California Health and Human Services Agency Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes: November 19, 2025

Working Group Members in Attendance:

- **Amber Irvine**, San Diego County Behavioral Health
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control, LA Dept of Public Health
- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Ian Kemmer**, Director of Behavioral Health, Orange County Health Care Agency
- **Ivan Bhardwaj,** Chief, Medi-Cal Behavioral Health – Policy Division, DHCS
- **Dr. Katherine Warburton,** Chief Medical Officer, California Department of State Hospitals
- **Keris Jän Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Jennifer Bender**, Deputy Public Defender, Riverside County
- **Monica Porter Gilbert**, Disability Rights California
- **Salena Chow**, COO, Judicial Council
- **Sarah Davis**, Judicial Council
- **Hon. Scott Herin**, CARE Judge, Superior Court of Los Angeles County
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tawny Macedo**, Housing Advisor, Business Consumer Services and Housing Agency

Working Group Members in Attendance Online:

- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Brenda Grealish**, Commission for Behavioral Health
- **Dr. Clayton Chau**, National Healthcare and Housing Advisors
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, Cal BCSH
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Kent Boes**, District 3 Supervisor, Colusa County
- **Ketra Carter**, Director, Homelessness Strategies and Solutions Department
- **Khatera Aslami Tamplen**, Alameda County Behavioral Health Services
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Mark Salazar**, Mental Health Association of San Francisco
- **Meagan Subers**, California Professional Firefighters
- **Monica Morales**, Office of Second District Supervisor for Santa Cruz County
- **Naomi Ramirez**, standing in for Jenny Bayardo, California Behavioral Health Planning Council
- **Nichole Zaragoza-Smith**, Homelessness Grants Program Design Section Chief, HCD
- **Ruqayya Ahmad**, Policy Manager, CPHEN

- **Sean Johnson**, standing in for Roberto Herrera, California Department of Veterans Affairs
- **Stephanie Regular**, Alameda County Deputy Public Defender
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tawny Macedo**, Housing Advisor, Business Consumer Services and Housing Agency
- **Tim Lutz,** Director of Health Services, Sacramento County

Working Group Members not in attendance:

- **Jerry May**, San Jose Fire Department, Local 230
- **Matt Tuttle**, President, San Jose Firefighters Union Local 230
- **Ruben Imperial**, Director, Stanislaus County Behavioral Health and Recovery Services

Welcome and Introductions

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

Linkins introduced Stephanie Welch, Deputy Secretary of Behavioral Health at CalHHS, who welcomed the Working Group. Welch expressed appreciation for collaborating with the Judicial Council and recognized recent CARE Convening participants for their work on criminal justice and child welfare issues.

She thanked new court and judicial partners for their engagement and looked forward to sharing insights and lessons learned from recent activities later in the meeting.

Linkins went over the day's agenda.

Linkins introduced new Working Group member Sarah Davis from the Judicial Council who will be replacing Salena Chow. She 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.

Linkins provided a brief recap of the August 27th Working Group meeting, which consisted of the following agenda items:

- Annual Report Overview presentation and panel discussion on the data and the issues associated with it.
- A panel of peers from Los Angeles on the role of peers in the CARE Act, underscoring the importance of using peers around engagement and in services.
- A presentation by Beau Hennemann who gave an orientation and opportunities for coordination between managed care plans and counties.
- Updates on CARE Subject Matter Expert Focus Groups with researchers, courts and psychiatrists.

Linkins shared the 2026 meeting dates:

- February 11, 2026
- May 13, 2026
- August 26, 2026
- November 18, 2026

Deputy Secretary Welch noted this may be the most attended meeting of 2025 and emphasized the importance of active engagement for all remaining meetings until the group sunsets at the end of 2026. With implementation underway, she stressed the need for real-time problem solving and meaningful involvement from those doing the work on the ground. Deputy Secretary Welch encouraged in-person participation from the Working Group and said members may be asked for input before the next meeting on how to structure the coming year.

The Role of the Courts in CARE – Panel Discussion with Q&A

Panelists:

- Hon. Alicia Ekland, Glenn County
- Hon. Hana Balfour, El Dorado County
- Hon. Sandra Bean, Alameda County
- Hon. Scott Herin, Los Angeles County

Linkins thanked the four judges for their participation on the panel. She began the discussion by asking panelists to share what have been the most effective elements of CARE so far in their counties.

- Hon. Herin summarized key strengths of CARE Court's functioning in Los Angeles. He said their court process begins with an informal, conversational process in court, which empowers respondents and justice partners, allowing for greater participation and flexibility during hearings. He also highlighted the composition of LA's multidisciplinary teams that ensure all resources, including peer support, are utilized efficiently. Hon. Herin expressed that patience and allowing professionals to work at their own pace contributes to better outcomes, as rushing has proven ineffective.
- Hon. Ekland highlighted that in Glenn County there is no longer a hospital, and they face challenges like travelling long distances for care and lack of healthcare for those at poverty level. She said that CARE has been crucial for providing consistent treatment to vulnerable individuals who would otherwise lack care and has diverted them from incarceration. While resource-intensive, these efforts focus on community-based support rather than custody, which benefits everyone.
- Hon. Balfour echoed Hon. Herin's comments, noting that the less formal, conversational hearings help everyone reach consensus instead of issuing orders. She emphasized that asking what individuals want works well. She said that El Dorado, like Glenn County, faces challenges with distance and resource access, and they are still working on connecting people to services through CARE.
- Hon. Bean said Alameda County's success is due to a wide range of engaged petitioners, like first responders, behavioral health, families, and state hospitals, and early outreach efforts. She highlighted the impact of diligent social workers keeping people engaged and emphasized the value of collaborating with Cohort 1 counties since October 2023, which helped Alameda's implementation in December 2024.

Linkins also highlighted that Alameda hired a consultant to facilitate collaboration between Alameda County stakeholders, building on the lessons from Cohort 1.

- Hon. Bean agreed with Linkins, emphasizing that having a neutral party to pull everyone together has been huge for effective collaboration, and she's not sure it would have worked if the court or county offices tried to lead their implementation process.

Linkins asked the panel about the biggest implementation challenges they have encountered and how they are working to address those challenges.

- Hon. Herin shared that the biggest challenge at the start was managing everyone's expectations, especially since most petitioners were family members. There was confusion and misinformation about what CARE is and isn't, so they put a lot of early effort into educating the community, emphasizing that CARE is about providing voluntary services to help keep people out of higher levels of care and restrictive settings. Managing expectations remains an ongoing challenge. Hon. Herin highlighted that justice partners have been collaborative from the beginning, thanks to a volunteer process for respondent's counsel. Their shared goal is to avoid conservatorship by providing community resources at a pace that fits the individual, not just the petitioners or families, which can be challenging but has worked out so far.
- Hon. Ekland shared that one of the biggest benefits of CARE in Glenn County has been securing short-term housing for individuals, especially those in unstable or unsafe living situations. She emphasized that temporary housing reduces chaos and helps individuals succeed in treatment. However, the main challenge they are facing is that the available housing is only short term. The Behavioral Health Department has received new housing funds and has tried creative solutions, like purchasing motels or homes, but suitable options are scarce, especially larger homes needed for group living in their rural area. As a result, some individuals doing well are now at risk of losing their housing due to time limits, which remains the county's biggest hurdle.
- Hon. Balfour noted that their main challenges are engaging respondents and helping everyone, including participants, counsel, petitioners, and others, to understand what CARE is, who it's for, and its benefits. Each new case involves figuring out how the program fits the individual. The Behavioral Health Department is also stretched thin due to high demands, including mental health diversion cases, making resource management another significant challenge.
- Hon. Bean said Alameda shares the challenges faced in other counties, especially regarding housing resources. She added that another challenge is engaging participants who are resistant to court involvement, both with social workers and in court itself. Despite efforts to make the courtroom welcoming, it remains a court building, which can carry negative associations for participants. She also encounters families who expect the court to order their loved ones into locked treatment facilities, but she does not have, and does not seek, such authority. Another challenge is maintaining confidentiality while enabling necessary communication between judicial officers, especially when trying to get referrals from criminal and juvenile courts. The limitations of confidentiality laws like HIPAA make this difficult, and she continues to look for procedural solutions to improve communication while respecting privacy.

