# California Health and Human Services Agency
# Community Assistance, Recovery & Empowerment (CARE) Act
# Working Group Meeting Minutes
November 8, 2023

## Working Group Members in Attendance:

- **Al Rowlett**, Chief Executive Officer, Turning Point Community Programs; Commissioner, MHSOAC
- **Anthony Ruffin**, Community Center Director 1, LA DMH Concierge Outreach Team
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, Cal BCSH
- **Dr. Veronica Kelley**, Chief of Mental Health and Recovery Service, Orange County
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Hon. Maria Hernandez**, Assistant Presiding Judge, Superior Court of Orange County
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Matt Tuttle**, President, San Jose Firefighters Union Local 230
- **Tyler Sadwith**, Deputy Director of Behavioral Health, DHCS
- **Sarah Jarman,** Director of Homelessness Strategies and Solutions, City of San Diego
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tomiquia Moss**, Founder & CEO, All Home CA
- **Tracie Riggs**, County Administrator, Tuolumne County
- **Xóchitl Rodriguez Murillo**, Deputy Secretary, Minority Veterans Affairs, CalVet
- **Zach Friend,** County Supervisor, Santa Cruz County
- **Zach Olmstead**, Chief Deputy Director, Department of Housing and Community Development

Working Group Members not in attendance:

- *Chevon Kothari, Deputy County Executive, Sacramento County*
- *Vitka Eisen, CEO, HealthRIGHT 360*
- *Dr. Fadi Nicholas, Chief Medical Officer at Sharp HealthCare in San Diego*
- *Eric Harris, Director of Public Policy, Disability Rights California*
- *Kiran Savage-Sangwan, Executive Director, California Pan-Ethnic Health Network*
- *Lorin Kline, Director of Advocacy, Legal Aid Association of California*
- *Khatera Aslami Tamplen, Consumer Empowerment Manager, Alameda County Behavioral Health Care Services; Commissioner, MHSOAC*
- *Charlene Depner, Director, Center for Families, Children & The Courts, Judicial Council of California*

## 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 introduced herself and the other members of the Desert Vista Consulting team: Ruby Spies, John Freeman, and Jennifer Brya. Linkins said that her team is present to support WG members with any technical issues or other needs.

Linkins displayed a list of all WG members and introduced a new member of the WG, Lauren Rettagliata. Rettagliata introduced herself and shared that she is the family member of someone with a serious mental illness and substance use disorder and she is also one of the authors of Housing That Heals, which was informed by her background in building community-based housing for vulnerable communities.

Linkins thanked Rettagliata and announced that Khatera Aslami has a new job with SAMHSA and will be stepping down from her position on the WG.

**Deputy Secretary Stephanie Welch** shared that CalHHS will be searching for a replacement for Aslami and that she brought a valuable perspective to the group from her lived experience and her extensive experience working in county-based peer support services and running a peer-led organization . Deputy Secretary Welch said that Rettagliata is replacing Christina Roup, who also took a job outside of California and was asked to step down. Welch said a challenge of hybrid meetings is that it is unclear to the people in the room which members are attending online, but there is also another new member joining, Sarah Jarman.

Linkins clarified that Jarman is online, but will be stepping down and will be replaced by Ketra Carter, who works with Jarman in San Diego.

Linkins briefly reviewed details of the meeting agenda and space. Karen Linkins reviewed WG meeting logistics and the virtual meeting guidelines for both WG members and members of the public, including the following details:

- ASL interpretation is available in the pinned video feed and a link for live captioning is provided in the chat. WG members should speak slowly enough to give the ASL interpreters sufficient time to sign.
- WG members on Zoom should stay on mute unless speaking. The “raise hand” feature should be used to indicate a question or comment.
- WG members should turn their cameras on as they are able.
- Members of the public will be invited to share during public comment.
- The WG will meet quarterly until December 31, 2026.
- Meetings may be a mix of in person and virtual, with in person meetings being held primarily in Sacramento, though potentially in other locations. A virtual attendance option will remain available even when an in-person quorum is required.
- WG members must attend 75% of meetings annually and have the option of sending a delegate to meetings they cannot attend.
- All WG meetings will be open to the public and subject to Bagley Keene requirements.
- The WG is not an oversight or voting group, but rather a body tasked with generating ideas and solutions.
- WG members must understand and respect Cal HHS’ duty to implement the CARE Act. They must also be respectful of other members’ expertise and differing opinions.
- Meeting agendas are posted online in advance of each meeting, and meeting summaries and slides are posted online as well.

Linkins reviewed the WG objective of generating ideas and solutions aimed at successful implementation of the CARE Act and reminded members of the expectation of respecting differences of experience and opinion within the group. She shared the dates for the four 2024 WG meetings, which will take place on February 14, May 15, August 21, and November 6.

## 2. CARE Act Implementation Update

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

### California Health and Human Services Agency (CalHHS):

**Deputy Secretary Welch** shared that a lot has happened since the August meeting, and that the WG will now have much more work to dive into. She thanked members who showed up in person. Welch requested that the Zoom view be adjusted so the members attending virtually are visible to the members in the room.

Welch reviewed general information about the role of CalHHS and updated the group that there was a Cohort 1 convening the previous week that some WG members attended. She described that CalHHS has the following ongoing responsibilities associated with the CARE Act:

- Leads coordination efforts with and between JC and DHCS
- Engages with cross sector partners at city and county levels and coordinates with diverse stakeholders via regular meetings
- Supports DHCS' training, technical assistance (TA), and evaluation work, as well as implementation of Behavioral Health Bridge Housing
- Supports communication through managing a CARE Act website, responding to inquiries, and doing proactive outreach to media and community. She emphasized that accurate public communication is highly important.
- Coordinates the WG, which serves as an essential mechanism to receive feedback, achieve successful implementation, and spread accurate information to the public.
- Collects feedback from the many diverse perspectives represented in the WG on how to achieve successful implementation, including the details of the annual report and evaluation plan, TA/training for a range of stakeholders, county implementation progress, housing access, and other emerging issues. All expertise that group members bring is relevant to these concerns.

Welch shared a summary of the topics that have emerged so far as areas of focus for the WG and the ad hoc subgroups, which have all now met once. These topics include the annual report and evaluation plan, TA/training for various stakeholders, county implementation progress, housing access, and other emerging issues.

Welch encouraged WG members and members of the public to spend time looking through the materials available on the CalHHS, DHCS, and JC websites.

### Judicial Council of California (JC):

Welch provided an update on JC activities on behalf of JC Director Charlene Depner.

- Court funding allocation methodology was approved in July and implementation funding was distributed to Cohort 1 and Los Angeles courts. Planning funding was also distributed to Cohort 2 courts.
- Rules, forms, and trainings are available on the JC website for court partners, including information for petitioners and respondents.
- Forms have now been translated into Chinese, Vietnamese, Korean, and Spanish. Counties are also working to provide materials in multiple languages.

