California Health and Human Services Agency
Community Assistance, Recovery & Empowerment (CARE) Act

Working Group Meeting Minutes
August 27, 2025

Working Group Members in Attendance:

- **Amber Irvine**, San Diego County Behavioral Health
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Brenda Grealish**, Commission for Behavioral Health
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control, Los Angeles Department of Public Health
- **Dr. Emma Rasmussen,** Deputy Director of Behavioral Health, Fresno County, standing in for Susan Holt, Behavioral Health Director and Public Guardian, Fresno County
- **Ian Kemmer**, Director of Behavioral Health, Orange County Health Care Agency
- **Ivan Bhardwaj,** Chief, Medi-Cal Behavioral Health – Policy Division, DHCS
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter
- **Kaino Hopper**, Parent and Community Member, standing in for Lauren Rettagliata
- **Dr. Katherine Warburton,** Statewide Medical Director, California Department of State Hospitals
- **Kelly Simon**, standing in for Stephanie Regular, from Alameda County Deputy Public Defender representing CARE Court participants
- **Kent Boes**, District 3 Supervisor, Colusa County
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Khatera Aslami Tamplen**, Alameda County Behavioral Health Services
- **Lisa-Sun Gresham**, standing in for Mark Salazar, Mental Health Association of San Francisco, Director of Community Programs
- **Monica Porter Gilbert**, Disability Rights California
- **Nichole Zaragoza-Smith,** Homelessness Grants Program Design Section Chief, HCD
- **Ruben Imperial**, Director, Stanislaus County Behavioral Health and Recovery Services
- **Salena Chow**, COO, Judicial Council
- **Hon. Scott Herin**, CARE Judge, Superior Court of Los Angeles County
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **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
- **Harold Turner**, Executive Director, NAMI Urban Los Angeles
- **Jennifer Bender**, Deputy Public Defender, Riverside County
- **Hon. Maria Hernandez**, Presiding Judge, Superior Court of Orange County
- **Tim Lutz**, Director of Health Services, Sacramento County

Working Group Members Not in Attendance:

- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Jerry May**, San Jose Fire Department, Local 230
- **Ketra Carter**, Director, Homelessness Strategies and Solutions Department
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Meagan Subers**, California Professional Firefighters
- **Roberto Herrero**, Department Secretary for Veterans Services, CalVet
- **Ruqayya Ahmad**, Policy Manager, CPHEN
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County

Welcome and Introductions

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

Linkins went over the day's agenda.

Linkins introduced new Working Group members: Khatera Aslami Tamplen, Alameda County Behavioral Health Services, Monica Porter Gilbert, transitioning in for Deb Roth, Disability Rights California, and Hon. Scott Herin, Los Angeles County.

Deputy Secretary Welch welcomed the new members and spoke to the perspectives they add. She expressed enthusiasm about the group now being more representative of partners involved in local implementation and highlighted that the day's focus would be on learning from those perspectives.

Linkins reminded the group to speak slowly for the ASL interpreters. She reviewed virtual meeting guidelines for the members who joined via Zoom and members of the public. She also reviewed essential operations information for the Working Group. She shared the dates for upcoming meetings and encouraged members to submit agenda item suggestions for future meetings. Linkins shared that the November 19, 2025 CARE Working Group meeting will take place in Los Angeles at the Westin Bonaventure, collocated with Judicial Council's Beyond the Bench Conference.

Linkins provided a brief recap of the May 21st Working Group meeting, which consisted of the following agenda items:

- Featured Topic: The Role of Public Guardians and Public Conservators in CARE Implementation
- The Alameda CARE Team Approach
- CARE Act Respondent's Counsel
- Implementation and Training and Technical Assistance Updates
- Updates on CARE Act Working Group Ad Hoc Groups

Deputy Secretary Welch thanked Los Angeles County for hosting a site visit for CalHHS and state partners in June 2025, which Secretary Kim Johnson was also able to attend. She noted that site visits are invaluable learning opportunities. Key takeaways included the role of peers on CARE teams—whether for engagement or ongoing support—and ways the state can help improve petitions from LPS-designated facilities under SB 42. Priorities remain ensuring petitions are high quality, referrals are simple, and processes are workable for busy hospital staff.

Welch emphasized that site visits also reveal opportunities for tailored technical assistance, such as addressing data and information-sharing challenges between SUD and mental health providers. She encouraged counties to draw on the resources and support available when barriers arise. On data reporting, she underscored that while CARE's significant reporting requirements can be challenging, the state is committed to supporting counties to meet these requirements and welcomed counties to raise challenges openly.

Annual Report Overview – Presentation and Response Panel

Linkins introduced Lauren Niles from Health Management Associates to provide an overview of the first CARE Act Annual Report published by DHCS in July 2025. The report covers the initial period of early implementation and highlights key data findings and opportunities for program enhancement.

Niles shared the following detail from the content of the report:

- The report covers Oct 2023 – June 30, 2024 (first 9 months) and reflects data from the following counties: Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, San Francisco (Oct 2023); Los Angeles (Dec 2023) which made up Cohort 1.
- Data sources include Judicial Council (JC) petitions, hearings, and disposition data, and County Behavioral Health individual-level data.
- In the first nine months, 556 petitions were filed and received by the courts; 18% resulted in an approved CARE agreement or plan, 39% were dismissed, and the rest were petitions still under court review processes at the time of this report.
- CARE agreements and plans were combined in this report for confidentiality but will be separated in future reports.
- In the first 9 months, courts held 782 total CARE hearings, including 403 initial appearances.
- Of the 556 petitions, County Behavioral Health Agencies received 497 petitions. Discrepancies between court and county data reflect petitions dismissed before county involvement.
- Data in the report reflects 490 unique CARE respondents: 160 were dismissed, 15 became elective clients (CARE eligible respondents who elected to receive County services and supports outside of the court process), 55 were ineligible but receiving services, 90 ineligible and not receiving services, 101 became CARE participants (being tracked for 12 months in their active service, and additional 12 months in a follow-up period), and 229 were still in the court process and evaluation awaiting their first disposition assignment.

- The annual report shows about two-thirds of CARE petitions came from personal petitioners such as spouses, partners, or family members. Another 22% came from system partners like hospitals, behavioral health professionals, public guardians, or conservators. 7% were filed by first responders or crisis teams, and 3% were self-petitions.