Linkins asked the panel about other procedural or administrative challenges they are experiencing and what changes may be needed to solve them.

- Hon. Herin said legislative changes are needed to ease transitions from LPS to CARE and improve communication and early involvement of CARE teams. There is a need for better collaboration with justice partners and a simpler petition process for first responders, noting that few such petitions are currently received. He suggests making CARE Plans and CARE Agreements synonymous in statute to reduce confusion, as few CARE Plans exist and cooperation is key at that stage.
- Hon. Balfour said that in her county, law enforcement and first responders are not aware of CARE and do not have the resources to pursue CARE petitions. The need for better communication has been discussed amongst judges to identify individuals who should

be considered for CARE, as she is frequently aware of them in various contexts. Yet, even after SB27, this coordination isn't always happening and the solution is unclear.

- Hon. Bean responded to Hon. Herin's concerns about first responders, sharing that Alameda conducted substantial outreach that has led to receiving many first responder petitions, and they have developed workflows to support those petitioners. If a petition is incomplete, her clerk contacts the relevant firefighter or behavioral health official to gather additional details. First responders are encouraged to attend court and are actively engaged with the cases they initiate, often assisting in locating respondents. Hon. Bean emphasized that first responders are a valuable resource and should be further engaged. She also added that she does not require the CARE 101 form.
- Hon. Herin stressed a need brought to his attention by the LA Department of Mental Health for a process allowing family members to file petitions anonymously, as fear of damaging relationships or causing a loved one to leave home often prevents them from seeking help. While anonymity raises concerns about integrity and respondents' rights, he emphasized that a balanced approach is needed to support families.
- Hon. Ekland agreed with the suggestions shared by other panelists.

Linkins asked the panel to share their criteria of determining eligibility and common reasons petitions fail to meet prima facie or eligibility thresholds. She said that as implementation progresses, understanding why some petitions are dismissed is crucial for statewide consistency.

- Hon. Herin said Los Angeles County is liberal in moving petitions forward. Even if the petition doesn't clearly show a schizophrenia-spectrum disorder, they won't initially dismiss it when there is any anecdotal sign of psychosis, because CARE is meant to identify people needing help. Granting a borderline petition at least triggers DMH outreach, and even if the case is later dismissed, the person is connected to services. He said most other dismissals involve not being able to locate the person. In a county of 11 million, he waits about six months before dismissing, after DMH confirms the person has not been hospitalized, arrested, or detained. He added that many state hospital petitions are filed prematurely, as people leaving forensic units must go through several steps, such as competency certification, criminal case resolution, and referrals for LPS or AOT, before CARE. Many never reach CARE because they are prosecuted or diverted to higher levels of care.
- Hon. Ekland said they have had no prima facie dismissals, likely because petitions so far come from agencies rather than families. Like Hon. Herin, they have a flexible approach and order reports when more information is needed. She stated dismissals have mostly been positive, i.e. people already engaged in services who no longer meet criteria. In a few cases, after months of trying to engage someone through outreach and flexible appearance options, all parties agreed to dismiss. Even then, the county continues outreach, and services remain available despite the dismissal.
- Hon. Balfour said that early on, she dismissed a petition at the prima facie stage due to insufficient information from a family member. Now, she prefers to hold a hearing to gather information directly, rather than immediately dismissing such petitions.
- Hon. Bean stated that, like her colleagues, she rarely dismisses petitions at the outset. If eligibility is unclear, she sets a hearing to gather more information from the petitioner and respondent, with Behavioral Health offering resources. Cases are held open for about six months if the person can't be located. After repeated outreach attempts,

sometimes up to 50 contacts, petitions may be dismissed only if the individual continues to refuse services, but every effort is made to engage those who meet the criteria.

Linkins asked for the panel to share an example of a case where CARE made a clear difference in someone's trajectory or well-being.

- Hon. Ekland described a standout success in Glenn County involving someone she had previously seen in dependency and criminal court, a person whose parental rights were terminated years ago. She said CARE Court came too late to change that outcome, but since entering CARE the individual has remained arrest-free and stable. She shared that the participant was initially very distrustful because all past court experiences had been negative. The court offered full accommodations, including remote appearances, audio only, and support from the social worker. Her caseworker's patient, consistent engagement helped her feel safe participating. The participant later told the court it was the first time she had trusted Behavioral Health or had a positive court experience. This participant is now engaged and doing well, with no new criminal or child welfare issues. Housing may soon be a challenge, but CARE Court led to a dramatic turnaround. Securing housing, help with Social Security income, and someone advocating for her within a system she once feared made the difference and changed her trajectory.
- Hon. Balfour described a CARE participant who, after cycling in and out of hospitals, entered a CARE agreement. He is willingly participating, stable, has avoided hospitalizations or law enforcement issues, and is now motivated to improve his housing situation. The CARE process has been highly effective in maintaining his stability.
- Hon. Bean described two people who made major changes through CARE. One is a woman in her forties with developmental disabilities who was unhoused, non-ambulatory, and initially arrived in a wheelchair. After entering CARE and moving to a skilled nursing facility, she steadily progressed, eventually walking on her own. She secured permanent housing and is now stable and engaged. The second is a man in his forties with a severe substance use history who had been living in an unhealthy home environment. Through CARE, he obtained housing, stabilized on medication, resolved traffic tickets through homeless court, and began using a bicycle for transportation. He secured a job he is excited about, and after significant dental repair due to meth use, he recently smiled in court, which Hon. Bean described as a wonderful moment.

Linkins noted that the Working Group is focused on missing or lagging data in this early stage of full implementation and are trying to determine which indicators or outcomes best reflect success in CARE. She asked the panel what they are watching most closely to understand whether CARE is functioning as intended.

- Hon. Herin said success cannot be measured by a single metric because each case looks different. He watches for signs that participants are gaining insight, communicating their needs more clearly, and working collaboratively with the team. He looks for increased comfort in court, reduced anxiety, a shift toward autonomy, and participants taking the lead in identifying what they want while the court and team support them. He described success as improved executive functioning: planning, adapting, and adjusting goals. Hon. Herin noted that even unrealistic requests can become opportunities for growth, as when someone asked for a car and the team redirected the goal toward getting a license and bus pass. As participants' ability to plan and adapt strengthens, communication improves and the program functions as intended.

