Orange County
- **Zach Olmstead**, Chief Deputy Director, Department of Housing and Community Development
- **Hon. Ebrahim Baytieh,** Judge, Superior Court of California, County of Orange, standing in for Hon. Maria Hernandez, Assistant Presiding Judge, Superior Court of Orange County

Working Group Members in Attendance Online:

- **Charlene Depner,** Director, Center for Families, Children & The Courts, Judicial Council of California
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control, LA Dept of Public Health
- **Dr. Clayton Chau**, National Healthcare and Housing Advisors
- **Lorin Kline,** Director of Advocacy, Legal Aid Association of California
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County

Working Group Members not in attendance:

- **Al Rowlett**, Chief Executive Officer, Turning Point Community Programs; Commissioner, MHSOAC
- **Anthony Ruffin**, Community Center Director 1, LA DMH Concierge Outreach Team
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Tracie Riggs**, County Administrator, Tuolumne County

1. Welcome and Introductions

Karen Linkins, Principal, Desert Vista Consulting, welcomed the CARE Act Working Group (WG) members, both those present in person and those who joined online. She thanked everyone in attendance for joining and said the meeting has a very full agenda, including robust presentations from the state, a presentation on forensic ACT, an update from RAND, and other updates.

Linkins asked all members to introduce themselves briefly. 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. She shared the dates for upcoming meetings and encouraged members to submit agenda item suggestions for future meetings.

Linkins introduced Stephanie Welch, Deputy Secretary of Behavioral Health at CalHHS and Ivan Bhardwaj, Chief of Medi-Cal Behavioral Health – Policy Division at DHCS to present on Behavioral Health Transformation in California.

2. CARE and the Broader Behavioral Health Transformation Landscape

Deputy Secretary Welch thanked members for coming and honored mental health awareness month by encouraging everyone in attendance to reach out to someone that they have not heard from in a long time to check in on their mental health.

Deputy Secretary Welch acknowledged that there have been significant changes in California's behavioral health landscape, particularly with the passage of Prop 1, which will substantially change the behavioral health delivery system. She said that her focus today will not be Prop 1 but it is important to recognize that many topics discussed by the Working Group are not exclusive to CARE but are instead focused on how to support the system to work better to serve people with the most significant challenges. She said that CARE is one piece of the larger mosaic of behavioral health initiatives introduced during Governor Newsom's administration and that the purpose of the Working Group is to assess whether the implementation of CARE is achieving the intended goal through examining how it impacts participants, their families, and their communities.

Deputy Secretary Welch shared a slide with brief descriptions of various behavioral health initiatives that CalHHS has implemented and provided more detail on CalHHS priority areas across all initiatives, including the following:

- Reduce stigma, misinformation, and discrimination related to behavioral health conditions and their differential impacts on different groups
- Reduce delays in accessing treatment

- Reduce disparities in service access, particularly that BIPOC and LGBTQ communities do not have sufficient access to culturally responsive care
- Reduce individuals in prisons and jails with behavioral health conditions through earlier intervention
- Increase high quality community care placements, including providing individuals with choice related to their treatment and housing settings
- Reduce homelessness and housing insecurity
- Increase satisfaction and trust in the quality of services

Deputy Secretary Welch shared a visual of California's continuum of care, ranging from prevention to long term support, and highlighted the following points:

- A lot of these services do not work on their own unless the entire system is functioning, which highlights the importance of the behavioral health parity and benefit alignment.
- Much of today's presentation by the state with focus on the $10 billion investment into Medi-Cal transformation.
- Recent investments cover everything from upstream interventions to supporting people deemed incompetent to stand trial get the services they need in their communities.
- Behavioral Health Transformation is the culmination of other existing initiatives which ties the larger puzzle together and will support service delivery for people with serious and long term support needs through BH Connect and elements of Prop 1. These Prop 1 components are: 1) The Behavioral Health Infrastructure Bond Act that provides $6.38B for behavioral health facilities and supportive housing. The current BHCIP program is insufficient to meet the level of demand for funds, which highlights the need for this additional funding which will allow more housing to be built and provide people with a wider array of options and quicker placements. 2)Modernizing the Mental Health Services Act, which is becoming the Behavioral Health Services Act. She said that this will not be a focus of the current meeting but it will be brought into future meetings and is directly related to CARE. 3.)Increase behavioral health system transparency statewide through examining how funds are being used and what outcomes they are yielding.
- More information is available on state websites and more thorough conversations on these changes will take place at future meetings.

Deputy Secretary Welch passed the floor to Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health – Policy Division, to present on BH-CONNECT, which she said is her favorite behavioral health initiative because it will enhance flow across the continuum of care and add valuable tools to expand care options.

Ivan Bhardwaj thanked Deputy Secretary Welch and introduced himself and discussed the responsibilities of the Medi-Cal Behavioral Health Policy Division, which includes overseeing county mental health plans and drug Medi-Cal programs. He expressed enthusiasm for discussing BH-CONNECT and explained that it stands for the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration. Bhardwaj said that while most acronyms don't carry their own meaning, this acronym highlights the initiative's goal of connecting various state investments in behavioral health infrastructure and crisis services, with a specific focus on Medi-Cal members with significant behavioral health needs. He explained that its primary relevance to CARE is that both initiatives aim to serve people with serious behavioral health needs, so there is an overlap in population.

Bhardwaj shared the following information about BH-CONNECT and the background behind the demonstration:

- The “why” for BH-CONNECT and CARE are very similar, which is that the country and California are facing a historic behavioral health crisis, which the Newsom administration has prioritized addressing. 1 in 20 people have serious mental illness, which is about 5% of the state's population, or 2 million people. Additionally, 1 in 13 children and youth have serious emotional disturbances.
- DHCS completed a comprehensive assessment report in 2022, Assessing the Continuum of Care for Behavioral Health Services in California, which remains relevant and identifies gaps and necessary investments in behavioral health services. It includes details on the ways that COVID-19 has increased behavioral health challenges.
- The report highlighted areas where investments needed to be made, which the state has been acting upon through investments in expanding community based services, building and enhancing infrastructure for behavioral health services, and developing initiatives to support children and youth, justice-involved individuals, and the unhoused population, which are the three populations of focus for BH-CONNECT.

Bhardwaj shared that BH-CONNECT includes the following elements for each target population:

- Children and youth: Ensuring evidence-based practices are covered under Medi-Cal, harmonizing tools used across child welfare and county mental health plans, promoting uniform and collaborative approaches in child welfare, and promoting stipends for youth activities.
- Individuals experiencing or at risk of homelessness: Expanding community-based services and supports, including housing and community health worker services, which are being expanded from Medi-Cal managed care plans to county behavioral health plans to increase CHW access.
- Individuals who are justice involved: Expanding evidence based practices, such as providing Forensic ACT, which is tailored Assertive Community Treatment for justice-involved individuals, adding forensic specialization to existing Medi-Cal peer support services, providing assistance for individuals transitioning out of incarceration, offering training and technical assistance to support law enforcement and align with initiatives like the CARE Act, and coordinating with other related initiatives.

