Frequently Asked Questions

I. Care Plan

1. The CARE plan definition says it is an individualized plan, created by respondent, supporter, their counsel, and county BH. Why then are we allowing the courts to order the plan modified "to better meet the needs of the parties?" What parties? How do the courts know what is better for the respondent? Assisted Outpatient Therapy (AOT)explicitly prohibits a court from ordering any services that are not in the written plan submitted by the licensed mental health treatment provider. Would this go against the respondent's advance directive?

   The CARE plan is an individualized, clinically appropriate range of behavioral health related services and supports provided by a county behavioral health agency, including, but not limited to, clinical care, stabilization medications, and a housing plan, pursuant to Welfare and Insitutions Code section *5982.*

   The Court may determine that the CARE plan does not include all required elements to address the behavioral health needs of the respondent. Sec 5976 clarifies that modifications to the CARE Plan to better meet the needs of the parties must be within the scope of county behavioral health services.

   If the CARE participant has an existing psychiatric advance directive in place, it will be considered. It is far more likely that the participant will work with the supporter, the behavioral health team and others, if desired, to develop a psychiatric advance directive prior to CARE Court graduation.

2. In the CARE plan definition, should there be a more robust menu of services, like in Welfare and Insitutions Code section 5348 for AOT?

   The CARE plan is an individualized, clinically appropriate range of behavioral health related services and supports provided by a county behavioral health agency, including, but not limited to, clinical care, stabilization medications, and a housing plan, pursuant to Section 5982. Though not required, counties are encouraged to employ medically necessary, evidence-based practices and promising practices supported with community-defined evidence, which may include assertive community treatment, peer support services, and psychoeducation.

3. Under the CARE plan (*see* Welfare and Insitutions Code section 5982 (b) (2)) it talks about medication being prescribed by a licensed behavioral health care

provider. Not all licensed providers can prescribe medication. Do we need a clarification that this does not expand scope?

It is not our intention to expand scope of practice and that can be clarified.

II. Eligibility Criteria

1. One of the criteria for CARE is that the respondent "currently lacks medical decision-making capacity." However, this proposal allows for an affirmation or affidavit by a BH professional who had examined the respondent within three months and states it applies to a respondent who meets or is likely to meet the diagnostic criteria. How does a three-month old examination qualify as "current?" Also, does not "likely to meet" contradict "current?"

   The affidavit submitted in the petition must be within 90 days, but as Welfare and Insitutions Code section 5977 (d) stipulates there is an evaluation review hearing where the court reviews the clinical evaluation conducted by county behavioral health as well as any other evidence from all interested individuals, including, but not limited to, evidence from the petitioner, the county behavioral health agency, the respondent, and the supporter. If the court finds that the evaluation and other evidence demonstrate clear and convincing evidence that the respondent meets the CARE criteria, the court is required to order the county behavioral health agency, the respondent, the respondent's counsel and supporter to jointly develop a CARE plan.

2. Why can only *one* previous 14-day involuntary hold for intensive treatment within the last 90 days qualify you for CARE?

   Welfare and Insitutions Code section 5972 outlines the criteria for when the court may order a respondent to participate in CARE proceedings if the court finds, by clear and convincing evidence.

   1. *The person is 18 years of age or older.*
   2. *The person has a diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.*
   3. *The person is not clinically stabilized in on-going treatment with the county behavioral health agency.*
   4. *The person currently lacks medical decision-making capacity.*

   Sections 5973 and 5974 outline who can submit a petition and what kind of information and evidence it must include. All petitions must include facts that

support the petitioner's belief that the respondent meets the CARE criteria, including identification of the county behavioral health agency with responsibility for providing care to the respondent, if known. In addition, the petitioner must provide either an affidavit as described in section 5972 OR evidence that the respondent was detained for intensive treatment pursuant to Article 4 (commencing with Section 5250) of Chapter 2 of Part 1 within the previous 90 days.

As summarized in the question above, a full evaluation review hearing, including a clinical evaluation, as well as hearing other evidence, must be conducted prior to the court issuing an order for a CARE plan to be developed, unless stipulated to by the parties.

The language, as currently drafted, should be amended for clarity.