- Hon. Ekland agreed, emphasizing that the key indicator is engagement. Success shows up when participants answer calls, reach out during crises, and stay connected to their caseworkers. She also looks at sustained participation over months, regular court attendance, and people expressing their goals, even if they do not meet every one.
- Hon. Balfour also defined success as engagement, even if it's minimal, when participants were initially reluctant. She sees value in helping participants take small steps toward involvement, which can lead to greater engagement over time and align with program goals.
- Hon. Bean agreed it's case-by-case, with participants accepting support incrementally. She noted challenges from rapid program expansion and limited social work resources. She now focuses on whether an agreement has been reached with the participant and whether they begin accepting mental health treatment, especially medication, which she sees as a major indicator that CARE is working.

Q&A

Linkins invited questions for the panel from Working Group members.

Lauren Rettagliata thanked the panel for the report and asked how courts are coordinating with county behavioral health departments to ensure participants receive thorough mental health evaluations, including through the 5200(a) process. She noted that the 2025 CARE annual report showed a notable number of participants had at least one jail booking, and wondered whether better evaluations could have changed those outcomes. She asked how courts are working with behavioral health to secure intensive assessments that clarify what medications or services would best help participants.

- Hon. Herin explained that Los Angeles County has not needed to use the 5200 process. Their outreach, engagement, and evaluation teams already include staff who can initiate a 5150 when criteria are met, which is faster than routing a referral through the court. These teams, which include social workers, psychiatrists, and psychologists, are consistently able to obtain comprehensive psychiatric evaluations without delay. He said that the court frequently orders medications to be made available when someone is willing to take them but cannot require compliance. He keeps medication as a clear option, encourages discussion with clinicians, and maintains a non-threatening approach. Because the teams can already act immediately in a crisis, he does not anticipate a practical need for 5200 in Los Angeles County.

Rettagliata followed up by noting concerns from families and members of the Grave Disability Workgroup about misuse of 5150s. She asked whether, given those concerns, the 5200 process is viewed as having any value.

- Hon. Herin said the 5200 process isn't without value, but in Los Angeles it would only slow down actions the clinical teams can already take immediately. Judges cannot decide on hospitalization; clinicians must determine whether medical criteria are met. CARE teams already have staff who can evaluate and place someone on a 5150 when needed and are obligated to act if criteria are present. If a 5150 isn't used, it usually means clinicians did not believe the criteria were met at that moment. Because the teams can already act in real time, 5200 adds little in practice.
- Hon. Balfour also shared that the 5200 process is not used in their county.
- Hon. Bean agreed with Hon. Herin, stating that when everyone, including behavioral health and the public defender, agrees an evaluation is needed, it happens. She

emphasized that the involved behavioral health staff and their contracted teams are experts and take the appropriate steps in response to the needs of participants.

Bill Stewart thanked the panel and asked about the unforeseen benefits experienced by counties through CARE, noting that behavioral health directors may have different perspectives than judges.

- Hon. Ekland shared that, though initially skeptical about CARE in Glenn County, she found its informal and flexible approach beneficial. For example, when someone was afraid to come to court, the team suggested she step off the bench to greet him, which helped ease his fear. This collaborative and voluntary process made participants more comfortable, reducing barriers to engagement and encouraging continued involvement from people who may have otherwise avoided services.
- Hon. Bean noted that CARE Court has unexpectedly made judges more approachable and integrated into the community, moving beyond their traditional, isolated roles.
- Hon. Balfour noted that while CARE's voluntary and collaborative approach raised concerns about effectiveness without strict enforcement, her experience suggested it could still yield positive outcomes for a significant portion of participants.
- Hon. Herin said CARE's unexpected benefit is that it connects those who often slip through the cracks to behavioral health services. He added that its collaborative model is more effective than adversarial systems, aligning partners toward the shared goal of voluntary, long-term treatment and autonomy, which improves both the process and outcomes.

Monica Porter Gilbert, Disability Rights California, asked the judges about their experiences and challenges in holding counties accountable through CARE, including use of sanctions, noting that county compliance is mandatory even though participation for individuals is voluntary.

- Hon. Ekland stated that, as a Cohort 1 pilot county, full support exists for CARE among the teams involved, making county accountability concerns irrelevant in their case.
- Hon. Bean said Alameda County hasn't considered sanctions against Behavioral Health. She suggested expanding the court's authority to include oversight over providers like regional centers and private insurers, to better address cases involving individuals with different disabilities.
- Hon. Balfour said her court has not yet reached a point where sanctions or fines were needed. She made clear the court's role is to press the county and require frequent return hearings. In her view, continued judicial pressure would likely produce results, as it does in other contexts, though they have not yet had to make a formal accountability decision.
- Hon. Herin added that a legislative fix is needed to give judges clearer authority to refer cases between programs like CARE and AOT. He said he has come close to threatening sanctions, but that DMH and county counsel are committed to the program and responsive when problems arise. Open communication has resolved issues before sanctions became necessary. He noted that an order to show cause is often enough to prompt correction, and while he is willing to impose sanctions if failures persist, that has

not been needed because the partners involved want the program to succeed and act quickly when concerns are raised.

Deputy Secretary Welch asked for a brief primer on how an order to show cause works, how judges decide whether to dismiss a case, and what role the other partners at the table play in that decision.

- Hon. Ekland explained that an order to show cause is a due process step before imposing sanctions, which provides a party with the opportunity to respond.
- Hon. Bean explained that an order to show cause involves requesting reasons or evidence before imposing sanctions, while deciding to dismiss a case focuses on gathering reasons in favor of dismissal. It is a process to ensure the court makes informed decisions.
- Hon. Ekland said that in her county, dismissals occur only after an extensive, documented process. The county is required to report monthly on engagement efforts, which can include different strategies, family involvement, and alternative outreach when trust is an issue. By the time a petition is dismissed, there is a clear record of these efforts, and dismissal does not prevent continued outreach or the petition from being refiled.
- Hon. Herin said early dismissals often resulted from lack of information from state hospitals, making it difficult for DMH to act. He would dismiss petitions with a note allowing refiling once the necessary details were available. That issue has largely been resolved, so future stats will likely change. He emphasized that dismissals are never done lightly. Only after extensive outreach efforts, and usually six months of no contact with emergency services or jail, will a petition be dismissed. The early learning curve in the first nine months affected initial processes, but now courts, county partners, and service providers have a clearer understanding of expectations and what can be done to engage participants.

Keris Myrick urged using language like “moving forward” instead of framing outcomes as successes or failures, which can make participants feel judged. She noted that medication adherence is common to struggle with and should not define progress; support should focus on participants’ goals and overall wellbeing, including connection and purpose. She also asked how counties are using CARE resources differently to help participants advance in their recovery.

- Hon. Herin explained that CARE differs from programs like AOT because the court engages early, holding county partners accountable from the start rather. This early engagement drives progress and accountability. He added that medication is available through CARE but not required; discussions happen only when participants are ready, with support from qualified professionals. The focus is on helping individuals pursue their own goals, i.e. work, school, housing, without pressure, supporting autonomy and long-term growth. The court does not frame outcomes as “success” in a binary sense, as living with mental health challenges is ongoing.
- Hon. Ekland said she appreciated the feedback about the word “success” and is becoming more intentional about language, recognizing how important it is in her role.