- Planning is underway for support for Cohort 2 counties.
- JC continues to give presentation on CARE information to a variety of partners.
- The JC CARE Communication Hub and CARE Act Mailbox are live. Courts can also access updates on the Judicial Resource Networks and be added to the available listserv.
- CARE information resources can be found on the Adult Mental Health page on the JC website.
- JC continues to meet with data specialists from all Cohort 1 counties and LA to ensure the needed processes are in place for data collection and reporting.
- Bimonthly check ins continue with Cohort 1 counties and Los Angeles. Other readiness assistance from JC includes trial runs on data submission and ongoing technical assistance to Self-Help Centers.
- A significant number of trainings have been completed and more are upcoming.

Welch thanked JC staff for their ongoing work and collaboration, especially regarding training development.

### The State Bar of California:

Christopher McConkey, Program Supervisor, Office of Access and Inclusion introduced himself and Rocio Avalos. Avalos greeted the WG and shared information about her role overseeing grants at the State Bar Office of Access and Inclusion.

McConkey shared the following information:

- 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.
- A part of the State Bar's mission is to promote access to California's legal system. Staffing the Legal Services Trust Fund Commission (LSTFC), which is a public commission, is one component of this work.
- The LSTFC administers state and federal funding for free civil legal services for low-income Californians. It administered over $150 million in 2023, and that number will be higher in 2024. The majority of these funds are distributed to nonprofit qualified legal services projects (QLSPs).
- The LSTFC funds both QLSPs and public defenders to provide representation to CARE respondents. It may also provide funding for specific entities to provide legal training and technical assistance for CARE implementation.
- The CARE Act requires that courts must appoint a QLSP to represent respondents. Where no QLSP is available for representation, a public defender must be appointed.
- All CARE funds that the LSTFC distributes 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.
- The LSTFC approved two grants to QLSPs, both in San Francisco, totaling $752,095. It also approved a grant for statewide legal training and technical assistance. The remainder of funds has been distributed to public defenders offices across the first eight counties.
- The LSTFC must collect all relevant expenditure and outcome data associated with these funds, which must be consistent with the data that they already collect.
- The LSTFC approved reporting requirements in August and launched a portal for public defenders and other entities to report their expenditure and services.

- The State Bar is conducting individualized outreach to provide technical assistance to all entities that received funds.

## Department of Health Care Services (DHCS):

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

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

- Technical assistance and consultation to support CARE Act implementation. This includes consultation with the California Interagency Council on Homelessness regarding training that DHCS provides to counsel and consultation with the Judicial Council.
- An annual report that focuses on analyzing the scope and impact of CARE model.
- An independent evaluation.
- Issuing guidance to counties regarding the circumstances under which it is appropriate to delay implementation.
- Administering funds (startup, accountability, and ongoing).

Sadwith shared information on CARE Act startup funding:

- AB 179 appropriated $57 million in funding to DHCS for the implementation of the CARE Act, all of which has now been distributed to counties. Counties have leveraged these funds effectively to prepare for launch.
- BHIN 22-059 details the appropriate uses of startup funds, which was released in November of 2022.

Sadwith reviewed the Behavioral Health Bridge Housing (BHBH) funding allocation:

- BHBH provides $1.5 billion in funding to county behavioral health (BH) and tribal entities through June 2027 to address the housing needs of individuals with significant behavioral health needs.
- CARE participants are prioritized for BHBH-funded housing.
- Thus far, DHCS has awarded BH agencies in 51 counties nearly $900 million and 8 tribal entities over $25 million.

Sadwith provided information on the claims process for administrative activities:

- DHCS is finalizing a claim form for counties to use for specific CARE activities not billable under Medi-Cal, such as court involvement, outreach, and data reporting.
- CARE activities will be claimed quarterly and paid at a statewide rate.
- DHCS is collaborating with state partners to further develop the details of the claims process. There will be public opportunities for input before the end of the year.

Sadwith provided updates on training and technical assistance:

- The legislature and administration are invested in trainings being developed and conducted for all appropriate stakeholders.
- To date, 900 participants representing a range of roles have taken advantage of trainings
- A range of digital resources are available through the DHCS site that provide accessible information to promote understanding of the CARE Act and process.
- Trainings are under development for peers and volunteer supporters.

- Trainings and technical assistance are under development to support BH agencies with meeting respondents' housing needs.

Sadwith provided an update on data collection and reporting:

- DHCS published the CARE Act Data Dictionary on October 9, which provides guidance and detailed standards on data reporting requirements for counties.
- The data points laid out in the data dictionary are fundamental for the annual report, independent evaluation, and general assessment of the CARE Act and its implementation.

Sadwith explained DHCS progress on developing a sanctions process, as required by statute:

- Guidance for accountability funds is currently being finalized. Accountability funds may be collected if a Judge determines that a county is not complying with the CARE Act.
- Any money collected from sanctions imposed will ultimately be returned to the county to serve the CARE Act population.

Sadwith shared a schedule of the reports that DHCS will be developing and sharing, concluding in 2028. The first report will be focused on early implementation and is being developed for the legislature. After the Legislative Report, all reports fall into the categories of Annual Reports or the Independent Evaluation.

Sadwith described upcoming DHCS activities:

- Development of annual report performance indicators, which will build upon the measured laid out in the statute.
- Finalize the selection of the Independent Evaluator, who will work independently from the state to evaluate the scope and impact of the CARE Act through specific lenses, such as impact on disparity reduction.
- Continue to work closely with Cohort 1 counties, who have been incredibly dedicated, and pull learnings to inform and engage Cohort 2 counties.

## Questions and Discussion:

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

- Herb Hatanaka commented on the portion of Sadwith's presentation focused on activities that are not billable under Medicaid. He shared that he was glad to hear there is a claims process because in his experience, court-related work is very time intensive and is not reimbursable.
    - Sadwith reviewed his slide of the specific activities that claims processes are being developed for.
- Bill Stewart asked for clarification around startup funds and if there will be sufficient funding for Cohort 2 counties.
    - Sadwith responded that the total amounts to be distributed and how those amounts are divided between Cohort 1 counties and all counties was determined by the legislature. He said there are learnings that DHCS is taking away from that process. He mentioned that LA was given an additional $15 million.
    - Stewart asked if there will be opportunities for Cohort 2 counties to receive additional funds.
    - Sadwith responded that all initial planning funds have been determined.
    - Welch clarified that startup funds were intended for costs related to preparing to meet the requirements of the Act, such as updating data systems and setting up mobile courts, rather than for ongoing costs.