Bhardwaj continued with information on the BH-CONNECT timeline:

- DHCS submitted an application in October 2023 to the Centers for Medicare and Medicaid Services (CMS), which is DHCS’ federal parent agency, aiming to take advantage of 2018 guidance and secure matching funds for short-term care (no longer than 60 days) in institutions for mental diseases (IMDs). Currently, there is an IMD exclusion for Medicaid, so this opportunity is transformative to increase access to care.
- The CMS requirement to secure matching funds is the expansion of community-based services and the commitment to meeting CMS milestones.
- BH-CONNECT will align with Behavioral Health Transformation and other ongoing state initiatives to strengthen existing investments and ensure quality care in residential settings.
- BH-CONNECT timeline milestones to date include: Public comment period on the application in August 2023; Application submission in October 2023; Current ongoing

negotiations with CMS on various components, which are not public as of now; BH Connect to go live in January 2025.

Bhardwaj identified key components of BH-CONNECT:

- Section 1115 Authorities: Through a demonstration waiver for new programs, states are able to bypass some federal rules, which is allowed by CMS under this authority. Various components fall under this authority, as was the case with the Drug Medi-Cal Organized Delivery System.
- Forthcoming State Plan Amendment: This can be thought of as the high level policies and procedures for providers that outline coverage, services, populations served, and payment and reimbursement models. DHCS publishes information notices that clarify the content of what is in the state plan with more detailed policy.
- Existing Federal Medicaid Authorities: Certain initiatives and activities can proceed without further CMS approval.

Bhardwaj explained BH-CONNECT statewide and optional components, effective as soon as January 2025:

- Workforce initiative: There is a statewide behavioral health workforce shortage, particularly in rural areas, which is the primary challenge that counties report related to implementing new initiatives. Over 90% of county behavioral health agencies report recruitment challenges, according to CBHDA. The vast majority of counties have trouble recruiting diverse staff to effectively serve communities of color. This initiative will provide $2.4 billion (requested from CMS) for long-term and short-term investments. Long-Term investments will include building partnerships with community colleges and public universities to expand the pipeline of behavioral health professionals. Short-Term investments will include hiring and retention bonuses, scholarships, and certification cost coverage for CHWs and peer support specialists. This initiative will go through 2028-29.
- Statewide Incentive Program: This program aims to support structural changes and infrastructure of county behavioral health plans through helping counties enhance their managed care infrastructure and meet quality metrics and reporting requirements.
- Centers of Excellence: Developing organizations built around evidence-based practices designed to support fidelity implementation. DHCS will provide training, technical assistance, data collection, and reporting to ensure county behavioral health plans can effectively implement evidence-based practices.
- Other CMS Milestones: This will include the development of a Statewide Bed Tracker, which is an innovative model for tracking available beds statewide, beyond local county trackers.

Bhardwaj identified BH-CONNECT initiatives for Children and Youth that include:

- Cross-Sector Incentive Program that encourages collaboration between county mental health plans, child welfare agencies, and managed care plans.
- Activity Stipends to support non-Medicaid reimbursable activities such as sports, art, and music to promote overall well-being.
- Clarifying coverage of Evidence-Based Practices such as multisystemic therapy, functional family therapy, and parent-child interaction therapy already covered under the EPSDT benefit for Medicaid members 21 and under.

- Implementation of a single mental health assessment tool for children entering the welfare system.
- Establishment of the County Child Welfare Liaison role, which was already implemented in MCP contracts in January 2024 and oversees care coordination for children in the welfare system, focusing on enhanced care management components.
- Alignment of the CANS Tool to harmonize tools used by mental health plans and child welfare agencies.

Bhardwaj continued with information about how BH-CONNECT also includes evidence-based practice programs that counties can opt into, focusing on community supports and bringing treatment to individuals rather than requiring them to seek out treatment. Other optional components include the opportunity for federal matching dollars for short-term stays in IMDs and specialized peer support services and other evidence-based practices for justice-involved populations, which will add another specialization to an existing benefit.

Deputy Secretary Welch pointed out that a lot of the optional new evidence-based practices are the types of programs that would be well suited to CARE respondents, including supportive employment and transitional rent services, and will expand the tools counties will have to provide appropriate services to support participants in their recoveries. She noted the similarities between the themes Bhardwaj discussed and the themes in Prop 1.

Bhardwaj echoed Welch's statements and continued with how BH-CONNECT Children and Youth Evidence-Based Practices include:

- Family Functional Therapy for ages 10-18, which is short-term and family-based, aimed at addressing behavioral or emotional problems.
- Multisystemic Therapy for ages 12-17, which is intensive and preventative, aimed at keeping youth out of the justice system and placements outside of their homes.
- Parent-Child Interaction Therapy for ages 2-7, focused on improving parent-child interactions through guided support.

Bhardwaj provided additional details on BH-CONNECT Evidence-Based Practices:

- Assertive Community Treatment (ACT), which is a multidisciplinary model engaging individuals in their homes, making treatment more accessible for their daily lives and reducing barriers to service access. California is catching up to some other states, but ACT will now be Medi-Cal reimbursable.
- Forensic Assertive Community Treatment (FACT), which is similar to ACT but tailored for the justice-involved population.
- Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), which is a team-based approach targeting early psychosis, aiming to provide comprehensive support with fidelity to the model. No other state in the country has implemented this.
- Transitional Rent Services for up to six months of rent support for individuals at risk of or experiencing homelessness for those transitioning from incarceration.
- Supported Employment, including job coaching, vocational assessments, and support to sustain employment while managing recovery.
- Medi-Cal Peer Support Services, which BH-CONNECT will expand with forensic specialization.
- Community Health Worker Services, which BH-CONNECT will expand from Medi-Cal managed care plans to county behavioral health plans.

- Clubhouse Services, which provide safe environments for socialization, work, and peer engagement.

Bhardwaj described how new rates are part of BH-CONNECT and that DHCS has been developing new rates for these new benefits, with varying proposed coverage authorities. New rates have been developed for Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), Clubhouse services, Supported employment, and Community Health Worker services for county behavioral health plans.

Bhardwaj identified Implementation Milestones for BH-CONNECT Evidence-Based Practices:

- January 2024: Release of Request for Information for Centers of Excellence to ensure evidence-based practices are implemented with fidelity through training, technical assistance, and support in data collection and reporting.
- State Plan Development: Ongoing development, with submission to CMS expected by summer 2024.
- Ongoing development of Behavioral Health Information Notices: Translating state plan policies into actionable guidance and making them available for public comment.
- January 2025: Start of implementation for BH-CONNECT evidence-based practices.

Bhardwaj explained BH-CONNECT Incentive Programs:

- Evidence-Based Practices Incentive Program: Over $1 billion allocated in partnership with CMS to ensure implementation success and fidelity.
- Statewide Incentive Program: $1.5 billion initiative to improve county managed care infrastructure and quality improvement capabilities, specifically for county mental health plans and drug Medi-Cal organized delivery system plans.
- Cross-Sector Incentive Program: $250 million initiative to foster collaboration between child welfare agencies, county mental health plans, and Medi-Cal managed care plans.

Bhardwaj described Statewide Assessment Program details:

- To achieve the goal of supporting counties improve their managed care infrastructure and performance on quality measures, county assessments will take place to identify gaps and strengths in county managed care programs focused on quality management and care coordination.
- DHCS is collaborating with the National Committee for Quality Assurance to develop the county assessments.
- DHCS will provide Training and Technical Assistance to support counties in meeting accreditation standards, tailored to the needs identified through the assessment.
- Completion of the county assessment is necessary for incentive eligibility and incentive funding may be available for assessment completion.
- The county assessment will take place over a nine month period from April to November 2024, so activities are well underway, though it is not too late for counties to opt in.

Bhardwaj took Questions from Working Group members.