Regarding medication, she noted that none of their current CARE Agreements include it, as all agreements are voluntary and mutually determined and many participants simply don't include medication in their plans. She added that agreeing to medication is not a condition for receiving services.

- Hon. Balfour said she thinks about outcomes, not "success," and doesn't use that term in court. Medication is never required, only something participants may consider as one possible support. Her focus is on helping people build the most independent, self-directed life they can, centered on what they need and want. Whether someone takes medication is entirely their choice.
- Hon. Bean said "success" is subjective for each participant, even though the state needs measurable outcomes. She noted CARE allows more people, not just behavioral health, to bring someone forward, which helps reach individuals who would otherwise stay under the radar. She added that medication is never required and is included only if the person agrees. She watches closely when medication issues arise and asks behavioral health to reassess. In some cases, like one participant who decompensated after stopping meds, it can be critical, but it's never pushed.

Dr. Kate Warburton wanted to know what information judges actually need to decide whether a case should move forward, and what components of the petition could be removed to make the process easier and more efficient in the interest of simplifying the process for first responders and other important petitioners.

- Hon. Herin said the new 102 form helps because clinicians complete it. For first responders, he suggested a simplified 102B/103 form that lets them alert the court without needing full clinical detail. Behavioral Health could then review the case and decide whether a full petition is warranted.
- Hon. Bean said the form could be simpler. She mainly needs it to include the person's date of birth to look them up, any known or suspected diagnosis, whether they're connected to services, and a brief history.

Salena Chow thanked the judges for their commitment and compassionate leadership, noting how their work is transforming engagement with individuals and families. She highlighted that, after a year focused on implementation, the coming year will be about charting the program's future. She invited them to share any needs or supports the Judicial Council can provide as the program matures.

- Hon. Herin emphasized that CARE has already proven itself as a viable option and that the progress made so far is significant. He stressed the need to align CARE with LPS to relieve pressure on an overburdened involuntary system and better use CARE as a step-down path for those who can transition out of LPS. He highlighted that CARE demonstrates the power of collaborative, person-centered work and urged continued efforts to integrate CARE, LPS, and AOT so all systems stay focused on one goal: supporting the wellbeing and autonomy of individuals. He underscored that deeper alignment will improve outcomes, reduce costs, and move the state forward.
- Hon. Bean noted that courts often lack a clear view of county resources. She suggested creating a centralized database of available services, including nonprofits, to share with

participants. Better coordination and access to this information through CARE could significantly help individuals connect with the support they need.

Linkins closed the panel, thanking the judges for their time and insights and noting it was the first opportunity for the Working Group to hear directly from them.

California Mental Health Courts Overview

Anne Hadreas, Supervising Attorney, Center for Families, Children & the Courts with the Judicial Council of California

Linkins introduced Anne Hadreas, Supervising Attorney, Center for Families, Children & the Courts.

Hadreas announced that new statewide and county-level data on petitions, hearings, and service agreements are now available on courts.ca.gov. As of September 2025, there were nearly 3,000 petitions statewide, with a record monthly high of about 251. She noted that while these data are useful, it's only part of the picture and a comprehensive evaluation by RAND will tell a more complete story.

Hadreas provided an overview of other mental health court processes, noting that the CARE Act serves a limited group and many with mental health conditions aren't reached by court-ordered programs. She excluded non-court programs and most forensic commitments, as they have minimal overlap with CARE. She began with background on LPS:

- The Lanterman Petris Short Act (LPS) established due process protections and replaced indefinite state hospital commitments.
- The LPS Act created the current civil commitment system, allowing involuntary hospitalization and medication only when someone cannot or will not accept voluntary care.
- Key holds under LPS include 5150 (72 hours) and 5250 (14 days) holds. A 5150 hold requires a person to meet criteria (danger to self, danger to others, or grave disability), and a 5250 hold requires psychiatrist/psychologist determination that an extended hold is necessary and requires a hearing to be held.
- 5200 process: anyone may request evaluation, but only the county agency can file; requires pre-petition screening and probable cause.
- Petitions for permanent conservatorship come only from the county public guardian and must be renewed yearly.
- Counties report initiating 5150s for CARE respondents when needed if criteria are met.
- There is no direct route from CARE to LPS.
- CARE Plan non-completion may be considered in a separate LPS hearing within 6 months, but it does not create an automatic presumption of grave disability.

Hadreas then gave an overview of Assisted Outpatient Treatment (AOT):

- AOT is a six-month, less-restrictive alternative to LPS; only county behavioral health agencies can file, and not all counties participate.
- Key differences from CARE: AOT allows short-term hospitalization in specific cases and covers any serious mental disorder if additional criteria are met; CARE requires a specific diagnosis and has tighter affidavit timelines.

- No direct pathway exists between CARE and AOT, though courts and county evaluations may recommend switching programs based on individual needs.

Myrick sought clarification on the funding differences, noting that both LPS and AOT are considered unfunded mandates, whereas CARE receives some state funding.

- Deputy Secretary Welch clarified that LPS is a legal process, not a program, and therefore cannot be considered an unfunded mandate.
- Susan Holt noted that while CARE provides funding for intensive outreach, AOT does not, leaving counties to cover these costs themselves. With shifting funding streams and new mandates, some counties are rethinking whether to continue AOT because the outreach demands are expensive and rely heavily on limited realignment funds. Much of the related care is not Medi-Cal reimbursable, making the financial burden even more challenging.

Hadreas continued her presentation, shifting to an explanation of Felony Incompetent to Stand Trial (FIST) and Misdemeanor Incompetent to Stand Trial (MIST) proceedings and their role in CARE.

- FIST and MIST courts can refer cases directly to CARE.
- Hadreas described the process of FIST and MIST proceedings, explaining the considerations involved in restoration and diversion pathways. MIST cases do not pursue restoration, instead moving into alternative pathways.
- If a case is determined to be ineligible for diversion, the court may modify treatment, refer to AOT/LPS/CARE, or reinstate competency.
- FIST CARE referrals require an eligibility hearing within 14 court days and individuals may be involved in multiple systems at once, requiring coordination across courts.
- MIST CARE referrals can occur during diversion consideration or after diversion ineligibility and if ineligible, options mirror felonies but without reinstating proceedings, charges are dismissed.
- Acceptance into CARE from FIST proceedings results in immediate dismissal of charges. MIST charges dismiss after six months if not returned to criminal court.

In conclusion, Hadreas discussed Mental Health Diversion and CARE.

- Diversion requires diagnosis, consent, no risk, and expert support; cases involving certain serious crimes are ineligible for diversion.
- Duration: up to 2 years for felonies, 1 year for misdemeanors; success dismisses charges, failure may lead to LPS or reinstated terms.
- There is no direct pathway from diversion to CARE path.

Linkins thanked Hadreas for her presentation and opened the floor for questions.

Q+A

Myrick asked how substance use or collaborative courts fit into the landscape Hadreas described.

- Hadreas explained that collaborative courts, especially for substance use, are tied to criminal charges and involve treatment agreements. There is no direct pathway or referral mechanism to CARE, though individuals can participate in both concurrently.

Deputy Secretary Welch closed the agenda section by noting that CARE's goal is to divert individuals from the most restrictive settings, like incarceration, and to provide voluntary treatment options. She emphasized the importance of thoughtful and responsible implementation, including discussions related to the LPS system.