- Judge Maria Hernandez asked Sadwith about data reporting for elective clients. She said that Orange County is seeing a number of cases of respondents who do not meet prima facie but who they still want to connect to services.
    - Sadwith clarified that eligible clients in the data reporting guidelines refers to respondents who do meet prima facie but are diverted through voluntary service engagement. He asked if that is the population she was referring to.
    - Hernandez clarified that she was referring to people who may not meet all eligibility criteria, as connecting those people to services would still be a success of CARE.
    - CalHHS Deputy Secretary Corrin Buchanan said that only individuals who meet prima facie will be referred to county Behavioral Health agencies for investigations, who are responsible for data reporting. She acknowledged the importance of capturing the type of success Hernandez described and said this data would be reported by the court.
    - Hernandez emphasized the need to capture this information and said that Orange County courts are working to connect everyone to BH services, even if through informal pathways.
    - Dr. Veronica Kelley said that when Orange County BH receives those referrals, they work to get people connected to services, for some using their private insurance. She said that these service connections are a large part of what CARE can accomplish, as these people who are informally referred would not have come to BH if it were not for CARE.
    - Welch suggested that the Data Ad Hoc Subgroup could take up the project of thinking about how to capture this data, as she believes it is critical. She said that maybe the independent evaluator could play a role in capturing this information.
    - Sadwith agreed on the importance of looking at this data, potentially through leveraging existing administrative data.
- Tomiquia Moss asked about the funds for QLSPs and public defenders. She asked about the process through which the funds are distributed to public defenders, why only two QLSPs were funded, and if there are any other possible uses for these funds given the low number of grants to QLSPs.
    - McConkey responded that the Budget Act required the LSTFC to use a formula to decide how much funding would be available per county for QLSPs and public defenders to represent respondents. The Budget Act also required that QLSPs be given the opportunity to apply for funding before any was allocated to public defenders. There was a competitive application process for QLSPs over the summer with a somewhat quick turnaround so that awards could go out in August. Only two QLSPs ended up applying, both in San Francisco, and both received awards. McConkey said that he is not in the position to speak to why only two applied, but the newness of CARE is likely a factor and nonprofits may have wanted to wait until next year.

## 3. Presentation by Dr. Warburton: How We Serve and Support

Linkins thanked the state partners for their updates. Welch introduced Dr. Katherine Warburton, Chief Medical Officer of the Department of State Hospitals (DSH). Welch shared that she got to know Warburton through working together on diverting people with serious behavioral health issues away from incarceration. Warburton has been involved with a variety of initiatives at the state level that relate to diversion and upstream efforts, including CARE. Welch said that she has been in meetings over the last several days with people who are thinking about the data that Warburton will be presenting on the increasing number of people in state prisons with

serious behavioral health conditions. Welch shared that as the WG starts actively thinking about solutions for this population, a grounding from an expert in the field is needed around who the population is in more detail. Welch said that Warburton's presentation should have happened in an earlier meeting, but she hopes it will be useful.

Warburton thanked Welch and shared that her motivation for becoming a forensic psychiatrist was a desire to help people with schizophrenia diagnoses and there has been a growing issue for decades of people with schizophrenia being incarcerated. She has spent her career serving this population through inpatient care, Assertive Community Treatment (ACT) teams, and now as the Medical Director of DSH. She said that she shared this background in order to provide context on her perspective. She said that CARE has the potential to improve the humanitarian crisis that she sees every day.

Warburton prefaced her presentation by saying that she will be focusing specifically on people with severe, untreated schizophrenia and the information she will be presenting does not apply to all people with schizophrenia diagnoses. Warburton presented the following information about schizophrenia, criminalization, and treatment best practices:

- Schizophrenia Spectrum Disorder is often diagnosed in late adolescence or early adulthood. It often has a prodrome, which there are many firsthand accounts of available to read.
- Around 1% of people have schizophrenia and it shortens life expectancy by around 20 years.
- Schizophrenia Spectrum Disorders have two types of symptoms, positive and negative.
    - Positive symptoms include hallucinations (misperceiving stimuli) and delusions (misperceiving reality through false belief). Auditory hallucinations that tell people to do dangerous or illegal things are the most common symptom that she sees in her work, as well as paranoid persecutory delusions that make it challenging for people to follow the law.
    - Negative symptoms include diminished emotional expression and avolition.
- The main difference between schizophrenia and schizoaffective disorder is that schizoaffective disorder has a mood component.
- Many people with schizophrenia are not aware that they are ill. Warburton shared citations for literature that supports this assertion.
- Warburton shared a deidentified case vignette: A transient male refused to leave a restaurant and the police were called and put their hands on him, which upset him and it became clear that he believed that the police were the devil and they wanted to kill him. He had signs of auditory hallucinations, such as that the police said he had removed his eye because he stated that the devil had told him to. The police attempted to arrest him, which he resisted, and he was charged with battery and resisting an executive officer.
    - This case vignette is a common scenario that Warburton sees often in the patients who enter state hospitals. DSH estimates that half the people who enter their system after being arrested on felony charges have a similar profile to the man in the vignette and it often leads to people ending up in prison rather than treatment.
- People with schizophrenia make up 20-30% of the homeless population, 15% of the state prison population, and 24% of the jail population. These are the outcomes that CARE is trying to disrupt.
- History reveals a cyclical pattern of the state locking people up in institutions and neglecting them then letting people out of institutions and neglecting them. Today this is happening through Incompetent to Stand Trial (IST) commitments.

- Before the 1850s, treatment of psychiatric patients was inhumane, which led to the development of asylums, which became overcrowded and conditions worsened. A movement for deinstitutionalization grew in response to these poor conditions and the abuse of involuntary treatment.
- In 1939, British psychiatrist Lionel Penrose described an inverse relationship between the number of people in psychiatric hospitals and the number of people in prisons, which became known as the Penrose Effect. The Penrose Effect has held up over time, and Warburton shared data and studies to illustrate this.
- The Penrose Effect is mediated by untreated symptoms being labeled as criminal behavior. Therefore, it is a lack of treatment that is leading to people being incarcerated at high rates, which CARE is meant to disrupt.
- There is a national IST crisis, which describes the sharp increase in recent decades of forensic patients in state hospitals. It reached the point of crisis in 2014. An IST commitment is ordered when someone's symptoms, such as hallucinations, impede their ability to stand trial and understand the proceedings. People with IST commitments are sent to state hospitals to be restored to competency and then sent back to court. There are a number of academic papers analyzing the increase in IST commitments.
- DSH worked with UC Davis to look at their system's data on the IST crisis. They found that 67% of these patients were homeless at the time of their arrest, 47% had not received any Medi-Cal reimbursable mental health services in the months prior to their arrest, 70% were rearrested within 3 years, and the overall number of IST referrals have skyrocketed. DSH has a long wait list and all that they are legally able to do for their IST patients is stabilize their symptoms and send them back to court, where their charges are usually dismissed and then the cycle of criminalization starts over again.
- DSH sent out a national service on the IST crisis in 2017 and heard from the responses that it is a lack of adequate general mental health and crisis services in communities that is driving this crisis.
- An international study found that police perception of whether a treatment bed is available is the largest factor in if a police officer arrests someone with mental illness or brings them to the emergency room. Warburton shared that she had a conversation with a police officer that echoed this finding.
- Warburton shared another deidentified case vignette: A transient male entered a sandwich shop, informed the employees that he owned it, and asked for money from the register. The police were called, saw he was clearly experiencing delusions, and arrested him on false imprisonment and robbery charges.
- Warburton shared California data on the increase in IST referrals, the increase in DSH beds in response, and the increase in people in state prisons receiving some type of mental health services.
- Warburton shared her hypothesis that the IST crisis is driven by people with schizophrenia spectrum disorders being untreated and unsheltered, leadings to increased contact with police, increased arrests, and increased IST referrals, which does not an adequate long term treatment plan.
- The cycle of criminalization increases trauma and CARE is designed to break the cycle through providing upstream diversion, and its success will be dependent upon the ability of the courts and treatment teams to provide the needed care, including medications, wraparound services, and housing.
- The Sequential Intercept Model is used when planning diversion programming and lays out every point at which somebody can be diverted.