Keris Myrick asked if the Medicaid waiver requires that everything be an Evidence Based Practice (EBP).

Bhardwaj responded that Medicaid waivers do not require this, but DHCS is pursuing the waiver as an opportunity to enhance EBPs. Myrick responded that in order to best address equity, Community Defined Practices (CDPs) should be considered in addition to EBPs. Deputy Secretary Welch said that Prop 1 contains language about advancing CDPs. She said it is important to be able to get federal reimbursement for EBPs, but Prop 1 enhance this and help CDPs become EBPs, which is required in order to get federal matching dollars. Myrick added that it would be helpful to see a visual of how Prop 1 and BH-CONNECT are related.

Myrick suggested that supported education be included along with supported employment. She added that only 2% of psychiatrists nationally are African American and suggested that some pipeline program funding be directed to HBCUs and other institutions serving racial minorities to address this and similar disparities.

Myrick suggested that peer support explicitly include family to family support as well as traditional peer support. She also emphasized the need to fund peer-run organizations to provide these services and help counties to partner with peer organizations.

Myrick asked what the NCQA's role is in regard to the county assessment. Bhardwaj responded that NCQA is running the county assessment and DHCS is pursuing two of their existing accreditation standards, quality management and improvement and care coordination. NCQA will assess counties' current capacity in both realms, which will inform DHCS' design of the program. Myrick suggested that social determinants of health and other recovery metrics also be examined through the assessment.

Deb Roth asked if there will be a requirement by the state that all counties utilize the peer support specialist benefit. She expressed concern because she has heard some counties intend to opt out.

- Bhardwaj said there is no current plan to require counties to utilize this benefit, though he agreed that every Californian should have access to these services. He emphasized that this presentation just focused on the Medi-Cal benefit, though there are also peers in every county funded through other means, such as block grants.
- Roth said she anticipates there will be cuts due to Prop 1
- Deputy Secretary Welch said she is committed to having longer conversations about Prop 1 but reminded members that BH-CONNECT goes live in January 2025 while Prop 1 changes will not go live until 2026, so there is more time to have thoughtful conversations about how to leverage all resources together at the local level. She added that many of these decisions are up to local authority and there will be many opportunities for local engagement and input, which she encouraged people with lived experience to participate in. She said she hears the concern, and it is being discussed in many different spaces and emphasized her commitment to increasing the involvement of people with lived experience in the continuum of care.
- Bhardwaj added that BH-CONNECT and CARE are both individual components of the larger puzzle of initiatives which will intersect with each other to enhance the continuum.

Bill Stewart thanked Bhardwaj and said that for the Clubhouse model, the structure and foundation of them are very important, and San Diego has adjusted their Clubhouse programs to align better with the successful ones. He asked if the state would require a specific structure for Clubhouses to ensure alignment with the model.

- Bhardwaj responded that this will be happening and is part of why Clubhouse services are included in the incentive program, because they are entirely new to the Medicaid space and will require a lot of startup funding to ensure counties can implement with

fidelity. He said that at the core of BH-CONNECT is the support from the state to make sure that EBPs are implemented effectively and correctly.

Herb Hatanaka said that the goal of developing a community-based system of care requires community organizations to develop the capacity to become Medi-Cal providers, which is very difficult for many organizations. He said the requirements are very complex, clinically and financially. Building this capacity will take a lot of money and ongoing technical assistance. He said that even in LA County, community providers are largely not equipped to handle this without a lot of organizational development assistance from the state.

Tim Lutz said that he is excited about BH-CONNECT and appreciates the areas of alignment between initiatives. He said that counties are looking for additional guidance about the opt-in process because Sacramento County wants to get going quickly and needs more details. He said he understands the workforce priority of the state but would appreciate local flexibility and funding in this initiative, as the investments need to start much earlier than college. Sacramento County has a partnership with their high schools to establish a pipeline program. He also said that given the challenges Sacramento has as a geographic managed care plan county, as much guidance and data sharing that the state can provide would be helpful to assist counties with the process of gaps analysis with MCPs.

- Bhardwaj said that the RFI for Centers of Excellence closed and they are looking to enter into contracts soon, so they should soon be able to provide more information on the opt-in process.

Dhakshike Wickrema asked how many counties have entered into the assessment phase for the statewide incentive program. She also asked if the incentives mentioned by Deputy Secretary Welch for counties to reduce homeless are related to this program.

- Deputy Secretary Welch said she doesn't remember what she was referencing.
- Deputy Secretary Buchanan said it may have been the Housing and Homelessness Incentive Program, which was funded by HBCA and is winding down, but had made progress in ending homelessness for managed care members.
- Bhardwaj responded to Wickrema's first comment and said that the opt-in process is ongoing, and he will share a tally when he has one.
- Wickrema said that as the state thinks about Prop 1 implementation and supportive housing in general, they should consider tying in ACT and FACT to support housing retention. She said that many providers on the ground are not currently connected to each other and aware of all available services.
- Deputy Secretary Welch added that managed care and ECM adds another layer of complexity and available supports for people in supportive housing.

Dr. Veronica Kelly said the opt-in is one of many initiatives and is a rolling opt-in, which Orange County does not currently have the staff capacity to engage in but hopes to soon. She said that BHSA will offer counties an opportunity to change their behavioral health systems to be more responsive to the needs of the people they are serving. She emphasized the importance of engaging in community planning processes for BHSA, as Deputy Secretary Welch had mentioned.

Xochitl Rodriguez-Murillo said she appreciated the emphasis on growing and diversifying the behavioral health workforce in partnership with educational partners.

Ruqayya Ahmad suggested the group look at the California Department of Public Health report that found evidence that CDPs are effective in reducing disparities.

3. Evidence-Based Practices for People with Schizophrenia: Presentation of the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Models

Linkins introduced Dr. J. Steven Lamberti and Dr. Robert L. Weisman to present on Forensic Assertive Community Treatment (FACT).

Dr. Lamberti and Dr. Weisman thanked the group and presented the following information about their work in ACT and FACT, beginning with Dr. Weisman's overview of ACT:

- Both Lamberti and Weisman are psychiatrists who work in ACT and FACT programs, as well as providing technical assistance on the models.
- They are co-founders of Community Forensic Interventions, LLC, which is their technical assistance entity.
- ACT stands for Assertive Community Treatment, focusing on delivering care to clients in their own environments, rather than requiring them to come into the clinic.
- ACT is a recognized EBP, alongside wellness self-management, supported employment, family psychoeducation, integrated dual disorders treatment (IDDT), peer support, and suicide prevention. EBPs are programs proven effective through randomized control trials and academic research and make lasting differences in clients' lives. Additional EBTs continue to be developed.
- At times, ACT is also referred to as PACT, which stands for Program for Assertive Community Treatment, which was the name it had when it was originally developed in Wisconsin. ACT is also sometimes called assertive outreach or mobile treatment teams, although these are not exact descriptors.
- ACT is a service delivery model, not a case management program, that provides comprehensive and holistic service delivery, focusing on recovery through community treatment and engagement that occurs wherever the client is located.
- Like with other models, engagement with ACT takes time. Building trust is a process, especially with clients who have had previous negative experiences with mental health services.
- Key to the ACT model is the design of multidisciplinary teams including doctors, nurses, social workers, counselors, and peers, with small and shared client caseloads.
- Services are *in-vivo*, meaning they are provided where clients live, whether in homes, shelters, or on the streets.
- ACT is the outpatient equivalent of the inpatient ICU due to its intensity and 24/7 nature.
- ACT offers clients an extended duration of services, ideally as long as they need that intensive level of service.
- ACT offers flexible service delivery, so clients could be seen weekly or up to daily depending on their needs at that time.
- The team is available to provide crisis management services at all hours, including weekends and holidays, which differs from typical clinics.
- ACT is designed for people with the most intensive service needs and serious conditions. The typical model of care does not work well for this population.
- Fidelity is crucial for the success of the ACT model.
- ACT team members have a wide range of skills, from nursing to therapy to employment support, to meet the range of client needs and tailor treatment plans to individuals.
- ACT was designed in part to be a recovery model for individuals who were coming out of state hospitals during deinstitutionalization.