Niles shared a summary of respondent demographics:

- The report shows over one-third of respondents identified as White, 21% as Hispanic, 18% as Black, and 7% as Asian. Respondents could select multiple racial categories.
- Just over half of respondents identified as non-Hispanic, 16% as Hispanic or Latino, 11% as Mexican or Mexican American, and about one-quarter were unknown.
- Nearly two-thirds of respondents were ages 26–45, followed by ages 46–65.
- About two-thirds were male.
- Among respondents, 7% were in the unpaid workforce, while about 60% were categorized as unemployed, not seeking work, or unable to work.
- Over half were Medi-Cal enrollees, 6% Medicare, and 40% unknown.
- At the time of petitioning, 41% were in permanent housing and 30% were unhoused.

Niles shared data on the CARE initiation phase, which encompasses the period between when a petition is filed and a disposition is assigned:

- On average, respondents waited about 76 business days (2.5 months) from petition to first disposition. Those entering a CARE agreement or plan waited nearly a week longer than those dismissed. For 85% of respondents, disposition took more than 31 days.
- Activities during this period varied, including outreach, service provision, county investigations, and trust-building. Future reports will capture more detail through expanded data points on outreach and engagement.

- Hon. Scott Heron explained that in Los Angeles County, petitions are usually reviewed within a day or two and assigned to the Department of Mental Health for engagement. Earlier petitions were mostly from family members, often not living with the respondent. The 31-day average to disposition reflects outreach and engagement, and trust-building, as this population often has significant mistrust. Quick dispositions within 14 days are uncommon, and delays are due to multiple factors, not inefficiency. He noted the 31 days is surprisingly low given the population and county size.
- Serene Olin explained that the disposition date is not the appearance date; it marks when the court approves a CARE agreement or plan or dismisses a petition. Multiple appearances may occur before this, but the disposition reflects the court's final determination. She said that of the 85% of petitions that took more than 31 days for a disposition to be assigned, some took up to 253 days, with the average being two and half months.
- Niles noted the time reflects only those with a disposition; others are not in the 261 as they remain under evaluation.

Niles shared information from the report on the services and supports accessed by CARE participants.

- The report defines “access” as CARE participants either enrolled in a program (e.g., FSP enrollment) or having received a service/support since their plan or agreement was approved. The first Annual Report offers only a point-in-time estimate, as participants contributed about three months of data. Future reports aim to trend engagement over time and assess whether CARE increases service use.

- The report found that 76% of CARE participants enrolled in a specialized program during their service period, with Assertive Community Treatment (ACT) being the most accessed at 48% and FSP at 31%.
- The most common Services and Support type that participants accessed were any mental health treatment service (94%), with the top two being targeted case management and medication support. 72% of participants received stabilizing medications.
- The report found 15% of CARE participants received CalAIM housing services during their service period, and another 31% received housing support outside of CalAIM.
- Three evidence-based components of CARE viewed as recovery supports are: stabilizing medication, comprehensive psychosocial and community-based treatment, and housing support.
- The report noted that some CARE participants experienced events signaling unmet needs not addressed through community-based or county services during their service period. The most common unmet need was securing or maintaining permanent housing.
- The CARE Act emphasizes person-centered care, including psychiatric advance directives (PADs) and volunteer supporters. There were no PADs reported for CARE participants at the time of this report.
- 32% of CARE participants and 8% of all CARE respondents had elected to use a volunteer supporter over the first nine months of CARE implementation, the majority of which were family members.
- The 15 elective clients captured in this first report received fewer services than CARE participants, had more data quality issues with higher rates of missing data, and were harder to track. Elective clients accessed only mental health and SUD treatment, with no CalAIM community supports or social services.

Niles discussed data limitations reflected in the report:

- Less than 1% of data was missing, but it was nonrandom, pointing to county-level reporting challenges.
- Common missing fields: employment, volunteer supporters, housing, substance use, arrests.
- Common unknowns: substance misuse and SUD diagnoses. Niles suggested this may reflect tracking challenges outside court jurisdiction, sensitivities in reporting, or data privacy concerns.

Niles reviewed key takeaways:

- Demographics**:** Majority were male, ages 26–45, English-speaking; 37% White, 21% Hispanic, 18% Black, 7% Asian. Findings suggest the need to expand awareness of the CARE Act, particularly for underrepresented populations and those with limited English proficiency.
- Process/Timing**:** From petition to first disposition averaged 2–3 months with wide variation. More information is needed on outreach and engagement, and services provided during this period, as well as capturing referrals from key system partners.
- Housing**:** Ongoing housing supports remain a critical need. Data showed promising increases in permanent housing among CARE participants, but many remain unhoused or instability in housing. Priority should be given to housing services, leveraging federal/state programs (e.g., BH-CONNECT, Prop 1).
- Evidence-Based Foundations: 63% of participants received the three recovery foundations (stabilizing medication, comprehensive psychosocial and community-based treatment, and housing). Elective clients accessed these services at much lower rates, suggesting the CARE process and court oversight may enhance access.
- PADs/Volunteer Supporters: Underutilized at this stage.
- Opportunities: Expand TTA to promote awareness, best practices, and access to services; reduce undesirable encounters (criminal justice, law enforcement, acute care) and refine analysis of CARE participants vs. elective clients in future reports.

In closing, Niles shared updates and reminders on recent CARE Act legislation.

- Senate Bills 42 and 1400 require counties to submit additional data on petitions.
- For the 2026 Annual Report, this expanded data reporting will enable HMA to include more information on outreach and engagement, outcomes and service patterns for petitioned individuals, county recommendations and court eligibility actions, and referrals from key system partners.
- These updates have been incorporated into the latest Data Dictionary (posted on the DHCS website), and data collection under the new requirements has already begun.

Linkins introduced Ivan Bhardwaj and Deputy Secretary Welch to comment on the 2025 Annual Report and SB 42 and 1400 amendments.

Bhardwaj explained the amendments made by SB 42 and SB 1400 aimed to expand the CARE story beyond a narrow focus on petitions and participant successes, adding context on outreach and engagement, dismissals, and voluntary engagement services. He reminded the group that counties are still building pathways and establishing relationships with the court systems.

Deputy Secretary Welch shared that since the first report reflects only the first nine months of Cohort 1 implementation, a short companion report was produced using updated data from the Judicial Council. She noted that Cohort 2 has generated significantly more petitions in their first months since launch, showing they benefited from the lessons learned by Cohort 1. Some counties have already filed over 100 petitions, often directly for clients they believe would benefit from the CARE model.

Deputy Secretary Welch emphasized that the number of petitions is not the goal. The purpose of CARE is to change lives, helping people access high-quality services, avoid institutionalization, incarceration, and secure long-term permanent housing. She highlighted two findings from the report: CARE is reaching the intended population and courts are helping

address participants' broader challenges, from medical and dental care to basic necessities, all of which are needed to support recovery.