- Per statute, a CARE plan includes an appropriate range of services and supports, including BH services, medication, and housing. This combination is known as the three-legged stool and should be based in the standard of care.
    - The American Psychological Association (APA) suggests that treatment include antipsychotic medication, especially long acting injectables, and assertive community treatment.
- The use of antipsychotic medication is very effective at reducing or eliminating symptoms at a similar rate of medication for other chronic conditions, such as hypertension, and is proven to help enable community integration and reduce the likelihood of arrest.
- People with a variety of chronic conditions struggle with medication adherence, not just people taking antipsychotics.
- Psychiatrists are responsible for working with patients to come up with medication solutions that minimize side effects.
- The AMA Principles of Medical Ethics defines informed consent and states that in order for informed consent to occur, there must be an assessment of the patient's ability to understand relevant medical information and make an independent, voluntary decisions. Insight into one's illness is required in order to have the capacity to give informed consent.
    - This can be understood through looking at how Alzheimer's is treated, though the same understanding of when informed consent is not possible does not get extended to people with schizophrenia who also lack insight.
- The CARE Act allows medication orders when informed consent cannot be given.
- Medication orders rarely mean that someone is forcibly given medication. They largely are used so that a conversation between a provider and a patient can occur more effectively than attempting to get informed consent from someone who lacks insight.
- Warburton shared examples of prompts related to medication from the optional CARE Plan/Agreement worksheet developed for counties.
- The gold standard of service models is ACT, which is proven to improve housing stability, medication adherence, and functioning. A key element of ACT is 24/7 access to a multi-disciplinary, community-based care team that can deliver highly individualized, intensive care. ACT has been shown to reduce both incarceration and hospitalization.
- Housing is necessary for people to stay connected to treatment and adherent to medication. A range of supportive housing options will be needed to meet the needs of CARE respondents.
- Warburton shared a third case vignette: Police were called on a transient male pulling roofing tiles from a roof. He took off his clothing and began throwing tiles at officers. He was agitated, talking to himself, and did not respond to a taser. He was charged with felony aggravated assault and vandalism. CARE could have potentially diverted him.

Warburton briefly summarized the slides she just presented. She expressed that the three-legged stool lays the foundation for recovery and is not in lieu of recovery.

Linkins thanked Warburton and welcomed questions from WG members:

- Herold Turner asked if it is possible to divert people from state hospitals to CARE when they also have criminal justice connections.
    - Warburton said that diversion can happen at a variety of points. DSH's diversion program provides a path for charges to be dropped through two years of treatment adherence. CARE is more upstream than DSH programs and can help people avoid criminal justice contact in the first place, though all existing

diversion strategies complement each other and someone coming out of IST restoration could still benefit.
    - Welch specified that the statute allows judges to divert misdemeanor IST cases directly to CARE, in part to avoid felony ISTs. She stated that this is one of the aims of the CARE Act and she hopes judges utilize that pathway.
    - Turner shared that he is hopeful that they can use this opportunity to address the systemic conditions that result in institutionalization.
- Rettagliata thanked Warburton for emphasizing the importance of early intervention. She said that in the current system, families sometimes hope that their loved ones will receive intervention through police contact and even jail because they are so ill and sometimes involved in the drug trade or being sex trafficked. She said that she has heard a clinician say that dozens of touches will be required to engage people, but she hopes intervention will happen right away because people might die in the time it takes to do 40-60 touches. She shared that there was a family member who attended another meeting whose loved one died on the street of fentanyl. She expressed how dire the threat of fentanyl overdose is and said that the housing that is provided should be structured enough so that people cannot refuse treatment once housed. She said she hopes that ACT can work for people who have delusions and auditory hallucinations.
- Keris Myrick thanked Warburton for the presentation. Myrick shared that she finds data presented without its full systemic and social context difficult to work with because of the various factors that can impact outcomes. She requested that moving forward, data that is presented be disaggregated by race and LGBTQ identity, as data is available, to look at relevant disparities and curate services and supports to specific population needs. She thanked LA County for investing in a training with Dr. Pat Deegan, including training on medication empowerment. She said that medication empowerment provides a mechanism to support people with medication adherence. Myrick shared that she has been fortunate to work nationally and internationally which has helped her realize the importance of focusing also on the negative symptoms rather than just the positive, because focus on negative symptoms has been shown to move this population toward recovery. This method is called Recovery Oriented Cognitive Therapy, which she argued should be better understood by this group and should be an element of the three-legged stool. This method has been rolled out in 5 different states, but not yet in California.
    - Welch responded that she would follow up with Myrick on bringing in a presenter on this topic to a future meeting.
- Al Rowlett echoed Myrick's request that data be disaggregated. He said that African American and Black consumers are 3 to 4 times more likely than white consumers to be diagnosed with a psychotic disorder. Immigrants also have a higher rate of being diagnosed with psychotic disorders. He said that he would like more information on how those disparities show up in the forensic population and more discussion overall on how to address and prevent disparities. Rowlett reflected on the data presented last meeting on the misdiagnosis of PTSD as schizophrenia within communities of color.
    - Warburton responded that she completely agrees and has seen all of this reflected in the literature on disparities. She said the existence of these disparities is what led them to bring Dr. Vinson on board as a special advisor. She suggested that the Data ad hoc group would be a good place to continue these discussions. She said that sheand the rest of the team are actively thinking about how to implement CARE in a way that does not perpetuate disparities.
- Hatanaka thanked Warburton and shared that he is very familiar with the IST crisis through his work. He said that he hears regularly from the clinicians that work for him how challenging it is to work with this population in a community-based setting because,

prior to CARE, they have had no ability to implement an intensive treatment plan such as ACT. He said that the Housing First model does not require the necessary supports. He said that he fully agrees with the elements of the three-legged school and hopes that they place emphasis on establishing standards of care, or else providers will implement a range of models at varying intensities.

- Bill Stewart thanked Dr. Warburton and said that he took away from the presentation the extent of the steps needed to break cyclical patterns. He said the presentation made him more excited about the potential of CARE.
- Sadwith said that DHCS is engaged in several efforts to fortify the legs of the three-legged stool. These efforts include the BH-CONNECT waiver that was recently submitted to the Centers for Medicare & Medicaid Services (CMS), which will cover ACT in Medi-Cal, among other new services. He said their goal is to simplify billing and give counties a comprehensive rate to cover all services included in evidence-based models. Additionally, they are investing in TA for counties and providers.
    - Welch suggested that they send out information about BH-CONNECT to WG members, as it was designed alongside CARE and is highly relevant.
    - Linkins agreed and said that Welch's suggestion relates to the WG's ongoing conversation on staying up to date on the range of state efforts.

Linkins thanked Dr. Warburton and moved to the next agenda item.

## 4. CARE Act Data Collection, Reporting and Evaluation Approach

Linkins introduced Marcus Cannon and Deborah Johnson from Riverside County to deliver an update on the first month of CARE implementation.