- The outreach model of ACT focuses on meeting clients in their own environments, contacting them as often as necessary. Contact is made at minimum 4-6 times a month, but the model allows for contact up to multiple times a day, which is sometimes needed.
- Caseloads are shared among the ACT team, which gives the client a wider network of support and provides backup for providers. Caseloads are also small, with the typical caseload being ten clients per team member, allowing them to maintain a high level of engagement.

Dr. Lamberti provided an overview of FACT and how it differs from ACT:

- The ACT model is assertive, which means that outreach is persistent.
- ACT is effective is minimizing unnecessary hospitalizations and homelessness, but does not prevent arrest and incarceration, which is a crucial gap due to the high prevalence of people with SMI in the criminal justice system.
- People with SMI are overrepresented in jails and prisons due to both systemic and individual risk factors. Service providers are unable to influence the systemic factors, but can work to treat the individual factors, such as untreated psychosis or mania, criminal thinking, addiction, and certain other factors.
- Research has shown that if individual criminogenic risk factors are reduced, likelihood of arrest decreases, which inspired the development of the FACT model.
- FACT and ACT both have high fidelity to the ACT model, which includes their team composition and their staff to client ratio. Both ACT and FACT also serve clients with the same diagnoses.
- FACT and ACT teams differ in that FACT teams only enroll justice-involved clients, such as those with histories of multiple arrests or who have been found incompetent to stand trial. Some FACT teams work closely with mental health courts and some others with parole, which impacts their admissions criteria.
- FACT teams address criminogenic risk factors, whereas ACT teams do not.
- In addition to the standard composition of ACT teams, FACT teams include criminal justice specialists and feature collaboration with criminal justice professionals. It is crucial that all collaborators in this partnership have shared values, otherwise there is potential for the client to be harmed through the involvement of criminal justice partners. The necessary shared values include believing that problem solving is preferable to punishment, client health and public safety are complimentary, and recovery is possible. When values are aligned, partnerships with criminal justice enable FACT teams to have legal authority to promote engagement, which can be necessary with clients who persistently refuse treatment. These partnerships also enable treatment to be offered as an alternative to incarceration.
- FACT clients have reported that experiences with arrest made them go from refusing treatment to accepting it because they had to. Once they got connected to services, including therapy and peer support, they engaged in treatment because they trusted their providers. A number of their current clients do not believe they are mentally ill but still engage as a result of this trust. The ultimate goal is to move from this stage to clients taking charge of their own recovery.
- Therapeutic alternatives that FACT teams have developed in partnership with criminal justice partners include: Addiction treatment for clients arrested for drug possession; and Anger management for clients arrested for verbal altercations
- FACT teams collaborate with judges, public defenders, and district attorneys to align objectives, solve problems, and share information before court appearances.

- Dr. Lamberti and Dr. Weisman, along with colleagues, published the first randomized controlled trial of FACT in 2017, which studied 70 adults in jail for misdemeanors who had a long history of arrests. Half of the group received FACT services and the other half received traditional intensive treatment. The study showed that after one year, those who received FACT had reduced instances of arrest and hospitalization.
- In 2019, SAMHSA recognized FACT as a best practice.
- A 2022 meta analysis found that effectiveness of FACT teams ranges depending on their methods. Dr. Lamberti and Dr. Weisman are applying for funding to validate their FACT fidelity scale.

Dr. Lamberti and Dr. Weisman took questions from the group:

Ahmad asked if there is research on the effectiveness of ACT and FACT on a more diverse population and if there was racial and ethnic data available for the Rochester study.

- Dr. Lamberti shared a photo of their first FACT team, pointing out the diversity of the team. He said they know people of color are overrepresented in the criminal justice system and that having providers who represent the clients they serve is crucial.
- Dr. Weisman said that he realized through working on the FACT team that he thought he was culturally sensitive, but his clients and their family members did not have trust in the university he was associated with.
- Dr. Lamberti shared an anecdote of a former African American client who was not interested in engaging until an African American case manager came along to engage him, which made a substantial difference in his engagement and recovery journey.

Stewart thanked the presenters and asked about the growth of FACT since its original inception. He said that implementing a model with such small caseloads could be a challenge in California due to the population size and workforce crisis.

- Dr. Weisman said this is a common question they get and an important component is that the services ACT and FACT provides are transitional, so clients move through to lower levels of care. Many more teams need to be developed and funded, but the number of teams has been growing.
- Dr. Lamberti said they published a study last year on cost-effectiveness, which showed that FACT is cost-effective when serving the highest need clients. New York state has invested heavily in expanding the model and has just released an RFP to launch eight new FACT teams in the state.

Deputy Secretary Welch said that people who are eligible for CARE have high service needs and the CARE model is designed to serve them for 12 months. She asked if they have looked at effective step-down options to lower levels of services that could be applied by California in CARE implementation.

- Dr. Weisman said that when they started out in the early 90s, they could see people for indefinite periods of time, which has since shifted. Assigned service periods like 12 months can be very challenging when dealing with the high complexity of client needs. At the University of Rochester, they have developed a mobile treatment team as an ACT-light stepdown to provide a nontraditional model for those with less intensive needs.

- Dr. Lamberti said that there is two ways to look at 12 months, one that all people are discharged at 12 months and the other that 12 months is the average length of treatment among participants, which offers more flexibility.
- Deputy Secretary Welch thanked the presenters for their responses and said that considerations of step-down models are happening related to an array of initiatives, not limited to CARE.
- Dr. Weisman added that there is a belief that once graduated from a high level of care, people will not need it again, though this is not always the case.

Hatanaka said that his organization is a large forensic provider in LA county and has utilized various versions of the FACT model. He has found it to be most effective when implemented in residential facilities with the FACT team on site. He said that the element of court involvement creates a strong incentive for individuals to participate, which is very important up to the point where people are farther along in their recovery and more invested in getting care. Without court involvement, he said he has observed that engagement is very difficult, even with a committed ACT team. He asked what engagement strategies they have used to overcome this challenge.

- Dr. Weisman agreed that delivering these services in a residential treatment setting is far easier, particularly because they know where participants are and all their basic needs are being met. It can be challenging to find residential providers who are open to partnering on this program because of the criminal justice component.
- Dr. Lamberti said that legal leverage grew out of the therapeutic jurisprudence model and is often referred to as "the hammer," but can also be seen as respectful guidance toward compliance. Providing choice is essential to get a person involved in treatment, even when that choice is between treatment and jail time. Conveying respect, empathizing, and providing clear explanations of treatment options are also essential. Repeated, verbal explanations are the best communication format. The combination of these approaches yields the best outcomes. He added that early in their research, they partnered with an 18 bed residential provider, which is often the missing link.