She assured that HMA and DHCS remain committed to supporting counties in reporting data, because CARE is about understanding how individuals with the most complex needs are being served, whether through CARE agreements, CARE plans, or voluntary engagement, and what outcomes they achieve. She closed by appreciating counties' dedication in supplying this critical data.

Linkins introduced Salena Chow from the Judicial Council to provide an update.

Chow shared that as of the July 2025 reporting deadline, all 58 counties reported a total of 2,421 petitions filed, with 206 filed in July, consistent with the monthly average over the last four months. Of these, 1,331 remain active after accounting for dismissals. Since the start of the CARE Act, there have been 514 CARE agreements, including 55 in July.

Linkins introduced the following Working Group members to offer their insights on the Annual Report:

- Keris Myrick, Person with Lived Experience of Schizophrenia Diagnosis
- Beau Hennemann, RVP of Local Engagement & Plan Performance, Anthem
- Ruben Imperial, Director, Stanislaus County Behavioral Health and Recovery Services

Myrick began by thanking everyone for the work on the report and presentation, especially the counties that collected data in the early months. She then shared the following thoughts and concerns:

- The Data ad hoc workgroup had not been able to provide feedback during development of the report, and some of the language seemed to place too much onus on the respondent for issues that may actually be system, policy, or service gaps. She suggested it would have been helpful for the workgroup to support HMA and RAND throughout the report development process.
- The definition of "recovery" in the report is unclear, as the citation used is about treatment guidelines for schizophrenia, not recovery. She emphasized that recovery includes four domains: health, home, purpose, and community. Myrick shared that many families report CARE respondents are not being connected to community or purpose. She underscored that these domains are recognized in federal principles and practices, including under the Biden administration, and must be part of how recovery is understood.
- The use of the word "voluntary" in the report to describe the CARE process raised concerns. She stressed the need to be real and transparent about the court component.
- Clearer disaggregation is needed in the presentation of housing and support data. Specifically, she suggested that hospital placements should not be considered a type of housing and more support types beyond CalFresh, SSI, and SSP must be captured.
- As Hon. Herin explained, building trust doesn't happen in the statutory timeline of 30 days. She said that therapeutic alliance accounts for over 70% of someone's ability to participate in treatment, whether with a court, provider, peer, or family. The reported delays often reflects that essential trust-building process.
- Further discussion is needed related to how equity and disparities are being assessed in CARE data reports. If using the general state population as the comparison group, it

looks like African Americans are overrepresented and Hispanics underrepresented, but if set against the public mental health or unhoused population, it's unclear. She stressed the need for context so we know if CARE is helping appropriately and not perpetuating disparities. The report mentions participants' preferred language, but it's unclear which non-English languages are represented or whether people are being appropriately served. Similarly, "hard-to-reach populations" are mentioned without specifying who they are.

- Discussions about PADs should not wait until the end of care. If a person is already engaged and willing to plan, that's the time to begin discussions. She suggested RAND or others consider tracking when PAD conversations start.
- She raised questions about volunteer supporters, emphasizing that people need choices related to who serves in that role, as a family member may not always be most appropriate.
- The report lacks focus on shared or supported decision-making. She cautioned against overemphasizing compliance, noting that all people only adhere to medication about 50% of the time. Expecting more than that is unrealistic and unfair, and again places too much onus on the individual.

In conclusion, Myrick stressed that future data reports should not only describe the process but also confront real gaps: housing, recovery supports, equity. Too many participants remain unhoused, and Housing First should be part of the discussion. For most people it works, but some may need other models, and services must be individualized. Finally, she emphasized families and individuals should not bear the burden of petitions and hearings, saying that CARE must deliver real support in real time and not risk becoming another system that looks good on paper but fails the people it was meant to serve.

Next, Hennemann shared his thoughts on the report, beginning by thanking the team for writing the report in a way that was readable and enjoyable.

- As Myrick discussed, it's important to present demographic data in a way that supports understanding if CARE is reaching the right populations. He suggested comparing CARE data with county housing, homeless, and mental health data, because his sense is that the breakdown isn't what we'd expect, which means outreach to other populations needs to continue.
- Echoing Myrick, he stressed the need to clarify what specific types of housing people are in and what is meant by "institutional" and "temporarily housed."
- 43% of insurance coverage being listed as "unknown" is troubling. From the managed care plan perspective, knowing coverage is essential to understanding how people access care. While insurance may not be the first priority at engagement, it highlights a big data gap that needs improvement, and his guess is much of that group is on Medi-Cal.
- Future reports should examine reasons for dismissals, and also provide more detail on services and supports beyond listing the "top three." He emphasized the importance of knowing not just what services people are connected to, but whether they stick with them, whether the services are helping, and how outcomes compare for those in CARE and those who receive services outside of it.

In his closing remarks, Hennemann said the RAND evaluation will be key for understanding long-term outcomes. He acknowledged it is still early in the implementation process, with some counties only six months in and many participants just a few months engaged. Over time, the

critical question will be whether CARE makes a lasting difference for helping people improve their overall health and maintain housing.

Imperial shared his reflections, which he said are informed by recent local work in Stanislaus County, where they convened stakeholders, staff, public defenders, courts, outreach teams, law enforcement, family members, and participants, over several months as part of a learning group.

- The conversations in Stanislaus echoed what's in the report, especially the need for outreach, engagement, and public education. Locally, they've talked a lot about what data really means, what does "housing" mean, or what does success in outreach look like. In practice, their outreach teams may need 60 or more contacts before someone trusts them enough for an assessment, showing why local data and experience are critical to defining success.
- For his county, success has been about building shared expectations and holding everyone accountable for their role in supporting people through CARE process. What matters most is how participants and families define success, whether that's recovery, housing, or support through the process.
- State funding for transitional board and care, permanent supportive housing, and transitional units, which CARE participants are prioritized for, has been essential to supporting positive outcomes. Having housing available early has allowed the county to expand quickly. At the same time, many participants still live with family, so outcomes depend on each individual's circumstances.
- Providing consistent support has also been essential in Stanislaus. Having someone walk participants and families through the process, whether as a supporter or treatment partner, has emerged as critical during graduations and throughout the program.

In closing, Imperial shared that the ongoing work is to keep engaging participants, families, and partners, using both data and lived experience to fine-tune CARE. He acknowledged the administrative burden of new data collection but stressed its importance. He said that at its core, CARE implementation is about trust, accountability, and making sure the program reflects both data and the voices of those most impacted.