Marcus Cannon, Deputy Director of Behavioral Health at Riverside University Health System, thanked the group and introduced himself and his supervisor, Deborah Johnson, Director of Innovation and Integration. Cannon presented the following updates from Riverside:

- Began CARE on October 2, 2023.
- Court, Behavioral Health, and partner agencies continue to collaborate and work toward optimization.
- Implementation activities (prior to launch and still ongoing) include planning, media efforts, community, and stakeholder meetings to correct misconceptions related to CARE and other BH services, website development for both the court and BH department, staffing and workforce development amidst hiring challenges, trainings, service provision, IT investment (developing internal mobile app to track CARE flow, improving electronic health records (EHR)), and data collection.
- Behavioral Health has received 40 calls to their access line since launch representing 30 unique callers seeking more information about CARE
- Riverside Superior Court has received 46 callers and scheduled 16 appointments for service for petition assistance.
- So far, 15 petitions have been filed in Riverside and 2 initial hearings have occurred. Out of the 15, 3 respondents have been homeless and 2 cannot be located.
- They have received 4 referrals from criminal court (misdemeanor ISTs) and 4 referrals from Adult Protective Services.
- The main challenges they are navigating include:
    - Workforce and hiring challenges across all county partners
    - The engagement timeline remains long and the same challenges exist with engagement as pre-CARE implementation

    - Shortage of housing and residential treatment beds, despite investments the county has made in recent years because the need is so large. They expect that CARE respondents will need Board & Care placements, which are already very strained. He said they need additional help from the state to increase Board & Care capacity. He added that more treatment and housing units will help the broader population of people with BH needs and potentially reduce the size of the CARE-eligible population.
- Cannon presented a de-identified case study of one of their CARE hearings. The case involved a very invested petitioner who travelled far to appear at the initial hearing and a respondent who does not believe they are ill and does not perceive a need for services, despite ongoing engagement from BH. While the respondent seems to meet criteria, they are in somewhat of a gray area in that some things are working well in their life, so their level of need is difficult for BH to demonstrate to them. The respondent did not appear at the initial hearing and had made it clear they did not intend to appear. The respondent also has a simultaneous criminal proceeding which is a complicating factor. Cannon said that he expects to see many cases with similar complexities. At the hearing, the petitioner was very disappointed that the Judge could not force their loved one to participate. The BH team is continuing to try to engage the respondent through a variety of methods but has not yet succeeded. Cannon said that they will have more to report as they have more cases to draw learnings from.
- Initial successes and positive outcomes have included community education, increased visibility of available services to engage more community members in services, some successful voluntary engagement because of the access line, the construction of multiple venues for appearance through in-person, virtual, and mobile options, and an increase in the coordination of services.
- Next steps include continuing to increase staffing, continuing to buildout housing through Bridge Housing funds that they are utilizing to construct 81 new beds in the next year, collecting and reporting data and conducting a local analysis, and strategizing for ongoing sustainability amidst high levels of change on the county (high population growth) and state level (realignment).

Cannon said he is available to answer any questions about their high-level overview.

## Questions and Discussion:

Linkins thanked Cannon for his presentation and welcomed questions from WG members:

- Beau Hennemann said that he appreciated the presentation of the case study and feels that case studies should regularly be part of the WG meetings. He said that he has recently been part of several conversations with local elected officials who already want to know how CARE is going, and that while it is still early, he appreciates the update. He asked Cannon how CARE is integrated with all other services available in the county and how funding sources and services are being braided. He asked what types of needs are coming up in Riverside among CARE respondents in addition to housing and substance use disorder (SUD) services.
    - Cannon said that this is a great question and sorting out the answer is one of the main challenges they are facing right now. He said that there are so many different programs, which is good, but those services still need to be coordinated, made more sustainable, and communicated effectively to the community. They are seeing success in emphasizing to the community that CARE is a tool, but not the only tool available.

- Stewart thanked Cannon for his presentation and asked if Riverside has collected any cultural data on respondents. He also asked if Cannon could share any information on the involvement of volunteer peers.
    - Cannon said that the Data Dictionary includes requirements to collect data on race, ethnicity, and other demographic data. He said that he does not have available that data in this moment, but it is being collected. He said that neither of the two cases they have had initial appearances on have made it to the point where conversations about volunteer supporters have occurred. He said they are working with NAMI on education about the volunteer supporter. He said that Riverside has a large peer workforce including people with lived experience of diagnoses, parent partners, and family advocates. Cannon said that they are optimistic that they can meet the needs of everyone who may want a supporter.
    - Deborah Johnson added that yesterday in court there was a family advocate present to assist the petitioner.
- Jodi Nerell asked in the chat about what housing has been requested by respondents.
    - Cannon responded that a very small percentage of respondents thus far have been homeless. He said that he does not have great data to give a substantial answer, but anecdotally, the respondent from the case study was living in his own home but his family felt that he needed a different housing setting.
- Rettagliata thanked Cannon and said that it is important when thinking about housing to be realistic about the lack of insight of respondents into their own needs. She said that in regular affordable housing settings, lease agreements are required, which is likely unrealistic for CARE respondents in the initial phase of their recovery. She said that master leasing situations will be required, and it is not realistic to ask people who are not stabilized to enter into standard affordable housing. She asked if the beds that Riverside has added in the last years were housing units or intensive treatment beds, because CARE is seeking to keep people out of intensive settings.
    - Cannon answered that the 500 beds they added were across the continuum of care, from treatment beds to permanent supportive housing through No Place Like Home funding. Additional No Place Like Home funded units are continuing to be constructed. He said that building out all types of placements are needed to support a variety of needs. In regard to leasing, Cannon agreed that master leasing is needed. He mentioned that they are also working on building out a transitional housing site which would not require individual leases. He also acknowledged that once stabilized, people can and should live independently.
- Myrick asked what percentage of respondents have a CARE plan vs. a CARE agreement.
    - Cannon responded that it is too early to answer that question.
- Welch added that more robust discussions on some of these topics will be possible at the February meeting. She shared that the snapshot from Riverside is helpful and representative of a program in its infancy. She said they will be continuing to discuss case studies and real-life experiences in appropriate ways at future meetings.
- Linkins invited Tracie Riggs, Dr. Veronica Kelley, and Judge Maria Hernandez to share any updates or insights from their counties.
    - Hernandez shared that statewide Cohort 1 counties are continuing to meet, including biweekly meetings between the courts. She shared that in Orange County, there have been around 20 petitions filed and around triple that number of contacts to their self-help center, which makes her hopeful because it means information is being provided to people who before did not have it. She also shared that she is pleased by the level of collaboration in Orange between BH

and the courts. She said that petitions are coming in from all over the county and they have taken steps to make filing and appearing very accessible.
    - Kelley added that so far, BH has seen 7 of the petitions that have been filed. Of those 7, 4 have been Medi-Cal recipients. Most petitions have come from family members. They are collecting substantial data and said that they need to think critically about how to measure equity and disparities given the breakdown they are seeing in their petitions. She said that they will share stories from people and families when it is their turn to share. She shared that they have some concerns about petitions being filed for people who are currently in hospitals on holds, because removing holds for a person to be involved in CARE can present a high level of risk.
    - Hernandez said they are also seeing a high number of filings from people currently in custody, which presents a variety of complications.
    - Riggs said that Tuolumne has only received one referral and that while it did not meet prima facie, a hearing was still scheduled to try to engage the respondent in services. The respondent identified as a resident from a neighboring county. The other rural county in Cohort 1, Glenn County, has yet to receive any petitions. She said that rural counties must be more self-sufficient. She shared that housing availability is a large challenge in Tuolumne, but they are currently constructing a variety of new housing sites. They still are seeing a high level of misunderstanding of what CARE is among the community. Riggs shared that Cohort 1 counties are doing a lot of work to educate Cohort 2 counties and she has personally been meeting with other rural counties to help them prepare. She shared that Tuolumne BH is working directly with public defenders and is very appreciative of them and the approach that the courts are taking in prioritizing the interests of the respondent.