Linkins thanked Dr. Weisman and Dr. Lamberti for their presentation and time.

Linkins broke the group for lunch.

4. CARE Act Implementation Update

Leaders from Department of Healthcare Services, the Judicial Council, and the State Bar of California involved in supporting CARE Act Implementation provided overviews of the roles and activities of their respective agencies.

Department of Health Care Services (DHCS):

Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health—Policy Division, presented updates on DHCS' training and technical assistance efforts, beginning with a refresher on their role and responsibilities:

- DHCS is a department under CalHHS
- DHCS is responsible for CARE training and technical assistance, consultation to support implementation, and data collection and reporting, which Health Management Associates has been contracted to assist with
- DHCS is also responsible for producing the independent evaluation, which RAND has been contracted for, and administering startup funds and ongoing guidance

- Two Behavioral Health Information notices have recently been published: BHIN 24-014: CARE Act Fine and Repayment Guidance; and BHIN 24-015: CARE Act Reimbursement Rates and Billing Guidance
- Both recent BHINs went through a public comment period to receive feedback, which was implemented to the extent possible.
- DHCS is currently working on finalizing Key Performance Indicators for the annual report, which will build upon outcome measures laid out in statute.
- HMA and DHCS are collaborating with RAND to plan for both evaluation reports.
- DCHS' first annual report will be published in July 2025 and will reflect data from October 2023 through June 2024.
- DHCS' early implementation report will capture court data and will be published December 1, 2024.
- DHCS is working through a variety of data questions in the Data Governance Work Group.

Judicial Council of California (JC):

Charlene Depner, Director for the Center for Children, Families and the Courts at the Judicial Council, presented Judicial Council updates:

- JC is leading regional convenings for Cohort 1 and 2 courts.
- JC is conducting court self-help readiness check ins.
- JC is meeting with potential early adopters from Cohort 2.
- Recent technical assistance has been in response to specific legal questions and requests for trauma informed guidance from judicial officers.
- Using Google analytics, JC has been able to see increased engagement with their CARE web page and resources, including thousands of downloads of CARE forms.
- JC is working with small courts to create a network to collectively operate an information line, increasing their capacity.

The State Bar of California:

Christopher McConkey, Program Supervisor, Office of Access and Inclusion introduced himself and briefly described the role of the Legal Services Trust Fund Commission.

McConkey shared the following updates:

- The role of the State Bar is to administer funding and reporting for legal services, nonprofits, legal aid, providers, public defenders, and other entities involved in CARE implementation. For CARE, the LSTFC distributes funding for respondents' counsel, which was about $200 million in 2024.
- All CARE funds that the LSTFC distributed for this fiscal were allocated in the Budget Act of 2023, which determined that the minimum amount of funding that QLSPs and public defenders could receive is $20,400,000 and the maximum funding that could be distributed for legal training and technical assistance was $1,020,000.
- For this fiscal year, all public defender offices in Cohort 1 counties received funding.
- Two QLSPs applied for and received funding for the current fiscal year, both in San Francisco County.
- The Budget Act of 2024 will determine funding for public defenders and QLSPs for the next fiscal year.
- In the waiting period before the Budget Act is passed, the LSTFC released a Request for Proposals (RFP), which estimates the amount of funding that will be available to counties. It estimates up to about $47 million for the representation of respondents and

up to $2 million for legal training and technical assistance. This is based off the Governor's proposed budget, but this number could change significantly when the budget actually passes, so the RFP also includes differing estimates based on various scenarios.
- The funding for each county will be based on their general population and there will likely be a funding floor.

Questions and Discussion:

Linkins invited questions from Working Group members on the presentations from LSTFC, DHCS, and JC. No members had questions.

5. RAND Presentation of CARE Act Logic Model

Linkins introduced members of the RAND team to present a current draft of their evaluation logic model.

Melissa Labriola thanked Linkins and presented the following information:

- RAND is a nonprofit research organization with the overarching goal of helping to improve decision making through research, evaluation, and analysis.
- The RAND evaluation team for CARE has relevant expertise in policy analysis, statistics, community psychology, multi-site evaluations, and other specialties.
- Melissa Labriola, Nicole Eberhard, Amy Shearer, and Stephanie Brooks Holliday are the leads on the CARE project. Amy is newer to the team and will be leading the development of the evaluation plan. While these four researchers are the leads, the team will be much larger.

Larbriola described how the goals of the evaluation are to:

- Document the theory of change of the CARE Act.
- Evaluate the program implementation, outcomes, and impact.
- Document lessons learned related to the CARE model.
- Make recommendations for ongoing implementation.

Labrioal explained how in the initial years of RAND's contract, they will provide subject matter expertise to support evaluation design, then in the later years they will be focused on measuring outcomes quantitatively. The purpose of the evaluation logic model is to:

- Provide a road map to present the relationships between the resources, activities, outputs, outcomes, and impact.
- Illustrate how the program is going to work and what the program will do to achieve the intended outcomes.
- Build shared understanding among stakeholders through making assumptions explicit and aligning on goals
- Identify necessary data to monitor and improve programming
- Share with stakeholders the problems the program seeks to address
- Identify what evaluation questions should be asked and why

Labriola continued with how the logic model structure includes evaluation questions, strategies and activities, process outcomes, and key outcomes. These components are also often referred to as inputs and outputs. The outputs are the intended, measurable effects of implementation, such as reduced substance use or increased housing. Outcomes can be split into short and long-term. Logic models follow an "if, then" structure, usually reading from the left to the right.

Putting this into a graphic roadmap helps get everyone on the same page about the “if” and “then.”

Nicole Eberhart presented the current draft logic model that RAND has developed for the CARE Act independent evaluation. Eberhart emphasized that developing a shared understanding of what should be measured is the first step, then a process can occur to determine how those things should be measured.

Eberhart shared a slide with the current draft and walked through each section:

- Evaluation questions are split into two categories, implementation focused and outcome focused. These questions include how prepared counties were to implement and what factors may be impacting the effectiveness of CARE. Outcome questions include if service engagement increased, if recovery and empowerment increased, and if outcomes were experienced equitably.
- Strategies and activities are split between the individual level and the system level. Individual level factors include participation in various parts of the process and the participation of advocates, including peers and family, in the court and treatment process. System level factors include county workflows, system coordination, data collection and sharing, and accountability levers.
- Implementation outcomes are also split between the individual and system level. Individual level implementation outcome measures include the number and description of individuals in different CARE pathways, levels of participant and caregiver satisfaction, levels of social support, and other factors. At the system level, implementation outcomes include coordination between system partners and an increase in county accountability.
- Key outcomes will focus only on individuals with CARE plans and will look at the extent to which participants were able to achieve the outcomes laid out in the “3-legged stool” of engagement in wraparound services, stabilization on medication, and stable housing. This section will also look at indicators of person-important recovery outcomes, such as increased meaning and empowerment, potentially guided by the CHIME framework. This section will also measure decreases in certain outcomes, such as hospitalizations, arrests, and conservatorships. All outcomes will also be examined for any disparities.

Eberhart explained that the logic model has been evolving and the current draft reflects feedback from a variety of stakeholders. RAND is hoping to get additional feedback from Working Group members.

Linkins invited group members to ask questions and provide feedback:

Stewart asked what other personal recovery frameworks there are in addition to CHIME and how RAND will select which framework they will align with.

- Eberhart said that CHIME is a widely used framework and in order to make their determination, RAND will seek input from experts and stakeholders and also look at factors such as measurability. These outcomes will be measured through the participant survey that RAND will field.