Deputy Secretary Welch thanked response panelists for deeply reading the report and shared a few additional reflections:

- Most of her own takeaways were related to how CARE teams can better engage clients in a timely way.
- Like Hennemann, she was perplexed by the high proportion of "unknowns" for reported insurance coverage.
- It is encouraging that local planning bodies are still meeting, and she would like the Working Group and state partners to think about how to support counties in using their own data in real time to drive quality improvement, much like the early days of full-service partnerships.
- The lack of SUD services reflected in the data is concerning and surprising given what the significant SUD challenges among this population. She urged the group to dive deeper into this issue, stressing the need to identify whether this is a data quality gap or a real gap in service access. She emphasized that, across CARE, BHSA, and DMC-ODS, the system must do a better job of addressing root barriers so people can get the substance use treatment they need.

Q&A

Kemmer thanked the presenters and said he especially appreciated the reminder that we are all here to make sure people get the services they need. He shared relevant context from Orange County:

- On the SUD question, he explained that in Orange County, many clients with schizophrenia don't fit into the general DMC-ODS system; instead, they receive SUD treatment through FSPs with a co-occurring model. Because those services are billed as mental health, they often don't show up as SUD treatment in the data.
- On the insurance issue, he noted that coverage is often unresolved at the time of petition but is updated as the process continues, which may not be reflected in early reporting.
- He agreed with Hon. Herin and Myrick about the importance of rapport building. He stressed that clients don't wait until a CARE agreement is signed to receive services, they are opened to treatment as soon as they are identified, usually through FSPs. In Orange County there are 16 people with CARE agreements and plans, and 73 people are already active in treatment. Building rapport, identifying supports, and making sure clients have choices is critical, even if it isn't fully captured in the report. He said the data should help tell that broader story.

Kelly Simon, Alameda County Deputy Public Defender, raised concerns about RAND contacting CARE respondents. She explained that as a public defender, she has an ethical duty to protect her clients' confidentiality, many of which also face criminal proceedings. She worried clients would not understand the distinction between the court process and an outside evaluator, which may undermine trust and even jeopardize criminal cases. She asked what RAND's process would look like and whether the risks had been fully considered.

- Labriola acknowledged Simon's concerns and emphasized RAND's extensive experience interviewing vulnerable populations. She stressed that participation is always voluntary and protected by strict procedures. She said RAND would work closely with counties and stakeholders, ensure informed consent, and make clear that interviews have nothing to do with criminal or CARE court cases. She underscored that respondents' voices are essential to understanding whether CARE is working, and that RAND's role is entirely independent and unbiased. She added that participants are assured of anonymity, may consult with attorneys or caseworkers, and are often incentivized.
- Deputy Secretary Welch added that DHCS is committed to hearing from people going through the process but agreed Simon's concern warrants follow-up. She said the goal is to ensure that feedback is gathered in an appropriate way.

Myrick said CARE data must be presented in the context of recent executive orders and the Big Beautiful Bill. She raised questions about employment data and the impact of the 80-hour work requirement on CARE. She emphasized tracking supported employment and education and tying them to meaning and purpose. Myrick also highlighted the need for family peer support, noting that many families house or financially support loved ones. She urged ensuring families get the support they need and capturing that more clearly in CARE data.

Dr. Hurley thanked Deputy Secretary Welch for highlighting the needs of CARE participants with substance use conditions, noting the assumption that treatment must only come through DMC-ODS. He stressed that SUD treatment can and should be delivered in specialty mental health

systems, though it's often under-documented and inconsistently provided. CARE is an opportunity to examine how these services are actually delivered. At the same time, counties must invest in DMC-ODS so their SUD systems can handle higher acuity co-occurring conditions.

Jodi Nerell said the Services and Supports group had previously discussed SUD programming, levels of housing and recovery supports, but had not discussed SNAP, which may require a broader conversation. She stressed the importance of ensuring participants can retain and renew Medi-Cal, since disruptions in coverage impact continuity of care. Nerell also raised concern about housing data in the report, which seemed to show most initial respondents in permanent or interim housing. With more unhoused respondents expected, she urged attention to avoiding long delays in the court process, regardless of the reason.

Deputy Secretary Welch explained that tools are continuing to be developed to better present the CARE process in plain language. She noted the data show referrals and petitions are coming less from family members, which means the population will begin to look different and may be vulnerable to long waits during engagement that could lead to crises like overdoses or heart attacks. She emphasized the need for a clear visual of the process and said progress is being made.

Grealish echoed Myrick's point about needing context for race and ethnicity data and suggested that census data could be leveraged to show over- and under-representations across demographic groups. She also highlighted the high prevalence of co-occurring disorders and suggested looking at outcomes separately for respondents with only a mental health condition versus those with co-occurring conditions, since the latter are more challenging. She raised concern about the amount of "unknowns" reported for insurance coverage, questioning whether it is a data collection problem, and connected it to her past work showing people with commercial insurance had worse justice involvement outcomes due to weaker system relationships with commercial plans. Grealish recommended stratifying CARE data by age and justice involvement, and suggested a deeper case review of dismissed or closed cases for non-engagement. Finally, she asked RAND about the status of the petitioner survey.

- Labriola responded that the survey team is ready and the first batch of petitioner contact information has been received, so they are aiming to launch in Fall 2025.

Linkins thanked everyone for their engagement and urged county representatives to take back the message about the importance of data collection and reporting. She invited everyone to break for lunch and return for the next session.

Implementation and Training and Technical Assistance Updates

Cassandra McTaggart shared training and technical assistance updates from the Judicial Council (JC):

- Recent trainings for judges and court staff have covered topics including best practices for CARE proceedings, motivational interviewing, and new updates to JC rules and forms.
- On demand recorded trainings are available for judges newly assigned to CARE courts.
- JC continues to host quarterly CARE office hours for judges and court staff.

- Upcoming trainings include regional trainings on de-escalation with instructors from Pacific Clinics.
- JC's annual Beyond the Bench will be hosted in LA in November with a day-long pre-conference focused on CARE.
- A comprehensive benchguide is available for judges online and updated fact sheets will soon be available.