Lunch and CARE videos

Deputy Secretary Welch shared newly released CARE videos, explaining that they were created to provide quick, accessible explanations about CARE based on feedback from the Working Group. They also serve to uplift the work happening on the ground across the state to engage and meet the needs of CARE participants and their loved ones. She shared that in Long Beach, interviews and quotes were recently collected to help further educate the community and develop more videos. Deputy Secretary Welch invited suggestions for improvement and ideas for additional videos to address local needs.

Linkins added that new short videos are being developed for different audiences, responding to requests from counties for clearer tools to explain CARE and address ongoing misunderstandings.

The CARE Act in Los Angeles County

- **Linda Boyd, R.N., B.S.N., M.N., District Chief, Los Angeles County Department of Mental Health**
- **Martin Jones, Countywide Chief, A.O.T. & C.A.R.E. Countywide Programs, Los Angeles County Department of Mental Health**

Linkins introduced Linda Boyd and Martin Jones from the Los Angeles Department of Mental Health.

Before beginning her presentation, Boyd added to the earlier discussion regarding the key differences between CARE and AOT. She emphasized the persistent outreach and early judicial oversight that are key elements of the CARE process, which she said are highly beneficial.

Boyd shared updates on LA DMH collaboration with hospitals and first responders in Los Angeles County:

- LA County is strengthening collaboration with its many LPS-designated hospitals, using new judicial referral forms to streamline the process.
- County staff provide frequent trainings for hospital liaisons, Hospital Association of Southern California (HASC) hospitals, ER teams, social workers, and discharge planners. Direct communication is encouraged, with staff sharing contact information for real-time referral support.
- Supervising psychiatrists are building connections with ERs and inpatient units, including coordinating when respondents require 5150 holds.
- Ongoing relationship-building across disciplines is central to supporting respondents effectively.
- LA County uses a co-response model with DMH clinicians embedded in 39 of 48 law-enforcement jurisdictions. Patrol officers call co-response teams when they encounter someone who may benefit from CARE. The DMH clinician typically completes the referral, which goes through an internal process for evaluation and petition filing.

- LA County Fire's Advanced Provider Rescue Units (paramedic + nurse practitioner) refer high 911 utilizers, with CARE teams joining initial outreach to build trust.
- A countywide paramedic checklist is being developed to identify potential CARE referrals. To reduce workload on paramedics, the county is exploring having the medical director submit referrals, with CARE teams handling outreach and petitioning.

Jones added that partnering with paramedics helps reduce non-psychiatric 911 calls from frequent users of the system. The pilot targets individuals who repeatedly call 911 without true emergencies, helping relieve strain on the broader emergency response system.

Boyd shared other updates on LA County's implementation of CARE since launching in December 2023:

- DMH staff are stationed in the Norwalk courthouse self-help center and available virtually through kiosks in 11 other centers to assist with petitions, resources, and virtual hearing access.
- Staff help respondents join hearings via LACourtConnect and conduct in-reach at jails to evaluate CARE criteria and begin engagement.
- LA County hosts monthly open office hours for petitioners and the community to learn about CARE; sessions are advertised on DMH social media, offer multilingual support, and maintain respondent confidentiality.

Jones added that they've included a peer on the team to help facilitate the call, ensuring they consider not just the clinical perspective but also what a peer might be experiencing or feeling throughout the process.

- Boyd thanked Harold Turner and the NAMI Urban LA and explained that every quarter, NAMI hosts a weekend of education open to anyone interested, sharing information on CARE, AOT, and Public Guardian services. These sessions draw 45–50 participants. Guests like Hon. Herin have presented, and participants have reported that they find the sessions very helpful.
- Boyd emphasized that CARE is unique because judges spend real time talking with respondents. This level of direct engagement doesn't happen in most other court systems.

In conclusion, Boyd stressed how much LA DMH values the collaboration among all partners who make it possible to provide respondents the care they need.

Q&A

Myrick asked about transportation for individuals to CARE hearings.

- Boyd shared if respondents want to appear in person, teams are available to assist with transportation. For virtual appearances, teams assist them from their residence or encampment.

Myrick noted that therapeutic transport applies only to mental health and raised concern about individuals with a primary substance use disorder and a co-occurring mental health condition. She asked for clarity on how those cases are handled.

- Jones responded that all CARE participants receive the same integrated services. Every team has substance use disorder counselors, everyone is screened, and needs are

addressed holistically. DMH CARE teams meet regularly with SAPC to resolve barriers. Transportation is provided regardless of substance use issues; it never limits services.

Myrick noted LA County has two peer respites and asked about how LA County's peer respites are used for CARE respondents, specifically for those in crisis who don't require hospitalization but need an interim level of support.

- Jones said that CARE in LA County has not typically used peer respites. Conversations about expanding this resource are ongoing, and it could be considered in the future. He noted that peer respites are highly effective but have limited capacity.
- Boyd explained that every CARE team includes substance use counselors. If someone requests residential treatment, the team works to secure it that day while also providing counseling and support during outreach and engagement.

Myrick emphasized that LA County's two peer respites are highly effective: one serves unhoused individuals, and the other helps develop housing alternatives. Staff at both support people with mental health and substance use conditions, helping them maintain or access housing.

Deputy Secretary Welch asked for an explanation of what a typical array of services looks like in a CARE Agreement in LA County and how many people are actively receiving treatment for substance use.

- Boyd explained that CARE Agreements are fully individualized and built around each respondent's goals and needs. Agreements always include benefits establishment, therapy and case management, and may also include medication discussions, housing support, substance use treatment, employment help, school enrollment, transportation resources like TAP cards or bus passes, and other practical supports, down to items such as a bicycle if that's what helps the client succeed. The agreement reflects whatever the client wants and needs to move forward.
- Dr. Brian Hurley explained that while CARE respondents are primarily individuals with serious mental illness and DMH leads the work, roughly half also have co-occurring substance use issues. Only a small subset receive specialty Drug Medi-Cal (DMC) services outside DMH. Most substance use treatment instead occurs within the mental health system, where teams already provide counseling and support. He noted that contingency management is limited to DMC-ODS certified SUD clinics and cannot be delivered within general mental health programs. He does not currently have data on how many CARE respondents are enrolled in DMC-ODS contingency management, but believes the number is small and can confirm with the data team. Overall, most respondents with substance use needs are receiving counseling through DMH, with relatively few accessing separate DMC-ODS specialty care.
- Jones added that DMH also provides MAT services, and their substance use counselors use a motivational interviewing approach.

Rettagliata noted that Los Angeles County received significant BHCIP funding and asked whether it is expanding needed housing supply, especially social rehabilitation facilities for people not yet ready for independent living. She highlighted the need for settings that provide daily living support, since many CARE participants don't fit traditional board-and-care homes, and asked what LA County is developing and whether more resources are still needed.

- Jones explained that through BHBH, LA County now has a wide range of housing options, including sites with amenities like chefs, laundry, and pet-friendly units. Working closely with SAPC and the housing division, the county matches people to housing that fits their recovery needs, whether supportive settings or single-occupancy units. They've been successful moving people from homelessness into housing, with only occasional challenges around preferences. Overall, the county has a strong continuum that meets most CARE participants' needs.
- Boyd added that LA County has also brought interim housing programs online and is making extensive use of enriched residential care facilities for CARE participants.