Deputy Secretary Welch said that she felt two pieces were missing from the evaluation questions section. The first is the level of consumer satisfaction of the whole process and if the process was effective in helping people achieve recovery. The second is about impact the court’s role had on the process and outcomes, linked to the county accountability component.

She added that whether participants were placed in the housing or treatment settings of their choice should be considered as another implementation outcome. She also added that a reduction in homelessness should be considered in the key outcomes section. She asked what the Working Group can expect to see out of the preliminary evaluation, since the group will have its last meeting at the end of 2026. She also asked what the evaluation will capture about people who engage voluntarily or have CARE agreements.

- Eberhart responded that most components Deputy Secretary Welch raised are present but may need to be elevated to be more prominent in the logic model, such as components related to consumer satisfaction. She said that the court piece is not explicitly called out in the systems section, which can be made clearer. In terms of measuring if people landed where they wanted in their housing placements, that is meant to be captured in the 3-legged stool section but they will adjust the language to capture the personal preference component. She said that by December 2026, they should already have outcomes for nearly all components, though the timing of the survey has not yet been determined.
- Labriola added that there will at least be some preliminary results from the survey. She said the only thing that may be unknown is any data they are linking to, but everything else will be able to be preliminarily reported.
- Eberhart said that the key outcomes will only look at people with CARE plans, because the RAND team feels that if they went through a different pathway, they are not really receiving the full scope of CARE, which makes measurement challenging as they do not want to be measuring the system of care as usual. For all respondents, the report will include a breakdown of demographics and who ended up on different pathways. There will also be a process evaluation that will try to capture why people ended up on different pathways. She said that there will not be administrative data on people who do not have CARE plans and they will not be surveying people who do not have CARE plans.

Depner asked how the evaluation will measure if CARE is working in an environment of so much change and new initiatives. She also asked what control group will be used. She said that each county is implementing CARE very differently, which will likely complicate the evaluation.

- Eberhart said that it has not yet been determined what the control group will be, but RAND has been discussing comparing individuals to themselves pre-petition to determine the effect the process had on their lives. She said they can also look at the services that participants received and how their outcomes vary based on those services. She agreed that counties are very different but said that RAND has done many multi-county mental health evaluations in California and has often been able to evaluate outcomes and find similarities in those outcomes through looking at certain model features. She emphasized that they will take local conditions and variation into account.

Rettagliata said that respondents have severe conditions and intensive needs. She asked why decreased conservatorships is seen as a measure of success, when it may be found through the CARE process that a conservatorship is what somebody needs. She expressed frustration about the perception that psychosis will vanish quickly with the right medication and said that sometimes a conservatorship is a needed step and should not be seen as a negative thing. She said the same is true with hospitalizations, because this may be a regular occurrence through some people's lives, which does not mean that they are failing or that CARE is failing.

- Eberhart said that RAND had the same debate about conservatorship within their team and would welcome additional feedback from the group. She said that in regards to

hospitalizations, they do hope to see decreased instances of hospitalizations as a result of engaging in treatment, which does not mean that hospitalizations may never be needed. Hospitalizations are very disruptive for people's lives and should be avoided when possible. She suggested that the language could potentially be changed to "preventable hospitalizations" and emphasized that she understands Rettagliata's concern.

- Deputy Secretary Welch said that the outcomes Rettagliata raised were identified in statute, so while she understands the concerns, these outcomes have to be examined. She said that nuances around hospitalizations and other events will hopefully be captured in the survey with the intention to measure if CARE was overall a positive experience.

Myrick thanked the presenters and said that the CHIME framework seems to fit well with the SAMSHA definition of recovery, so those could be considered together. She also suggested that safety be incorporated into the consideration of stable housing.

- Eberhart said the housing language suggestion can be incorporated.

Chau said that he has heard from parents in multiple Cohort 1 counties whose adult children started the process then decided they wanted treatment and off-ramped, so this could potentially be a control group. He also said that from a harm reduction perspective, people who have co-occurring disorders and engage in intensive drug treatment programs should be seen as a potential positive if it leads to improved outcomes.

Wickrema asked how various components will be defined in the context of the evaluation, such as the preparedness of counties, the effectiveness of care, and what is meant by stable housing.

- Eberhart said that some of these terms are defined in the data dictionary and others likely need more explicit definitions.

Eberhart thanked the group for their feedback and said that all feedback received previously has been very helpful for their iterative process. She said that in terms of next steps, RAND will be finalizing the logic model, drafting and sharing the evaluation plan, and designing the stakeholder engagement plan.

Linkins thanked Eberhart and Labriola for their presentation and openness to feedback. She encouraged RAND to utilize the ad hoc groups as other stakeholder bodies for feedback.

6. Updates on Time Limited Ad Hoc Sub-Groups

Linkins introduced the co-chairs of the three ad hoc sub-groups to provide updates from January meetings.

Keris Myrick of the Data Collection, Reporting & Evaluation sub-group provided the following summary of their previous two meetings:

- In one of the meetings, RAND presented an earlier version of the logic model and the group provided robust feedback, which they clearly listened to and incorporated.
- HMA presented in the March meeting on the data submission experiences of Cohort 1 and what training needs emerged that HMA will apply to training for Cohort 2. It was too early for the group to look at the data, but HMA is currently examining it. HMA also updated the group on the actions of the Data Governance Work Group.

- The group discussed approaches of different Cohort 1 counties, including San Diego's partnership with UCSD on a local evaluation.
- NAMI presented preliminary findings of a brief survey of family petitioners about how they feel the process is going.

Linkins opened the floor for questions from WG members.

Hatanaka asked what the difference is in the process for people with CARE agreements and CARE plans.

    - Deputy Secretary Buchanan explained that the CARE agreement is a voluntary settlement agreement with the same process as the CARE plan.
- Hatanaka asked if people with CARE agreements are able to opt out of the process partway through.
- Deputy Secretary Buchanan said that there are three primary pathways: the voluntary pathway where people engage quickly outside of the court, the CARE agreement which is a voluntary agreement with a court component, and the CARE plan.
- Deputy Secretary Welch said Hatanaka is likely getting at the same question she has about the evaluation, which is about what information will be known about people and their outcomes depending on their pathway. She said she also has confusion about this.
- Serene Olin spoke more to the three separate pathways and said that the voluntary pathway is the only one with no court supervision, but the county is required to submit data on people in all three pathways.
- Deputy Secretary Welch asked that in the instance that people who are on the voluntary pathway just engage in one service then disengage, how counties will be able to continue reporting data on them.
- Olin said that the county is collecting data on the services that people in the voluntary pathway are supposed to be receiving, meaning that people disengaging in services will be captured in the data reported.
- Jennifer Brya said that in the logic model, the evaluation will be leaving out large amounts of data on people in other pathways that is being reported by only focusing on people with CARE plans in the key outcomes section. She said that the outcomes should focus on all three pathways if counties are indeed reporting data on all pathways.
- Eberhart said she will work with HMA offline to sort out this question about what data is available. She said they are not intending to survey anyone without a CARE plan.

Stewart asked if Myrick had more information on UCSD's plan for data collection.

- Myrick responded that this information was not covered in depth, but it seems to be above and beyond what is required in statute.