Linkins thanked the presenters and reiterated that they will continue to ground conversations in real life stories.

## 5. Updates on Time Limited Ad Hoc Sub-Groups

Linkins introduced the co-chairs of the three ad hoc sub-groups to provide updates from the first meeting of each group that occurred in October.

Jodi Nerell of the Services & Supports group provided a summary of their October 31 meeting:

- 20 members attended
- Warburton presented a similar presentation as the one she presented at this WG meeting
- Linkins shared information about the purpose and goals of the subgroup
- The subgroup will be meeting through the end of 2026 with the purpose of advising on the range of clinical and non-clinical services and supports available to CARE respondents.
- Members had the chance to ask any questions they had on the group and on Warburton's presentation.
- Members shared suggestions on engagement strategies and other short-term strategies.
- There was a fruitful public comment section.
- The next meeting will likely occur in January.

Linkins shared that the next meeting may occur in December and opened the floor for questions from WG members.

- Welch asked if there was discussion at the meeting around prioritizing topics and strategies. She said that from what she is hearing from Cohort 1 counties, she feels that discussion on engagement methods should be prioritized.
    - Linkins said that the focus of discussion in the first meeting was on outreach and engagement and it will also be the subject of the second meeting.
    - Nerell agreed.
- Hennemann asked for more information about the composition in the group in terms of what backgrounds members are bringing to the table and if there are any perspectives that are missing.
    - Nerell shared that there was a broad range of perspectives represented, including outreach workers, family and peer partners, and several clinicians.
    - Welch said that more members can continue to be added. She thanked Jenny Bayardo for the membership outreach that she did. She said that there is representation from a range of perspectives already involved, such as disability rights, housing experts, and providers working in different spaces.
    - Linkins shared that the goal was to get both broad representation as well as representation from people with direct knowledge and frontline experience.

Susan Holt of the Training, Technical Assistance & Communications sub-group shared updates from their first meeting:

- About 8 members attended as well as members of the public
- Linkins facilitated introductions of members and reviewed the goals and purpose of the group, which is to review, assess, and provide feedback on training and communication materials and strategies, and to provide recommendations to be applied at the local level to support uniform implementation.
- Warburton gave a presentation that was useful for the purposes of level setting
- Discussion occurred around the direction to take the group's work, and the priority emerged to target training and communication to specific audiences, such as court professionals.
- Providing materials in a variety of languages was also identified as a priority.
- There was a suggestion by a member to create documents focused on what to expect for both respondents and petitioners from each of their perspectives, and potentially utilizing the voices of people who have been through the CARE process in the future for continued material development.
- The second meeting will occur on December 1.

Welch shared that she was not able to participate in the sub-group meetings to the extent that she hoped. She said that the main WG had suggested that a journey map tool be developed for respondents, which is something that the Training and Technical Assistance (TTA) group could be responsible for producing. She said that a draft has already been developed that the subgroup could look at. Welch added that an expectation-setting document for providers could also be useful. She said that her initial hope was to bring a draft to the group today, which did not end up being possible, but the team has now gathered useful feedback, including from Myrick, and the TTA group can think about how to adapt the draft to create the best possible version of the tool. Linkins added that this will likely be the focus of the December subgroup meeting, and that it is a challenging project.

Beau Hennemann of the Data Collection, Reporting & Evaluation sub-group shared that very little was asked of the co-chairs for the first meeting. He provided the following summary:

- The structure of the first Data meeting mirrored the meetings of the other two sub-groups.

- Around 10 group members attended in addition to a high number of attendees from the public.
- The public comment period produced a number of very useful suggestions.
- Warburton presented on grounding the CARE Act in its broader context.
- Discussion occurred around the objectives of the sub-group, which included questions that relate to the independent evaluation and the topics it will take up.
- Most of the meeting focused on talking with DHCS on various data reporting requirements to understand what data points will be collected.
- There is not yet much data to review, but they will be reviewing data once it is available around the end of Q1 of next year.
- Most of their work will likely relate to the independent evaluation.

Co-chair Myrick added that she believes the total membership is greater than the number who attended the first meeting, though there were already a diversity of perspectives represented. She encouraged WG members to attend future Data meetings.

Linkins said that there are members of CalHHS, DHCS, and JC present at the sub-group meetings to interact with and learn from members. She emphasized that the purpose of these groups is to create recommendations that will then be operationalized.

Welch added that Health Management and Associates, Inc (HMA) also participates in the meetings of the ad hoc groups, who have already developed and delivered substantial training and technical assistance. She asked the members of HMA present at today's meeting how the ad hoc group members can be supported in getting caught up on the work HMA has already done. Welch asked HMA to respond:

- Laura Collins of HMA said they have developed a substantial number of materials and can select a few key materials to share with members of this group and the sub-groups. She said they are just about finished with the Volunteer Supporter Toolkit, which they can draw from.
- Welch said it would be useful for the TTA group to receive an overview of everything that HMA has developed so they can ensure they are not duplicating efforts.
- Holt mentioned the variety of workforce and hiring challenges, including high turnover, and suggested that some sort of syllabus could be developed for new hires to get up to speed.
- Collins said Holt's suggestion is a great idea and they are already talking about something similar as part of an implementation toolkit.
- Marc Avery said that the HMA CARE Act website would be a useful tool in developing a syllabus.
- Collins said that they have already learned a lot from attending the sub-groups in regard to potential gaps in their materials. She assured everyone that they are present at all meetings and taking notes on any outstanding needs.
- Rettagliata added that BH Directors have to go before the County Supervisors in order to hire new staff, so any syllabus developed should also seek to educate County Supervisors on the level of need that exists.
- Avery said that in many ways, implementation is the easiest phase because all counties are starting from the same place. As time passes, turnover and other challenges arise, which creates a plethora of training needs. He encouraged the TTA group to consider these factors.