Deputy Secretary Welch clarified that the Behavioral Health Infrastructure Program (BHCIP) and the Bond Behavioral Health Infrastructure Program fund facility development, while Behavioral Health Bridge Housing (BHBH) requires counties to prioritize CARE participants for resources like tiny homes, interim housing, rental assistance, and assisted living settings. She noted that although dozens of BHCIP-funded facilities have already opened and are providing services, these are not all housing sites. The original BHCIP program launched in 2022, so some facilities are now coming online, but the bond-funded facilities are still in development.

- Boyd added that while waiting for permanent housing, CARE can place participants in motels and provide food, groceries, clothing, and other necessities. Staff also meet people experiencing homelessness in the field to provide immediate support until more stable housing is available.

Jennifer Bender asked about the extent to which LA County helps CARE respondents obtain Social Security benefits.

- Boyd shared that LA County transports clients to Social Security and also uses the CBEST program, which helps DMH clients apply for benefits at clinics.
- Jones added that CBEST is a benefits establishment program, though staff have long assisted clients in securing benefits. Many respondents already have benefits, but teams ensure access to Medi-Cal, SSI, CalFresh, and other programs as a foundational step for recovery. He added that most petitions come from family members, and by intervening early, the program helps prevent respondents from becoming unhoused.
- Dr. Hurley clarified that CBEST (Countywide Benefits Entitlement Services Team) works with local resources to help clients access state and federal entitlements. While federal SSI still requires a formal application, CBEST includes direct enrollment support through an MOU with DPSS.

Deputy Secretary Welch asked Dr. Hurley whether this is considered a best practice in LA County.

- Dr. Hurley believes this is a best practice but is unsure how widely it's replicated in other counties and lacks visibility on whether it's LA County–specific or more broadly established.

Deputy Secretary Welch noted that identifying best practices is part of the state's ongoing role in CARE implementation, and they can research this further.

Linkins thanked the presenters and closed the Q+A portion.

Recent Legislative Changes to CARE: Senate Bill No. 27

- **Stephanie Welch Deputy Secretary of Behavioral Health, CalHHS**
- **Dr. Katherine Warburton, Chief Medical Officer, California Department of State Hospitals**
- **Tyler Shill, Judicial Council**
- **Laura Collins, Health Management Associates**

Deputy Secretary Welch explained that SB 27, which was signed this Fall and will be effective as of January 1, 2026, makes several updates to support effective implementation and improvements to the CARE process. The bill:

- Clarifies clinically stabilized and ongoing voluntary treatment.
- Adds bipolar I disorder with psychotic features as an eligible diagnosis.
- Allows certain court referrals to function as CARE petitions without a full petition needing to be filed.
- Permits earlier CARE consideration in misdemeanor IST cases.
- Allows nurse practitioners and physician assistants to complete petition affidavits.

Overall, SB 27 streamlines court processes, clarifies criteria, and expands first-responder teams' ability to initiate petitions.

Deputy Secretary Welch explained that the field needed clearer definitions of "clinically stabilized" and "ongoing voluntary treatment," since individuals who meet these conditions are not eligible for CARE. The new law now defines this more precisely:

- The person's condition must be stable and not deteriorating.
- They must be actively participating in treatment and managing symptoms through medication or therapy.
- Enrollment in services alone does not indicate stability. Individuals must be engaged, and programs must provide adequate services to support recovery.

Deputy Secretary Welch turned the presentation over to Dr. Warburton.

Dr. Warburton shared that SB 27 adds bipolar I disorder with psychotic features, excluding intoxication-related psychosis, as an eligible CARE diagnosis. She explained that adding it to the list of eligible diagnoses is unlikely to drive a major increase in CARE referrals.

- Bipolar disorder affects about 1.5% of the general population, but only about 8.5% of IST patients in state hospitals, versus nearly 78% with schizophrenia spectrum disorders.
- CARE is intended for individuals with chronic psychosis who are not clinically stabilized, not in effective voluntary treatment, and showing substantial deterioration or risk of serious relapse.
- Because many people with bipolar disorder have long periods of stability, most will not meet these additional CARE qualifying criteria

In closing, Dr. Warburton emphasized that accurate initial clinical assessments are critical to ensuring the right people enter the CARE process, which was designed for individuals with chronic psychosis, lack of insight, and high risk for criminal legal involvement, homelessness, or death. An estimated half of people with schizophrenia spectrum disorders are untreated, and CARE is meant to direct intensive resources and civil court oversight to this specific group. She

underscored that accurate diagnoses are essential for the system to work as intended and offered her team's support for any questions on proper clinical assessment.

Deputy Secretary Welch clarified that SB27 will not drastically increase CARE eligibility, countering claims of a fivefold rise. She emphasized that while encouraging people to access services is important, a diagnosis like bipolar disorder alone does not make someone eligible for CARE. The focus remains on serving the highest-need, high-risk population responsive to this model. She also noted the importance of discussing ways to support people with bipolar disorder in accessing treatment and services across the state's behavioral health systems.

She opened the floor for clarifying questions or comments before moving to the next part of the presentation.

Susan Holt noted her appreciation for the clear explanation of clinical diagnostics and raised concerns about potential misdiagnosis of bipolar disorder. She observed that once a diagnosis is recorded, it often persists, making it difficult to correct if initial assessments were inaccurate. She emphasized the importance of rigorous clinical review as petitions are considered.

- Dr. Warburton noted that diagnostic uncertainty is common and some with emotional regulation issues may be misdiagnosed as bipolar. CARE is intended for individuals with psychosis causing risks like legal involvement or homelessness, and thorough clinical assessment is essential for eligibility.

Linkins introduced Tyler Shill, Judicial Council, to clarify elements of SB27.

Shill noted that the discussion will focus on statutory referrals to CARE under Welfare and Institutions Code section 5978, specifically from criminal court, AOT, and LPS conservatorship, in the context of SB27.

Shill explained that SB27 allows misdemeanor incompetent to stand trial (MIST) courts to refer defendants to CARE earlier, either instead of or alongside diversion hearings, with agreement from the defendant or counsel and a reasonable belief of eligibility.

- MIST to CARE pathway 1 (new under SB27): referral before diversion eligibility hearing; CARE Court must hold an eligibility hearing within 30 court days.
- MIST to CARE pathway 2 (existing): referral after diversion hearing if the defendant is ineligible or unsuitable; CARE Court holds hearing within 14 court days.

Shill described the court-to-court referral process created by SB27 that will allow CARE courts to treat certain referrals as petitions at the discretion of the CARE judge.

- Starting January 1, 2026, CARE courts may treat referrals from AOT, conservatorship, misdemeanor IST, or felony IST proceedings as petitions if they include all required information and make a prima facie showing under section 5972.
- If treated as a petition, the CARE court must notify the referring court and no separate petition form is required.
- If not treated as a petition, an appropriate petitioner investigates, which may result in filing a petition or not filing after investigation.

Shill laid out several other changes made by SB27 to the CARE process:

- SB27 changes to the graduation process: respondents must now request to graduate or remain in CARE, and the court issues a graduation plan if the respondent has successfully completed the program.