Myrick followed up on the CARE pathways discussion and said that people who engage voluntarily and then disengage may still be accessing county services in some capacity and they also may be accessing services through the private system. She asked how this data might be captured. She also said that if people completely disengage with CARE and services and continue not to do well, that they would likely be repetitioned or end up on a pathway to conservatorship. She said it would be valuable to know if people end up actually doing very well when they disengage, which might point to a conclusion that CARE was not what was really needed. She asked what the county accountability piece regarding engaging people looks like for pathways other than the CARE plan pathway, since county accountability was a large part of the intention of the legislation.

- Deputy Secretary Buchanan said that there is accountability on the county through their data reporting obligations, which will capture outreach efforts. Additionally, some judges are requiring additional court involvement from the county beyond what is required in statute for other pathways.
- Linkins said that the pieces Deputy Secretary Buchanan spoke to indicate the ways in which the process of CARE creates the conditions for accountability and continuity of care.

Myrick encouraged additional group members to join the Data ad hoc group.

Linkins said that the co-chairs of the other ad hoc groups were unable to attend today's meeting, so she and John Freeman would report the remaining updates.

Freeman shared updates from the recent meetings of the Training, Technical Assistance & Communications sub-group:

- At the March meeting, Dr. Warburton gave updates on trainings she has been developing with HMA, HMA gave an in-depth overview on their recent and upcoming TTA, and the Judicial Council gave updates on their recent TTA activities.
- At the April meeting, Paul Hernandez from Fenton presented on the communications work that his team did for Los Angeles County for their CARE rollout, including lessons learned. The lessons that Hernandez shared included the importance of starting early, not overestimating demand, emphasizing the benefits of CARE, creating simple and repetitive messaging, educating petitioners on the details of the process, and leveraging trusted messaging ambassadors.
- The recordings of all ad hoc meetings are posted on the Working Group website.

Linkins opened the floor for questions from WG members.

Myrick asked who is considered trusted communicators in CARE communications strategies (peers, counties, families, etc.)

- Freeman responded that it is all of the above, depending on the audience. He said that Cohort 1 counties have talked about the various channels they have found to leverage these different communicators to get information out there.
- Amanda Ternan from HMA said that HMA has liaisons in each county that make sure counties have access to all comms materials that have been developed by the state. She said that counties report that the largest point of confusion in their communities is on what CARE is and is not, so HMA has continued to do trainings focused on providing clarification. She said that HMA is developing a communications toolkit that can be customized by each county. Additionally, NAMI CA is conducting outreach through their contract with CalHHS.
- Myrick said she continues to feel that CARE Act as a euphemism for CARE Court may erode trust, because it is not forthcoming. She said that people may not find courts to be caring.
- Ternan said that there is a physical CARE Court, but in trainings, HMA refers to CARE as the CARE process when talking about the process, and CARE court when talking about the court. She said she agrees that this can be confusing.

Linkins provided summaries of the recent meetings of the Services & Supports group:

- Instead of an April meeting, there was a decision made that it would be beneficial for members to attend HMA's robust two-day housing training. This training will be posted soon.
- At the March meeting, Tami Mariscal and Brock Kolby from Tuolumne presented on the broader continuum of care, which was a bit of a precursor to Deputy Secretary Welch and Bhardwaj's presentation today. Mariscal and Kolby explained the landscape in Tuolumne, which is a county that is both a behavioral health plan and direct services provider. They framed CARE within their broader continuum, focusing on the three-legged stool and the housing options they are developing. They spoke about being able to collaborate with the Board of Supervisors to advance these developments and about creative strategies they are using to bolster their workforce, such as pipeline programs. They also spoke about the complexities of state funding, federal funding, and commercial insurance.
- All the ad hoc meetings are online, and the members of the Services group are diverse. At the March meeting, group members put forward interesting ideas about how to effectively delivery services in the field.
- Moving forward, the group will begin taking up specific topics that were raised at the March meeting such as workforce challenges and how different sectors can collaborate to address complex problems.

Linkins opened the floor for questions from WG members.

Deputy Secretary Welch asked if there is a way that the key learnings from each ad hoc groups can be packaged up for Cohort 2 counties, since nobody has time to go back and listen to all meetings.

- Linkins said that is a great idea and can happen in addition to these report outs at Working Group meetings.
- Freeman added that they could collaborate with HMA to get these learnings into their newsletters.
- Linkins said that RAND, HMA, and the Judicial Council attend ad hoc meetings, so they are all absorbing the feedback.
- Depner said that JC has been creating opportunities for Cohort 1 judges and court staff to answer questions from Cohort 2.

Hatanaka asked if the group can hear updates from Cohort 1 counties about implementation.

- Linkins said that limited updates are provided during the ad hoc meetings and there will be a more robust update for this group at the August meeting.
- Deputy Secretary Welch said that the last Working Group meeting was very focused on Cohort 1 updates and asked what Hatanaka would like to hear in terms of updates.
- Hatanaka said that CARE is such an involved legal process and there is so much work that counties are putting into getting people to the point of a CARE agreement. He said that since the last update was three months ago, he is wondering how the counties are doing.
- Deputy Secretary Welch said that is a fair request and since the last presentation was focused so much on engagement, perhaps the August presentation can focus more on initial hearings and next steps in the process. The first data report will not be ready until December, but they can try to provide some numbers from Cohort 1 counties in August.
- Hatanaka said that there is a lot of scrutiny on the CARE Act, particularly focused on how many people got to ordered agreements and plans. He said that he believes it is an important finding that other pathways are emerging from the CARE Act for people to receive care, which is changing the system.

7. HMA/DHCS TTA Updates

Laura Collins, joined by Serene Olin and Amanda Ternan, presented updates on HMA's training and technical assistance for Cohort 1 and 2 counties.

- The priority for 2024 is moving from theory to practice now that all counties are coming online. Last year, they were in a more theoretical space, but are now engaging with county subject matter experts to participate in the development and delivery of trainings since they are on the ground doing the work.
- HMA is partnering with peer and family SMEs, racial equity SMEs, trauma informed care SMEs, and advocacy organizations.
- HMA is also collaborating with state partners on training development, particularly Dr. Warburton and the Judicial Council.
- HMA is providing TTA support through 12 county liaisons assigned to 58 counties. There was a liaison model for the eight Cohort 1 counties last year, which they have now expanded. Liaisons are the primary point of contact for counties who triage questions and requests from technical assistance. They are currently getting a high volume of questions, which is very exciting to see such a high level of engagement. Liaisons have connected with 55 of the 58 counties except for some small counties experiencing changes in leadership. The liaison model is working well and is flexible to meet the specific needs of counties.

Collins, Olin, and Ternan shared that the TTA timeline for the remainder of 2024 has been developed, which encompasses TTA for Cohort 1 and 2. Cohort 1 is attending trainings as well as presenting at them, such as the recent housing training. Collins shared the visual of the timeline. The timeline also includes placeholders for priority topics that arise. TTA activities by quarter include the following:

- Quarter 1: The quarter began with the Cohort 2 kickoff and also included trainings on the role of the peer in the CARE process, data file submission, the petitioning process, and the first training in the schizophrenia spectrum disorder series, which is being developed by Dr. Warburton and Dr. Avery. HMA also posted several links from SMI Advisor that can inform clients in their clinical work. The quarter ended with the rural affinity group TA call.
- Quarter 2: Trainings to date have covered topics of schizophrenia spectrum disorder course & outcomes, data collection and reporting, and best practices related to housing. Upcoming trainings will include a data dictionary walkthrough, a training for first responders, an open forum with the Judicial Council on cross-sector collaboration, and an overview of APA guidelines. Collins emphasized that these topics were identified as priorities by counties and ad hoc groups and there is additional space for new topics to be added.
- Quarter 3: Trainings will cover issues unique to rural counties, an implementation readiness session, methods for integrating families and other existing supports into CARE, and more content in the schizophrenia spectrum diagnoses series, including guidance on clinical assessments.
- Quarter 4: Trainings will cover treatment planning, working with justice impacted individuals, updates on volunteer supporters. There will also be another affinity group call for rural counties. There is no specific definition used for rural counties, as many counties have rural areas as well as urban ones, so any county is welcome to attend. It has been beneficial for the counties who have attended prior rural affinity group calls to be able to talk to each other.