Linkins facilitated other questions and comments from WG members:

- Myrick said that this might pertain most to the Data group, but she shared concerns about how Transitional Age Youth CARE respondents will be housed and if skilled nursing facilities will be overused for young people. She also asked if the group can develop a better understanding of how county workforce needs are situated within the national workforce crisis. She shared concerns that the positions may not be easily filled, even with buy in from County Supervisors, as BH departments will be in competition with other departments across the country.
- Kelley said that some of their respondents are Transitional Age Youth and they have specific housing for that population that will be used, and she believes this is the case for other counties as well.
- Hatanaka said that the workforce issue is the elephant in the room. His organization has been doing substantial recruitment for two years and is still struggling and currently competing with Los Angeles Department of Mental Health and other county programs for the same pool of potential hires. He said that his staff is stretched thin. He shared that he is hopeful that CARE can be a draw in regards to effective recruitment, since it would give people new in their careers specialized experience and it is being prioritized by the state.
    - Welch responded that she appreciates this positive perspective and agrees that being involved in CARE from the ground level would be very valuable experience. She also shared that it has been a challenge in the past to find clinicians with the right expertise to work with this population.
- Warburton shared that she started a residency program at one of the State Hospitals and is hoping to replicate it across the state. DSH thinks about workforce issues as three distinct challenges: recruitment, hiring, and retention, and works to address each one, including an in-house continuing education program to get people more knowledgeable about working with forensic populations. She added that as part of DSH's IST outpatient programs, they are partnering with workforces in communities and building valuable relationships.
- Welch said that she has been observing that people new to the field have absorbed high levels of stigma about this population. She emphasized the need to correct common misconceptions to address the piece of new professionals being resistant to work with this population. She suggested that they could bring in people to these meetings to discuss their lived experience, though she said that she is aware that there is already a shortage of time in the WG meetings. She shared her surprise that people would not want to work with this population, because she feels it is rewarding.
- Myrick agreed with Welch about the impacts of stigma. She said that the language they use is incredibly important to avoid furthering stigma. She said that people with schizophrenia diagnoses are often told that they don't understand things and therefore are dismissed. She said the belief is very prevalent that people with schizophrenia cannot recover or can only recover to a point, which intensifies the stigma against them and harms their ability to enter the field. She also shared that she has spoken with residents who deem work with people with schizophrenia, which often involves courts and coercion, to be a form of moral injury, which she said the group should wrestle with. She suggested that more residents could be engaged in this process who could serve as peers to other residents who are hesitant to work with this population.
- Rowlett said that he recently spoke with social work students who expressed that they viewed the concepts of care and court to be incompatible with one another. He encouraged the students to get involved with legislative and policy advocacy work to influence the legislative perspective on working with people who have schizophrenia diagnoses.

- Hernandez said that she heard from many residents at forums that they were uncomfortable with the word court, which influenced how they chose to form their messaging. She added that she does not think that courts are incompatible with care. She told Warburton that she needs to keep presenting and be at the forefront of Cohort 2 so they can build upon the baseline that she established. She said the courts need different messaging, but operate very collaboratively. She urged Welch to not try to keep the meeting as short as possible, because members are already travelling long distances and she wants to get as much out of the meeting as she can, especially in regard to hearing stories of lived experience.
- Welch said that in thinking about future meetings, hybrid meetings are very practicable, but in-person meetings are very valuable and more time on the agenda would be great. She suggested that if it is possible with Bagley-Keene, it could be useful to go on a site visit. She said that they will be meeting together for a long time and that maybe this group can be used to increase education about the different elements of the state's BH system. Responding to comments about language, Welch said she feels very strongly that it be referred to as the CARE Act.

Linkins said that this was a great discussion that covered the next agenda item, which is a freeform discussion on the various topics of the day. She reminded Working Group members to communicate with her in between quarterly meetings, including suggestions for agenda items. She said they will continue to highlight specific stories and maintain a focus on solutions. She said that the group will be meeting for 5 years or so and has a great opportunity to address some major issues. She asked the group what the best method of communicating with them is between meetings.

- Stewart said that San Diego has tools for collecting data on servicing respondents and wondered how to give tools for this to Cohort 2.
- Kelley shared that every county is approaching serving respondents differently. In Orange County, they are careful that the people who are doing outreach and building trust are not the ones that serve people. She said it would be useful to share county stories on this topic.
- Myrick stated that while it is called the CARE Act, she is concerned that avoiding the word court is not honest, because there is a court involved. She shared her worry that burying the term could create distrust. She requested that they have transparency in their messaging.
- Welch said that something they do not emphasize enough in their messaging is that accountability in CARE goes both ways and the court is also there to ensure that the county follows through on delivering services. She shared that she used to work in collaborative courts and it is incredibly different from how criminal courts operate. She asked the group how many people have previously watched a collaborative court proceeding. Most WG members raised their hands, but she added that many members of the public who are tuned in might not be familiar with what those proceedings look like. Welch asked if any members have specific issues they want to put on the February agenda.
    - Nerell suggested including a discussion of the possible intersection of SB 43 with CARE.
    - Welch said that she has a list from Myrick of things that could be good to discuss.
    - Hernandez suggested they could discuss the messaging of CARE Act vs CARE Court and said that CARE is not the same as other collaborative courts because there is no criminal component to CARE whatsoever.

- Myrick agreed with Hernandez and added that she wants to know if respondents would be required to say they had a mental health court order on any future forms that ask that question. Welch said she doubted that would be legal in California. Myrick said it is legal and she has had to answer that question on federal government employment forms. She said it is also relevant for foster care, adoption, and military service.

Linkins transitioned the group to public comment.

## 6. 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.

- Mary Anne Bernard said that she is a retired lawyer and also belongs to multiple family groups. She said that her and other family members of people who are extremely sick, lack insight, and have been neglected by the state are very happy to see CARE being implemented. She said she thinks the group is doing a great job. She said that she is very glad to hear that people are being connected to services before petitions are being filed. She also shared that she is happy to hear that ACT is being uplifted. She said the system to date has functioned according to the rule that the people who want help, get it, and those who do not are thrown to the streets. She shared that she is very glad that people who are too sick to know they need help are finally being engaged, and she said she is shocked that some people do not believe this population exists.
- Claire Warshaw said that this group makes her extremely nervous because of what they talk about and how they talk about it. She said that she has been writing a book and has also put together a booklet of suggestions for the psychiatry system. She said that she make 7 flyers that she will put on the table. She shared that people, even psychiatrists, seem not to believe in remission, which has caused large problems for her. She said she does not think CARE seems safe and it seems designed by wealthy, white academics.
- Jason Robison said he is a member of the Services & Supports ad hoc as well as being a family member and a person with lived experience. He is an employee of a housing provider and said it is important to include recovery housing in all housing discussions. He said that recovery housing is well known for SUD treatment but it is just as effective for mental health treatment. He shared that it is utilized at a high rate in LA County, and is both effective and affordable to scale. He said that he would want to see a presentation to balance Dr. Warburton's on recovery oriented practices. He said it is very important to understand the trauma that people have experienced in the BH system and in courts in order to plan for successful outcomes.
- Clare Cortright shared that she is a mental health consumer who has experienced psychosis. She said that in these meetings there seems to be a lack of clarity from the state around what problem they are trying to solve. She also said that she is hearing a lot of stereotyping from this group and there seems to be a belief that psychosis is always entirely impairing to a person's ability to think about treatment. She said that she has worked in crisis residential settings as a provider and from that perspective as well as the perspective of a consumer, the system has both a lack of access and a quality of care issue. She said that as a provider, she talked to clients about anosognosia who had never heard the term before even when their clinicians believed they had it. She said that she facilitated conversations with clients about what is real and how they know, and she said these types of conversations are not encouraged anywhere in the system.