Laura Collins shared training and technical assistance updates from Health Management Associates (HMA):

- HMA continues to provide daily support to counties suited to their needs and the changing landscape of implementation.
- Recent trainings have covered paths out of CARE, with a focus on graduation planning, and various forms of supports in the CARE process.
- Recent office hours have covered MIST and FIST referrals and data reporting. Data office hours are hosted on a regular basis.
- HMA has developed new FAQs on priority topics, such as claiming and the role of the volunteer supporter.
- The peer video providing an overview of the CARE process is now also available in Spanish. HMA has provided guidance to counties on methods for sharing this video locally.
- HMA continues to collect stories of success from counties, related to both client outcomes and implementation successes.
- Ongoing training and technical assistance needs include additional data support, support with housing, and guidance on developing psychiatric advanced directives.
- Trainings and resources continue to be revised as needed to reflect legislative changes.
- New trainings and resources are being developed in response to county needs.
- Counties continue to receive targeted support and technical assistance through HMA liaisons.

Updates on CARE Communications

Linkins introduced Sarah Hutchinson and Jim Webb from the Neimand Collaborative to share information on upcoming improvements to the CARE website.

Webb provided an overview of their recent work on updating the website:

- The CalHHS CARE web page is the most frequently visited program page on the CalHHS site.
- The Neimand team used web analytics to gain insight into the current user experience of the web page.
- Using these learnings, the Neimand team developed a mock-up of a new web page, designed to improve the user experience and present core information and resources more clearly.

Webb shared his screen and walked the group through the current mock-up, which is viewable through the meeting recording.

Featured Topic: Role of Peers in CARE Act

Representatives from the Los Angeles County Department of Mental Health

Dr. Sarah Church-Williams, Program Manager I
Kimberly Manzares-Mora, Senior Community Health Worker and Peer Support Specialist
Kristen Ayala, Certified Addiction Counselor
Theresa Arredondo, LCSW, Program Manager I

Linkins introduced Dr. Sarah Church-Williams, Program Manager I, Los Angeles County Department of Mental Health (DMH), and her colleagues.

Dr. Church-Williams introduced herself and described Los Angeles County DMH's system of geographic service areas, explaining that she serves as the program manager over Service Areas 5 and 6 for the CARE program. Dr. Church-Williams shared that LA DMH holds a core belief that recovery is a journey of partnership, respect, and empowerment, which is why they are deeply committed to integrating certified peer specialists and staff with lived experience into every level of their system of care, including on every one of their CARE teams. Peer staff know firsthand what it feels like to navigate these systems while also trying to heal, and because of that, they create an immediate sense of trust and possibility for CARE clients and offer a kind of hope that is grounded in reality.

Dr. Church-Williams said peer support is especially vital in the CARE process, where clients are often deeply isolated, wary of services, or disillusioned with traditional systems. Peers meet people where they are, sometimes literally, and patiently build relationships that support clients to take the first step toward treatment, stability, and a better life.

Dr. Church Williams introduced her colleague, Teresa Arredondo, who has played a key role in developing and supporting this work.

Arredondo shared that she is a program manager over Service Areas 3 and 4 in the county. Service Area 3 is the San Gabriel Valley and Service Area 4 includes Skid Row and Hollywood. Arredondo introduced peer panelists to share about their experiences supporting clients through the CARE process:

Kim Manzares-Mora, Certified Peer Support Specialist and Senior Community Health Worker with the CARE program, shared the journey of a participant from the San Gabriel Valley.

- Manzares-Mora's client was petitioned by his father. Prior to CARE, the client had previously worked with an FSP program for 12 years. After a long period of unstable housing, the client had been close to being permanently housed when COVID hit. During the pandemic, he relapsed into substance use, stopped taking medication, and became homeless with his girlfriend, who later passed away from COVID. The loss pushed the client deeper into substance use and exacerbated his mental health challenges. His father was hopeful that CARE could help and submitted a petition to support him.
- When Manzares-Mora first began outreach to the client after the petition was filed, the client told her to leave him alone and walked away. Rather than chasing him, the team kept engaging patiently, using person-centered approaches, which gradually opened the door to trust.

- Over time, Manzares-Mora supported the client in taking his medication, re-establishing SSI benefits, applying for food stamps, and getting a TAP card. He reconnected with a familiar DMH clinic and built relationships with the CARE Court team and Hon. Herin.
- One of the client's main priorities was permanent housing. Although he refused shelters, Manzares-Mora validated his decision and worked with him to become document-ready for permanent housing.
- The client now engages consistently with his therapist, psychiatrist, nurse, and substance use counselor, and has completed a housing application through PATH for a low-income apartment. While awaiting approval, Manzares-Mora continues working with him using OARS tools—open-ended questions, affirmations, reflective listening, and summaries.
- The client still has good and bad days, but his voluntary involvement and progress reflect the hope and purpose of Los Angeles' CARE program.

Kristin Ayala, Certified Addiction Counselor and Substance Use Counselor for the CARE team in Service Area 7, shared the story of one of her clients.

- Ayala's client was petitioned by his mother in early 2024, who was desperately seeking help for her son. At that time, the client struggled with daily living activities, such as maintaining basic hygiene. He rarely spoke beyond mumbling, avoided eye contact, and appeared constantly symptomatic despite receiving a long-acting injectable.
- The CARE team began weekly outreach, harm reduction education, counseling support, and assistance with daily needs. Ayala used motivational interviewing to ensure the client felt empowered rather than directed. Over months, he began warming up and eventually agreed to attend a Narcotics Anonymous (NA) meeting. There, he engaged for the first time and thanked the team afterward, opening the door to exploring treatment.
- The team connected him to outpatient treatment and monitored his progress weekly. Through advocacy, he was also enrolled in contingency management, receiving gift card incentives for negative stimulant tests. He began testing negative for methamphetamine, attending groups, and participating in counseling.
- Ayala has consistently supported the client with his personal goals, such as applying for a training program and beginning a process of tattoo removal.
- Last month, the client successfully completed his outpatient treatment and chose to continue with recovery court services, including individual therapy. He also expressed interest in employment, and the team is now working to connect him with the Department of Rehabilitation for vocational support. The client currently remains stable and continues to meet consistently with the CARE team.

Arredondo thanked Manzares-Mora and Ayala. She highlighted that the success stories shared by peer staff illustrate common interventions that differ from mainstream clinical approaches:

- One of the core skills used by peer support staff is joining clients in their recovery by validating their experiences and standing alongside them with respect. In one case, staff connected with a client through a shared love of music, using that common ground to build trust.
- Another skill is to follow the client's direction, which allows clients to feel greater control and choice, creating investment in their own growth while viewing staff as supportive rather than threatening. For example, when Manzares-Mora's client initially declined

housing, she respected his autonomy and supported him in finding housing that fit his needs.
- Peer staff approach relationships with minimal authority, rejecting hierarchy and emphasizing equality. Substance use counselors also model this by using supportive, hands-on interventions, such as accompanying a client to an NA meeting rather than just making a referral.
- Across cases, peer staff rely on motivational interviewing to encourage change and use harm reduction frameworks to support clients in reducing substance use.