Additional TTA activities and resources in 2024 will include: Affinity groups, open forums, and office hours; Early implementation support to counties, including data collection and submission support; Ongoing coordination and collaborative TTA with the Judicial Council; Release of new resources, such as FAQs, resource guides, and toolkits. These materials are informed by Cohort 1 counties.

Collins provided an overview of the CARE Act Resource Center website features, including the county directory of Cohort 1 county CARE websites, updated FAQs, and contact and TA request forms. The website has recently been updated in accordance with feedback from this group and the ad hoc groups. The main change has been to add a feature to allow users to filter trainings and resources by audience. Key resources and trainings have also now been pinned on the website.

Collins took questions from group members.

Deputy Secretary Welch said this group will likely have a lot of interest in the implementation readiness training, including herself, and asked Collins that WG members be notified about the details of that training. She also asked if counties have asked for opportunities to get together in person for TTA, since navigating the website still seems overwhelming. She said she thinks it would be helpful for this group to hear feedback on how various audiences are receiving the trainings and other resources and if they are working for people. She said that the makeup of the Working Group is strategic, because everyone in the group is someone who CalHHS would want to sit at the table locally to implement CARE, so it would be more relevant to the group to hear who is engaging with the training than to hear specifics about the training content.

- Ternan said that when people register for trainings, they have to say who they are representing and what stakeholder type they are. There are also evaluations for attendees to fill out after every training. HMA submits monthly dashboards to DHCS that cover all of this information through Google Looker. HMA can talk to DHCS to determine what types of information from these dashboards would be best to bring to this group. Overall, the feedback from stakeholders has been very positive. Counties are frequently asked about what other topics they want covered and HMA recruits subject matter experts to address these topics. Trainings are followed by open forum discussions to increase engagement.
- Deputy Secretary Welch said that she loves in person meetings and people don't have as much face-to-face interaction in the Zoom era. While in person trainings may not always be realistic, if there is enough of a demand for them it may be worth trying to make them happen. She said it seems like there is a lot of really great information available, but she would never have time to go through it.
- Collins said the liaisons are very useful for helping counties figure out where to start and which trainings would be useful for them to meet their specific and unique needs.

Myrick thanked the presenters for the wealth of information. She said that she sees that there are SMEs for racial equity and cultural competence but asked if there are relevant trainings as well.

- Collins said that this content is infused throughout all trainings, and there is also a trauma-informed care series that incorporates racial justice and equity concepts.
- Myrick asked how these topics are also infused in the SSD series, especially due to the diagnostic disparities that may be perpetuated. She said that the need to not perpetuate disparities through this process has been her issue since the beginning. She also said that having worked at the county level, she knows that sometimes people ask for the training they think they need, which is not the training they really need. She said that she always worries about SSD trainings developed without the input of people with relevant

diagnoses who were perceived as people who would never get out of the system and get better, even though many of them are doing better and have evidence about what works that gets left out of trainings. She added that she was deeply involved with NAMI and a member of the leadership, but when she hears that NAMI is involved with all training but doesn't hear the same about peer organizations, it can be troubling that there doesn't seem to be a state level peer collaborator.
- Collins said that HMA contracted with Painted Brain as their primary peer collaborator and has been working closely with them in various capacities on training development.
- Myrick said this also relates to the topic of medication adherence and understanding the power of "no." She said she learned this from Dr. Aaron Beck who developed CBT, who understood that when somebody says "no," this is an issue related to understanding the role of medication in that person's life and recovery, rather than an issue of adherence. She asked how this subject is addressed in training, because it often gets reduced to a binary question.
- Collins thanked Myrick for the input and said this is important perspective for them as they continue content development.

Roth asked that for the August meeting, the slides be sent out in advance of the meeting.

Dr. Warburton responded to Myrick and said that she hears her and agrees and would like to have additional conversations together about content for the SSD series.

Myrick said they can connect.

Linkins said that she hoped members would stay for public comment. She displayed a slide with the next meeting dates.

Deputy Secretary Welch asked if any members had any agenda item requests for the August meeting, with no commitment that they could be fulfilled.

- Wickrema said that because of how many new initiatives are being rolled out, somebody at a previous meeting had asked for a visual of how they fit together. She said the presentation this morning was very helpful but for stakeholders like small counties and providers, a visual map would be beneficial. She said this would not necessarily have to be an agenda item but could be.
- Deputy Secretary Welch said that she is currently working on this and it is a challenging thing to produce due to the scale.

8. 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.

- Stewart Gaiber introduced himself as a community connected veteran and member of the San Diego County Behavioral Health Advisory Board. He said he is not speaking on behalf of any organizations. He thanked the members of the group and asked what the experience has been in CARE implementation of serving veterans and seniors. He asked if there are any metrics that speak to this. He said that there is evidence-based literature pointing to how these populations have distinct needs. He said he has heard from community members that treatment resources in San Diego may not be adequate to execute CARE plans.
- Kaino Hopper thanked the group for their diversity and willingness to make sure CARE is responsive to the needs of the people it is meant to serve, which is a group that includes her daughter. She said she is grateful for the FACT presentation and thinks these

offramps from the justice system are very important and could have served her family well. She said she has been attending as many Working Group meetings and ad hoc meetings as she can and appreciates the hybrid format. She said she would love to be a family member who could have her daughter back under her roof through CARE, though it is often too difficult to get a placement in the community. She said she hopes those concerns are addressed and appreciates the crisis response part of the dialogue.

Linkins adjourned the meeting, thanked everyone in attendance, and reminded the group that they can email with questions and suggestions for the August agenda.

Deputy Secretary Welch said that Myrick had good ideas that could be followed up on.

Linkins thanked everyone again and said she would see them on August 21.

Appendix I: Public Zoom Chat

From John Freeman - DVC to Everyone:

Good morning everyone! We are just getting situated here in the meeting room

From John Freeman - DVC to Everyone:

Welcome all!

From John Freeman - DVC to Everyone:

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

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

From Ruby Spies to Everyone:

More information about Behavioral Health Transformation is available on the DHCS website: https://www.dhcs.ca.gov/BHT/Pages/home.aspx

From Ruby Spies to Everyone:

DHCS' 2022 report Assessing the Continuum of Care for Behavioral Health Services in California can be accessed through the following link: https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

From Ruby Spies to Everyone:

More information about BH-CONNECT is available on the BH-CONNECT page of the DHCS website: https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

From John Freeman - DVC to Everyone:

We will have an opportunity for public comment later in the session. Please always feel free to send comments to the CAREAct@chhs.ca.gov

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From John Freeman - DVC to Everyone:

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

From John Freeman - DVC to Everyone:

Links to County and Court CARE sites: https://care-act.org/library/county-website-directory/

From John Freeman - DVC to Everyone:

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