- Stacey Dalgleish from the LA County Mental Health Commission thanked the group and said hello to Myrick. She said that she has never been to a collaborative court proceeding which she would like to rectify. She said that she only found out about this meeting because a very active member of the commission mentioned it. She said that if there is a way to get information about these meetings out to more groups, it would be beneficial. She agreed with Myrick on not obscuring the language of court and needing to be very honest and realistic in communications. She asked if it is possible to pin the meeting room on the Zoom feed for future meetings.
- Teresa Pasquini said she has attended all meetings and really appreciates the progress that has been made. She said she attended the first meeting with a large group of family members and now is beginning to trust the process much more. She shared that she has been exposed to many elements of this system through trying to help her son, who has been in civil and criminal courts off and on for the last 20 years and has never been in a collaborative court setting. She said she attended all ad hoc meetings and is incredibly grateful to Dr. Warburton for her presentation. She also thanked Riverside for their presentation.
- Elizabeth Kaino-Hopper said that she would like to echo the comments of Pasquini and Bernard. She shared that she is a family member of someone currently criminalized for her mental illness. Her family member is currently in an FSP IST diversion program, but the medication empowerment aspect does not work for her. She said that with a lack of insight comes with an inability to understand she is ill. She said that Dr. Warburton's presentation spoke to her concerns. She shared that she is grateful that a range of services are available and that there will be some people for whom a court order might be necessary.
- Steve McNally from the Orange County Behavioral Health Advisory Board shared that the California Bridge Project is a good example of an online syllabus. He said that he is glad to hear the comments on language and has also heard from his community that language other than "court" is preferred. He said that implicit bias training is necessary for people developing resources. He said that NAMI has speakers available who could contribute and the group should also talk to consumers who can contribute their perspective. He shared that his son is in recovery from schizophrenia.
- John Underwood from Housing is A Human Right OC said that he has been an advocate for the needs of homeless residents for many years. He shared that he appreciates this group as it helps him humanize the people who will be implementing CARE. He said that as referrals get made by a variety of petitioners, it is important to keep in mind that people who present with symptoms consistent with schizophrenia may be experiencing severe distress associated with being homeless, which may go away once they are housed.
- Linda Mimms from San Diego County shared that she is a member of the TTA ad hoc group and is also a member of the National Schizophrenia and Psychosis Action Alliance. She expressed her appreciation for the meeting, especially Dr. Warburton's presentation. She said it is crucial that people who work with this population understand the nature of the disease. She said that she can see from Riverside's presentation that a wider range of people are already being connected to services, which is a great outcome. She said she hopes that with proper training on the symptoms, outreach workers will operate with more compassion.
- Tanya shared that she petitioned the court on October 2 for her son and she went into court today. She encouraged more training to ensure everyone knows what the resources are and what is appropriate. She said she does not know how voluntary medication will work. She said that her son is incapable of making a choice, so giving

him choices is not helpful. He needs a structured program to be designed for him, which could then be voluntary. She said that her son has auditory hallucinations and he was placed by the court in congregate sober living, which does not match his needs. She said that she knows things are still getting figured out but she hopes it happens sooner rather than later because she is trying to save her son right now.

Linkins adjourned the meeting, thanked everyone in attendance, and reminded the group that the next meeting will be on February 14, 2024.

## Appendix I: Public Zoom Chat

10:46:50 From Captions To All Panelists:

Could the host please assign me to closed captioner. Thank you

10:51:05 From Captions To All Panelists:

Once the meeting begins captions can be viewed in zoom via the CC/subtitle button. Here is the link to view them in transcript format if anyone prefers that. https://www.streamtext.net/player?event=DOR

11:02:04 From John Freeman To All Panelists:

Thanks all! We'll get started in just a moment

11:06:57 From John Freeman To All Panelists:

Please let me know if there are any issues or challenges with audio, etc. Thanks!

11:11:47 From John Freeman To Everyone:

If there are any working group members in the audience not on as panelists, please raise your hand and I can promote you to panelists.

11:12:23 From John Freeman To Everyone:

See CalHHS CARE Act website: https://www.chhs.ca.gov/care-act/

11:12:49 From John Freeman To Everyone:

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

11:20:30 From Jennifer Brya To Everyone:

Department of Health Care Services (DHCS) CARE Act Website: https://www.dhcs.ca.gov/Pages/CARE-ACT.aspx

11:20:47 From Jennifer Brya To Everyone:

- Judicial Council of California (JCC) CARE Act Website (court forms and more): https://www.courts.ca.gov/48654.htm

11:21:05 From Marcus Canon To All Panelists:

I apologize for the interruption. My computer showed that I was on mute.

11:36:20 From John Freeman To Everyone:

Trainings and Technical Assistance materials are available at the CARE Act Resource Center https://care-act.org/

11:49:25 From John Freeman To Everyone:

Slides will be posted to the CalHHS site shortly.

11:50:10 From Keris Myrick To All Panelists:

Can folks identify who there are when speaking ??

11:54:10 From John Freeman To Everyone:

Dep. Sec. Corrin Buchanan providing this response.

11:55:44 From John Freeman To Everyone:

Yep Sec Welch speaking now

12:27:36 From Karen Linkins To All Panelists:

Welcome, Ketra! So glad you could join the meeting today!

12:34:06 From Ruby Spies To Everyone:

Here is a link to today's slide deck, posted on the Working Group website: https://www.chhs.ca.gov/wp-content/uploads/2023/11/11082023-CARE-WG-Meeting_slides-posting.pdf

12:46:00 From John Freeman To Everyone:

For members of the public, there will be an opportunity for public comment in a bit.

12:54:00 From Keris Myrick To All Panelists:

If it is possible to include to have a presentation from Dr Becks team - I cannot stress the importance of our need to understand the impacts of the negative symptoms which get ignored sadly .so we should learn more about how focus on the negative symptoms an evidence based approaches hat can support this particular population in moving forward in their recovery

13:25:18 From Jodi Nerell To All Panelists:

For the Respondents that were interested in housing, what type of housing was most requested?

13:31:36 From Keris Myrick To All Panelists:

What percentage of respondents have a Care plan versus have a care agreement?

14:04:24 From Keris Myrick To All Panelists:

The development of a journey map is a process and it does also help provide a visual for wha we have so much written (super helpful for visual learners too)

14:11:12 From John Freeman To Everyone:

Materials available CARE Act Resource Center https://care-act.org/

14:25:35 From Keris Myrick To All Panelists:

That is so right Stephanie!

14:42:31 From Jodi Nerell To All Panelists:

Emerging Issue: SB43 Impact and intersection with CARE Act.

14:49:35 From John Freeman To Everyone:

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

15:01:59 From Keris Myrick To All Panelists:

We love Mark Karmatz!! Thank you Stacey from bringing his name into this meeting 🙄 And miss you to Stacey

15:02:53 From Keris Myrick To All Panelists:

Sorry I have to run to another meeting - thank you all for such a productive meeting.