Arredondo closed by thanking the group for the opportunity to showcase the work of peer staff and the resilience of CARE participants.

Q&A

Linkins thanked the panelists, expressing appreciation for the stories shared and the efforts being made to support clients. She invited questions and comments from the group.

Deputy Secretary Welch noted that she had met Manzares-Mora and Ayala during CalHHS' June visit to LA. She explained that this Working Group has been particularly interested in promoting the use of peers in the CARE process and asked for suggestions on how to increase the integration of peers into CARE teams in other counties.

- Dr. Church-Williams responded that for Los Angeles County, peers are embedded in every team. Peer support is not framed as a separate service, but rather part of how staff work, since most have lived experience that they bring into their roles. Peer services are not specifically promised unless linked to peer resource centers located in some clinics.

Deputy Secretary Welch reminded the Working Group that in Los Angeles County, the county provides CARE services directly rather than through contracted teams. Other counties may operate differently, depending on whether contractors have the capacity to provide peer services. She added that in some counties, peers are assigned through the court under a separate contract, with peers working in the courtroom. That model is distinct from peers who provide ongoing support once a CARE plan is in place.

Deputy Secretary Welch invited others in the room to share how their counties utilize peers in their programs.

- Kemmer explained that Orange County also has a contract for peer services and has trained all peers in their system on the CARE process in order to maximize flexibility and ensure that if a peer assigned to a particular client is not the right fit, other trained peers from contracted programs can step in and provide support.

Dr. Hurley commended the LA CARE team and added context to Deputy Secretary Welch's earlier point. He notes that while the CARE program in Los Angeles is operationalized through DMH's directly operated programs, some services are contracted, such as the outpatient SUD treatment program accessed by a client in one of the example cases. He also emphasized that peer services can serve as gateways to treatment, alongside community self-help resources like NA meetings and other contracted services. When CARE is working well, it often draws together multiple supports, county-operated, county-contracted, and community-based. CARE's success comes from weaving together these different layers of support.

Dr. Church-Williams noted that NAMI is another resource they use to support peer relationships. She explained that peers help start relationships and connect participants to supports that continue beyond CARE Court, building a lasting community.

- Harold Turner, Executive Director of NAMI Urban Los Angeles, shared that he had attended a previous presentation, found it enlightening, and expressed interest in staying in contact to ensure peers are aware of the program and its successes.

Irvine returned to Deputy Secretary Welch's earlier question, explaining that in San Diego, contracted providers deliver CARE services once individuals are enrolled in a CARE agreement or plan, and those FSP providers have peers on staff. The internal BHS CARE team also has peers, who work closely with clinicians to build trust and rapport. Peers are also used to support completion of psychiatric advance directives, often breaking the process into smaller steps over time, which has proven successful.

Myrick emphasized that peer-run organizations outside of county contracts can be part of support networks and highlighted the importance of peer respites as a safety net for clients, particularly those seeking housing who might otherwise fall through the cracks. She stressed that peer support must always be voluntary. Even under a court-ordered CARE plan, a respondent must actively choose to work with a peer. Mandating peer support is against best practices and the practice guidelines for certified peer specialists. This voluntary approach is critical for building trust and ensuring clients do not feel coerced.

- Deputy Secretary Welch reinforced that all CARE plans must be developed with the client, applying supportive decision-making to ensure the client participates in decisions about the plan's contents.
- Hon. Herin clarified that CARE plans are rarely ordered, are only used when a client is not interested in participating in the program, and even then are never forced. He explained that a CARE plan directs the Department of Mental Health to provide services but does not compel the individual to comply. CARE remains a voluntary program with a focus on providing every available resource to eligible participants while respecting their autonomy, recognizing that forced recovery is rarely effective.
- Myrick thanked Hon. Herin for the clarification on CARE plans and noted the importance of accurate data. She emphasized that future reports should clarify that CARE plans are court-ordered for the county, not the individual, to prevent misunderstandings.

Linkins asked the panel for recommendations for other counties on implementing peer support in CARE.

- Manzares-Mora highlighted that the first step is always to ask clients if they want services or support, emphasizing that peers should never force services but respect the client's choice.
- Ayala emphasized that implementing peer services must always benefit the client, requiring step-by-step guidance, reassurance, and ongoing support so the individual feels understood and supported throughout the process.

Jennifer Bender thanked the panel for sharing their stories and asked about the client-to-peer ratio and frequency of check-ins.

- Arredondo explained that the typical ratio is 10 clients to 1 staff member, though some service areas are more impacted. The goal is to meet with clients weekly, adjusting the pace depending on client need and willingness to engage, while maintaining regular

contact even with clients who are doing well. A county-wide resource team supports areas with higher caseloads.
- Dr. Church-Williams added that some clients require more intensive support. Depending on needs, peer staff may accompany clients to appointments, check in multiple times per week, or even see clients daily. The frequency of engagement is guided by the client's needs, ensuring resources are matched appropriately.

Linkins concluded the discussion by thanking the panel for their time and for sharing their learnings. She emphasized the importance of their efforts and encouraged the panelists to continue sharing stories and updates, noting that the Working Group is eager to stay informed on their progress.

Roles of Health Plans and Coordination with Counties

Beau Hennemann, RVP of Local Engagement & Plan Performance, Anthem

Linkins introduced Beau Hennemann to present on the role of health plans in CARE implementation and the broader system of care in California.
Hennemann shared an overview of his role, organization, and California's system of delivering care for Medi-Cal members through managed care plans:

- Hennemann, who works for Anthem at the statewide level, explained that their involvement in CARE has been minimal so far because the program is primarily run at the county level by behavioral health departments and locals. He acknowledged the counties' role in implementing CARE and stressed that, as the program stabilizes and counties better identify participants' needs, managed care plans (MCPs) should become more engaged to help navigate healthcare complexities and connect members to services.
- Currently, there is little communication or data sharing between counties and health plans, with no referrals coming to health plans through CARE. However, as the system evolves, there is an opportunity to improve collaboration and better connect managed care plans and county CARE teams to support their members.
- It is critical to link CARE respondents to additional services beyond mental health treatment because many are also dealing with chronic health conditions and haven't seen a primary care doctor or had basic health screenings in years. When first engaging someone in crisis or without housing, you don't immediately ask for their insurance card or suggest a checkup. However, as they stabilize and engage with support, it's important to start addressing their underlying health issues and reconnect them with the healthcare system.