- The definition of licensed behavioral health professional is expanded under section 5975(b), allowing nurse practitioners and physician assistants to provide affidavits regarding respondent examinations.
- Notice to federally recognized tribes is now the duty of the county.
- Data collection clarification: trial courts must now report the number of initial appearance hearings held.

Shill ended his presentation by sharing that public-facing resources and technical assistance from the Judicial Council are available online, with contact information provided for questions or comments.

Linkins asked Laura Collins with HMA to discuss the resources HMA has developed for SB 27, highlighting the opportunity to ensure counties have the tools to explain the new changes.

Collins summarized updates to HMA's Technical Training and Assistance (TTA) materials reflecting SB 27.

- CARE Act Resource Center brief is live on the website and easily accessible.
- Over 30 trainings are available and 15 resources are being updated, some minor, some major, including a new training on bipolar I with psychotic features with Dr. Warburton's input.
- Targeted TTA sessions with counties are planned for early December; a recorded SB 27 training will be released prior to office hours.
- FAQs, data collection, and reporting guidance are being revised.
- Stakeholder communication continues via monthly emails, one-to-one TA calls, and centralized communication to improve efficiency while retaining liaison access.
- Small county meetings and peer-to-peer county office hours remain active to address unique concerns and facilitate information sharing.

Collins concluded by highlighting recent CARE Act resources developed in response to county requests.

- Wallet cards are available online; customizable, translatable into nine languages, include QR codes to petitioner and county contacts.
- A PADs toolkit is available online for counties, developed to help respondents express treatment preferences before graduation.

Ivan Bhardwaj, DHCS, noted the wallet card is very helpful in English and Spanish and asked for more detail on plans for SB 27 data collection, including challenges counties are facing, lessons from SB 1400, and anticipated next steps for supporting counties beyond general technical training and assistance.

- Serene Olin with HMA explained that most SB 27 data changes can be handled within the current data dictionary, and the team is being cautious about adding new requirements given the reporting burden created by SB 1400. Eligibility updates will need to be incorporated, and capturing new CARE pathways can be addressed through guidance using the existing system-referrals module. She noted counties are unsure how to report informal vs. formal system referrals, and that clearer JC forms and targeted TTA will help ensure consistent reporting.

Amber Irvine requested clarification on the updated permissions for sharing medical records. She asked for confirmation that while the legislation allows jail-based providers and county behavioral health to share records with the courts, it does not permit those entities to share records with one another.

- Shill confirmed that SB 27 does not change those confidentiality rules.

Irvine noted that as San Diego implements SB 27, there may be situations where the mental health competency judge lacks the records needed to make a CARE referral or file a petition. She questioned whether the judge would need to obtain records from the jail and then use those to forward information to the CARE judge, and asked Hon. Herin for his feedback on how else the court could gather the necessary information to convert a referral into a petition in the most streamlined way.

- Hon. Herin explained that Los Angeles' mental health court and DMH are deeply involved throughout competency proceedings. Judges already have access to competency evaluations and related records, which typically include the information needed for a CARE referral. In LA, DMH can identify cases that appear more appropriate for CARE and act on them before they ever reach the judge. While a judge could issue a detailed referral order, Hon. Herin noted it's usually unnecessary in LA's system because DMH integrates this work early, making the process largely automatic.
- Linda Boyd added that in Los Angeles, the process already integrates CARE and AOT review into competency cases. After diversion is considered in the Hollywood Mental Health Court, judges issue a minute order requesting a suitability report covering LPS, CARE, and AOT. Teams then review records, conduct in-custody outreach, assess the client, and determine whether they meet criteria for CARE or AOT. The programs coordinate weekly and decide which track fits best. Because this system is already functioning, Boyd noted there is discussion about keeping the current process unchanged for now in LA.
- Hon. Herin agreed with Boyd and added that CARE court is unaware of these competency-related activities until a petition is filed. There is no direct communication between the competency court and CARE court, so assessments and referrals happen without CARE court's awareness. He noted this raises concerns about information-sharing and whether a defined time frame should begin once the competency judge makes a referral, to ensure timely action, even if CARE court is not directly involved in that early stage.
- Linkins noted that Irvine's question highlights a need for clarification and urged the TA team to connect with her, as other counties may face similar issues, LA being an exception.

Jennifer Bender emphasized that referrals to behavioral health alone aren't enough, as CARE addresses service gaps, and expressed concern that without clear guidance, quasi-confidential competency proceedings could lead to mistakes or public disclosure. She supports a uniform confidential referral process statewide.

- Anne Hadreas noted that competency reports are quasi-confidential, and with consent, information can be shared while maintaining confidentiality. She added that if the court cannot provide the information, it defaults to a referral to behavioral health, though the CARE timeline may not yet apply.

Linkins closed the discussion, thanking everyone and emphasizing the importance of addressing additional technical assistance needs and continuing ongoing conversations.

Implementation Updates

Stephanie Welch Deputy Secretary of Behavioral Health, CalHHS

Deputy Secretary Welch provided a high-level summary of recent CARE activities at the state level.

She thanked participants of the two Fall CARE convenings and the Judicial Council's recent Beyond the Bench CARE pre-conference event, noting these opportunities to bring counties together were invaluable for prioritizing technical assistance, identifying lessons learned, and sharing best practices from the first year of CARE implementation. Deputy Secretary Welch highlighted key takeaways:

- Counties and court partners want clearer guidance on how to move efficiently from referral to petition so CARE can truly prevent escalation to more restrictive levels of care while still honoring dual accountability and respondent choice.
- Monday's Judicial Council convening underscored concerns about shrinking behavioral health resources and the need for clearer communication about upcoming Medi-Cal and behavioral health reforms that are actually designed to strengthen services for high-need populations, including those served by CARE.
- There is a need to better support judicial partners through rapid system changes, improve communication between courts and counties, and encourage more system petitioners, especially those working in crisis services, jails, and state institutions.

Deputy Secretary Welch noted that last week's oversight hearing reinforced both the progress and the challenges in communicating CARE's early impact. She explained that the publicly available validated data only covers the program's first nine months so far, which can frustrate stakeholders who want real-time insight. That is why ongoing collaboration with counties is so important, so the state can accurately describe how CARE is affecting people's lives between the release of formal reports. Deputy Secretary Welch thanked counties for sharing information and for hosting nearly a dozen site visits so far, with more planned next year, emphasizing that these visits are essential to understanding how to continue improving implementation.

Deputy Secretary Welch reviewed the latest Judicial Council data and added that counties' CARE outreach and diversion efforts have connected more than 6,000 people to behavioral health services, including over 3,000 individuals connected to county services outside of the CARE process as of June 2025. She emphasized that CARE is effectively engaging people often labeled "hard to reach," largely because of the presence of people with lived experience on CARE outreach teams who serve as credible motivators alongside court and county professionals.

Deputy Secretary Welch underscored the need for continued improvement in 2026, bringing in the context that between 2023 and 2025, active mental health cases in jails increased by 10% statewide even as overall jail populations declined. She stressed that this underscores the need for CARE's core objective, to ensure people with severe untreated conditions do not end up receiving their only care through incarceration, and that this must remain central to the work ahead.