Hennemann explained that through CalAIM, MCPs now also provide enhanced care management and community supports:

- The expansion of covered services represents the health insurance industry's evolution over the past 10–15 years, now increasingly taking a holistic approach by helping members access all needed services, not just primary and specialty care.
- Enhanced care management (ECM) is a core CalAIM service, offering intensive, in-person case management through health plans contracted with counties and various organizations. ECM focuses on identifying individual needs, setting goals, and

connecting people to services, physicians, and specialty providers. It is provided at the health plan level and includes basic, complex, and behavioral health case management, with ECM reserved for higher acuity populations like those experiencing homelessness, serious mental health issues, and substance use disorders. These groups overlap significantly with the CARE population. While ECM is not intended to replace CARE and neither are intended to be long-term, it can support individuals as they move through the CARE process, especially for ongoing coordination and access to community supports.
- Community supports, like housing, food, recuperative care, and sobering centers, are also available through health plans under CalAIM. These community supports are not broadly utilized, partly due to lack of education and immediate needs taking priority. Leveraging these supports through health plans can help coordinate care and use funding more efficiently, freeing up county resources.

Hennemann emphasized that the behavioral health system in California is complex, with Medi-Cal plans handling non-specialty services and counties managing severe mental health. Coordination is essential to ensure individuals get the right care as their needs shift between health plans and counties.

Hennemann concluded by highlighting that at this point in CARE implementation, it's now time to focus more on CARE respondents' broader needs covered by health plans. CARE provides an opportunity for counties and health plans to get better at working together and integrating all services being provided. Enhancing coordination with health plans will help meet these needs and support individuals as they transition out of the CARE process.

Linkins thanked Hennemann for his presentation and opened the floor for questions.

Q&A

Dr. Warburton said a focus group of psychiatrists has been discussing barriers to CARE implementation. The most important barrier identified is lack of integration between systems, which divides people into either the SUD or mental health system, when a more holistic approach is required. Without that, the burden falls on the individual rather than the system to integrate primary care, mental health, substance use disorder treatment, and case management. Dr. Warburton said it was exciting to hear about CalAIM-enabled enhanced case management and asked whether managed care plans are envisioning a model that integrates primary care, psychiatric services, and other supports on one team. She emphasized that there is a population that will need these types of community services for long periods of time and that it would be valuable if managed care plans could build a model that addresses the specific needs of this group.

- Hennemann responded that the overall intent of CalAIM is to have a more fully integrated model. The gold standard is for case management to be provided by the same provider where a member already receives primary care and behavioral health services, which is why FQHCs were a starting point. County Behavioral Health does not provide primary care, but the goal is to strengthen coordination between health plans and county services for people with severe mental health needs.
- Hennemann also noted that as health plans have worked to implement this model, multiple approaches have been necessary because it is not easy to find providers who can offer both primary care and behavioral health. Capacity issues have led to bringing in other types of providers for enhanced care management, and when those providers do not deliver both primary care and behavioral health, additional work is needed to

ensure coordination. Hennemann emphasized that this remains the intent of CalAIM and Enhanced Care Management, progress has already been made, and the system will continue to improve over time toward that vision.

Deputy Secretary Welch noted that DHCS is convening plans and stakeholders to discuss the role of managed care plans in integration and community planning. She observed that even for those immersed in this work, it is overwhelming to understand how different planning processes will align to ensure resources reach communities, a central goal of Proposition 1, CalAIM, and integration efforts.

Deputy Secretary Welch asked Hennemann whether there is a model or template that shows how managed care plans can best partner with county behavioral health departments to serve CARE participants, particularly to support transitions post-graduation into long-term care and recovery. She also raised transitional rent as a potentially transformative resource for counties, particularly given that many CARE participants are transitioning from hospitals, incarceration, or other institutions.

- Hennemann responded that the first step is having more conversations with local managed care plans. Most plans already have MOUs with county behavioral health, which include ongoing meetings on coordination and data sharing, which should be expanded to include CARE. He emphasized the importance of better data sharing so all partners can see what an individual needs, who is providing services, and who is paying for them.
- On transitional rent, Hennemann agreed it is an important resource and also highlighted recuperative care services, temporary housing with support after hospitalization, as another benefit that could help CARE participants stabilize before connecting to longer-term services.

Deputy Secretary Welch noted that plans need to know when someone is a CARE participant and said she would look into how the state can support that data sharing.

- Hennemann agreed, pointing to the lack of data as a major barrier. He said that currently, 43% of participants don't have insurance information identified, which makes coordination nearly impossible. If someone in CARE has chronic conditions and needs specialty care but their care team doesn't know their insurance or who to call, the burden falls entirely on the individual. Identifying insurance at the outset of the process is essential to allow plans to coordinate services and connect participants with appropriate care.

Imperial said this is an important topic for the group to continue monitoring. Just as mental health care is central to recovery, physical health care is equally critical for many participants. He added that managed care plans should also be accountable for clients' health care, not just referrals to care. He said the issue is complex at a systems level but can be addressed locally through multidisciplinary teams. Drawing on his recent experience, he shared that while county behavioral health and the CEO's office were directly engaged in CARE Court planning, managed care leadership was not. He suggested the group explore how managed care plans could be more directly involved in CARE Court planning and accountability.

Grealish thanked Hennemann and raised a question about transition-age youth who may still be on their parents' commercial plan. She noted that these individuals could go through the CARE

process, and asked how plans like Anthem would support them, particularly with early identification and intervention to keep them on a positive path.

- Hennemann responded that commercial coverage looks different than Medi-Cal. On the commercial side, plans do not cover housing supports or provide case management at the FQHC level, but they still carry the responsibility to ensure members have access to needed care. He said coordination remains essential, especially for individuals with multiple chronic conditions and behavioral health needs, even if the provider networks and benefits differ. Hennemann added that a key question is how many CARE participants are actually in commercial insurance, since there may be some within the 43% whose coverage type is currently unknown.
- Grealish gave the example of a 23-year-old experiencing a first episode of psychosis, possibly related to marijuana use, who is still on a parent's commercial plan. The parents have filed a petition, and she asked what that process would look like under CARE.
- Hennemann responded that even on the commercial side, insurance plans still hold responsibility for behavioral health, mental health, and psychiatry services. However, it is more complex than with Medi-Cal. For Medi-Cal's 1.3 million members statewide, benefits are standardized, though networks vary by county. In contrast, commercial plan benefits depend on the employer's contract, making coverage and services less clear-cut and more complicated.

Tamplen asked Hennemann to speak about the role of peer support services, noting the strength of LA County's peer support program and the challenges with billing under managed care. Since peer certification is currently through Medi-Cal Specialty Mental Health Services and Drug Medi-Cal, she asked if a CARE respondent receiving services through managed care could continue peer support, whether plans can bill for it, and if contracting with peer- and family-run organizations is possible.

- Hennemann responded that yes, peers are being used, but through a separate peer support billing structure. Instead, they are incorporated into ECM provider teams and are billed under ECM. He added that Medi-Cal also covers community health worker services, which in some cases could include peer organizations, though the model and requirements differ from peer certification. He noted that while the community health worker benefit is useful for lower-intensity needs, it may not provide adequate supports for those coming out of CARE processes.
- Deputy Secretary Welch added that while the peer support certification process was designed specifically for the specialty behavioral health system, peers are used by managed care plans through ECM.

Lutz thanked Hennemann for the presentation and reflected on the intersection of managed care and county behavioral health. Lutz suggested that if ECM is retained in the next federal waiver, there may be an opportunity to create enhanced payments for peers within ECM, since ECM aligns well with peer support functions. Lutz also highlighted opportunities for deeper collaboration between managed care plans and counties, noting that in Sacramento, behavioral health, homeless services, and managed care partners are working together to establish a flexible housing pool. This pool will leverage Behavioral Health Bridge Housing (BHBH) dollars along with other behavioral health housing support funds through BHSA implementation, with transitional rent included. Managed care plans are expected to contribute to funding the launch in January 2026.

Linkins concluded by noting the group's strong interest in this topic and affirmed that insurance and integration will continue to be discussed as CARE moves from theory to practice. Linkins thanked both the group and Hennemann.

Updates on CARE Subject Matter Expert Focus Groups

Dr. Kate Warburton, State Medical Director, Department of State Hospitals, and Salena Chow, Judicial Council

Linkins introduced Dr. Kate Warburton, State Medical Director, Department of State Hospitals, and Salena Chow, COO, Judicial Council to share reports on two focus groups they are each helping to convene, one of psychiatrists and one of CARE judges.

Dr. Warburton reported on the psychiatrists' group, which has identified three areas to prioritize. First, establishing guidance on a minimum standard of care for CARE participants, which integrates SUD treatment, psychiatric care, medical care, and case management. Second, recommending reestablishing a system of centralized state oversight, covering LPS, CARE and AOT, and restoring the ombuds function for LPS once held by the former DMH. Finally, defining core competencies and training for all CARE roles, starting with clinical staff to deliver both psychiatric and SUD treatment, by reviewing existing curricula, identifying gaps, and developing training with continuing education credits to build a properly trained workforce for this complex population.

Chow reported on the judicial focus group, emphasizing their initial meetings have been preliminary conversations among a small panel of judges and not reflective of every court. They discussed the overlap between CARE and the criminal justice system and the need for better coordination and information sharing. Judges also raised the importance of clearer screening and placement processes to identify the best pathway for individuals between CARE, AOT, diversion, and LPS. There was significant discussion about conservatorship, step-downs, and transitions between levels of care, including handoffs from state hospitals. Services and access were another focus, particularly the disruptions caused by rotating case managers and the need for more consistent warm handoffs. On court practices, judges noted variations in the amount of continuances they grant, the preferred frequency of bringing respondents back, and the local cadence of meetings between court and county partners. Finally, Cow said the judges emphasized culture and mindset, underscoring the value of therapeutic engagement, patience, trust-building, and developing a shared definition of success across partners. The group plans to meet again in September.

Linkins added that these focus groups will continue to bring updates and recommendations to the Working Group.

Deputy Secretary Welch thanked those in the focus groups for focusing on these priorities and said there may be opportunities to launch additional ad hoc groups based on emerging interests, like one focused on the role of health plans.

Closing Thoughts

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, CalHHS

Deputy Secretary Welch shared updates on upcoming activities, including a visit to Humboldt County to learn from a rural community. Regional convenings of county teams will also resume, with dates set for October and November.

Deputy Secretary Welch also highlighted a separate project with a steering committee of public safety, justice, behavioral health, and housing partners to develop planning tools and resources for new behavioral health initiatives targeting justice-involved populations.

She concluded that it will be a busy Fall, with more to discuss at November's Working Group meeting, which will have a focus on court partners.

Public Comment

Linkins opened the Public Comment period and shared instructions for making comments. Members of the public shared the following comments:

- Laurel Benhamida, Muslim American Society Social Services Foundation and REMHDCO, said she was very impressed by the updates being made to materials online and the efforts to make them more readable. She was also impressed that materials in the Resource Center are available in 23 languages. She asked how those 23 languages were chosen and what tools were used for the translations. She said she would appreciate a presentation on the CARE process with a respondent or family member who speaks a language other than English. She also said it would be valuable to hear a judge's experience with interpretation in the courtroom. She closed by thanking everyone again for their good work.
- Jay Calcagno, on behalf of the California Behavioral Health Association (CBHA), thanked the group and said CBHA represents community-based providers offering mental health and substance use services to vulnerable populations. Many members are on the front lines of CARE Act implementation, facing challenges with data sharing, referrals across counties, and maintaining the continuum of care. Calcagno expressed appreciation for the discussion on technical assistance and training and encouraged the Working Group to consult directly with providers to identify where support is most needed. Calcagno also highlighted the essential role of peer service providers and urged continued investment in technical assistance, education pathways, and career mobility. Calcagno said CBHA stands ready to assist in ensuring equitable implementation of the CARE Act that supports both the workforce and the clients it serves.
- Meron Agonafer, CalVoices, said the team from Los Angeles presented compelling evidence on the essential role of peer support services in assisting the CARE population. Agonafer noted that the state plans to allocate approximately $53.9 million for CARE courts and $53.3 million for health entities in fiscal year 2026–27 and beyond. According to the CARE Act annual report, around 101 CARE participants received either a CARE agreement or CARE plan. Agonafer emphasized that it would be both fiscally and strategically beneficial to reallocate future CARE funds to peer-run and other

consumer-run organizations that provide direct care to individuals with behavioral health conditions. Agonafer also shared that peer support services help individuals engage in recovery and reduce the likelihood of relapse.

Linkins concluded the public comment period. She closed the meeting and announced that the next Working Group meeting is scheduled for November 19th in Los Angeles from 10:00 am to 3:00 pm.