She also highlighted that a major focus for the Working Group next year should be addressing the significant variation in implementation and early outcomes seen across the state. Even though petition filings are not a perfect metric, they are one of the only regularly shared data points, and higher petition numbers in a county often signal that stronger engagement is occurring. She noted that one Cohort 1 county is filing petitions at five times the per-capita rate of another, and counties with high per-capita petition rates like Humboldt, Alameda, San Diego,

Stanislaus, and Tuolumne vary widely in size and resources, so the differences aren't tied to county type.

What is consistently seen in counties that are performing well is strong collaboration across all partners, meaningful use of peers throughout the process, active referrals coming from criminal and conservatorship systems, and the delivery of robust behavioral health services. These counties are also using Behavioral Health Bridge Housing creatively, planning for Prop 1 housing funds, and expanding evidence-based practices like ACT and FACT with integrated mental health and substance use treatment for participants with complex needs.

Deputy Secretary Welch emphasized the need to understand whether creating easier referral pathways actually leads to more appropriate CARE petitions. Some counties with strong referral systems aren't generating many petitions, and it's unclear whether that reflects effective diversion into voluntary care or gaps that haven't been captured in the data. There remains a need to determine whether refining referrals or simplifying and improving the petition process will lead to better, more accurate petitions for people who meet CARE criteria.

She stressed the urgency of timely engagement of CARE respondents, noting that delays can result in jail time, hospitalization, or worsening medical conditions. She also highlighted progress beyond last year's debates about voluntary vs. involuntary framing, urging the group to recognize CARE as a less restrictive alternative to other, far more coercive systems. Deputy Secretary Welch encouraged continued honest discussion about what "restrictive" really means in this context and how to keep the individual's best interest at the center.

Deputy Secretary Welch ended by emphasizing her belief in the efficacy of the CARE model and thanking the counties and individuals who allowed her to observe court proceedings, where she has seen people secure housing and receive meaningful support. She shared the story of one participant and his CARE team, who worked together to help him find a path forward, a reminder that CARE is ultimately about purpose, belonging, and community. She said she has never before seen, in 25 years, people come to court because it feels like a safe place to support their recovery. She thanked everyone for their work and invited others to share reflections or priorities for next year.

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.

- Vanessa Ramos said she came as a family member and LA County resident, and while she's impressed by what she heard in the meeting, the families she meets through a mutual aid group report the opposite: their loved ones, many of whom they believe are among the original 7–12,000 estimated to meet CARE criteria, can barely function, yet families are still expected to house them and take them to outpatient care. She said families keep asking why there wasn't greater investment in improving AOT first, because without fixing AOT the CARE Act is ballooning the population by adding people with substance use issues and people who are unhoused, overwhelming counties already struggling to manage. She noted that calling CARE an "AOT-lite" reflects what many families feel, that CARE is better suited as a step-down, and that reframing it that way could help make meaningful change without wasting more money.
- Lynn Rivas, executive director of CAMHPRO and someone with Bipolar I with psychotic features, acknowledged everyone's good intentions and argued that housing plus

assertive community treatment or full service partnerships could achieve similar outcomes to CARE at a lower cost. She urged that outcome analyses compare CARE to well-resourced, noncoercive models rather than accept coercive approaches as the baseline.

- Alison Monroe from Oakland, a family member who lost her loved one with schizoaffective disorder to an overdose, said that many families she works with through FASMI are not satisfied with CARE Court as it is. She doesn't see it functioning better than AOT, especially for people who are far sicker than those being discussed. Families already use the same engagement techniques judges and outreach teams rely on, and they're not enough for the individuals they're trying to help. She said families supported CARE because it originally included a path to conservatorship and a defined role for family members. She believes the conservatorship path must be restored, because 5150s and short 5250 holds are insufficient for those placed on repeated holds without real safety or treatment. Families need a way to help their loved ones stay safe, take medication, avoid substance use and exploitation, and have a judge who understands their circumstances act when needed.
- Laurel Benhamida from the Muslim American Society Social Services Foundation and REMHDCO said it's been a long but valuable day and highlighted a few points. She found the presentation comparing Lanterman, CARE, and other court-involved processes especially useful for training staff. She asked whether ICE presence in courts is having a chilling effect, noting that the issue didn't come up today but is widely discussed in other mental health settings. She also remarked that the LA housing examples sounded almost custom-built, with pets, laundry, and other supports, but it wasn't clear whether those were interim or permanent options. She added that some colleagues might interpret Dr. Warburton's comments as disagreeing with including Bipolar I with psychotic features, and she is unsure how to respond if asked. Finally, she echoed frustration with having only nine months of data and requested that links to testimony, convenings, and related materials be posted so the public can access them.
- Kaino Hopper thanked everyone for another informative day and spoke to the agenda item on the role of the court in CARE. She shared that her daughter recently left a long state hospital stay, and both she and Adult Correctional Health filed CARE petitions. On the court date, her daughter appeared stable. Family had helped her with clothes and a purse because they were the ones she trusted, not behavioral health staff. Hopper asked judges to hold behavioral health workers accountable for verifying respondents' self-reports, noting that people can appear composed in court while still having disorganized thinking or unrealistic beliefs about their functioning. In her daughter's case, no CARE Agreement was put in place, and two months later she was dysregulated and back on the streets. Kaino said that if the long histories from both family and Adult Correctional Health had been combined, the pattern would have been clearer. She urged courts to ensure behavioral health staff are completing thorough assessments as emphasized in the implementation materials.
- Jean Harris from NAMI Imperial County thanked everyone for the information and described a recurring problem she sees in Los Angeles County. When someone with a severe mental illness is arrested in the Antelope Valley, they are taken nearly 100 miles away to Twin Towers. Families follow the case through mental health court, but once the person is found competent, they are sent back to Twin Towers, then back to criminal court, and ultimately released from Twin Towers with no shoes, no phone, no money, and far from any support system. She said this cycle repeats endlessly. She noted that AOT and FSP are offered but refused, and when she has encouraged families to petition

for CARE, many are found ineligible. She said eligibility remains confusing and asked where families or advocates can go to clearly understand who qualifies and how to get help in such a complicated system, because too many people fall through the cracks.

- Teresa Pasquini thanked Keris Myrick and Vanessa Ramos for supporting families and said she was offended by Hon. Herin's comments about managing family expectations, which she felt misrepresented families' understanding and experience. She noted that the film *No One Cares About Crazy People*, filmed in part at a CARE Working Group meeting she attended, is now being shown nationally and that CARE is being watched as a potential model to duplicate elsewhere. She said that she wants CARE to succeed but, as her son's conservator for 23 years, she has refiled for conservatorship because she does not trust CARE to meet his needs. She agreed with the need for legislative changes to allow step-downs from LPS conservatorship but insisted families must be included, since her son wants her to remain his conservator. She urged the group to stop portraying conservatorships and the families who seek them as harmful, emphasizing that families often serve as the only safety net—and raising the question of what happens to their loved ones when families are no longer there.
- Patricia, a family member and longtime advocate, shared that her son with schizoaffective disorder was deteriorating despite years of FSP case management. She tried to submit a CARE petition, but after completing her portion, she waited two months for the Berkeley behavioral health department to complete the CARE 101 form. The case manager refused to proceed without her son's release, contrary to the law, delaying access to services. She emphasized that while programs may be well-designed in theory, they often fail at the local level when not implemented with fidelity, citing similar issues with AOT in her county.