3. Why is a court allowed to refer a person to CARE who is the subject of AOT or conservatorship proceedings? Shouldn't that be the decision of a treating mental health professional—to determine which program is the most clinically appropriate for the person?

   We would envision county behavioral health or the individual and their Counsel advising the judge in AOT or LPS conservatorship proceedings on the appropriateness of referral to CARE Court.

4. Is "Schizophrenia spectrum or other psychotic disorders" too narrow? Do you see "other specified psychotic disorder "and "unspecified psychotic disorder" as opening this up? More generally, what is the population we are talking about here?

   A diagnosis within the disorder class of schizophrenia spectrum or other psychotic disorders is one of the four criteria for CARE Court outlined in Welfare and Insitutions Code section 5972. CARE Court is specifically designed to target psychotic disorders that interfere with a person's ability to understand reality or make rational decisions due to symptoms of hallucinations, delusions and disorganized thinking, which are the characteristic symptoms of Schizophrenia and Schizoaffective disorders. Like other brain diseases such as neurocognitive diseases (dementias), this category of disease can interfere with an individual's medical decision-making capacity, and that is the focus of CARE Court. By including "other psychotic disorders" in the qualifying diagnoses, the program is inclusive of other individuals experiencing psychotic symptoms who may not

have received a formal diagnosis of schizophrenia but who lack medical decision-making capacity due to psychotic symptoms.

CARE Court focuses on diseases that impact insight and decision making to avoid conflating these illnesses with other illnesses that may impact functioning but do not interfere with an individual's ability to make medical decisions for themselves. Those served by CARE Court are most likely to benefit from antipsychotic medications to reduce the symptoms of hallucinations, delusions, and disorganization that cause impaired insight and judgment in individuals living with Schizophrenia spectrum and other psychotic disorders.

5. Is this intended for persons who currently lack decision-making capacity, or for persons who are experiencing mental illness but have not yet reached incapacity/are coming off a hold and have stabilized? If it is the former, how can the person meaningfully participate in a settlement agreement/help devise a care plan/give legal consent to a settlement as contemplated by the language? If it is the latter, what is the basis for mandating a person's participation, unless it is provided as a diversion option for persons charged with a misdemeanor?

   Medical decision-making capacity is one of the four criteria outlined in Welfare and Insitutions Code section 5972. Medical decision-making capacity is a functional assessment regarding a particular decision that evaluates four key components: an ability to express a treatment choice, an ability to express an understanding of causal relationships and outcome probabilities, an ability to appreciate the nature of the illness, treatment options and likely individualized direct outcomes, and an ability to rationally discuss the risks and benefits of treatment options and the reasoning behind a choice.

   CARE Court is intended for individuals who lack medical decision-making capacity because their illness is untreated or undertreated, and therefore may require a court ordered CARE plan to secure that treatment, but who can still be supported in making choices about aspects of their care such as preferred medications, psychosocial interventions, and housing environment and who can still regain decision-making capacity through that care.

   Medical decision-making capacity is distinct from the LPS criteria for a psychiatric hold in which the individual must be a danger to self, danger to others, or be gravely disabled.

6. If the petitioner is the family member, what evidence does the petitioner need to provide or present to demonstrate prima facie evidence that the respondent lacks medical decision capacity? Alternatively, is it the goal to provide that if you have

been subject of a 5250, you are deemed to have lacked medical decision-making authority?

The criteria for CARE Court participation is outlined in section 5972, including facts (f) and evidence (g). For the petition, the petitioner can provide as evidence (g) either the affirmation or affidavit of a qualified behavioral health professional or that respondent has been subject to a hold for intensive treatment pursuant to 5250. Through the evaluation review hearings, the individual still would be evaluated to determine if they lack medical decision-making capacity, unless the parties stipulate otherwise.

7. Is there a way to allow persons who believe they need mental health services to opt in on a more voluntary basis? For example, persons who are coming out of 5150/5250/5270 holds or conservatorships and who want wraparound services?

The legislation does not provide for a self-petition process—but this is something that should be considered. With regard to it being on a voluntary basis, the CARE Court settlement agreement process creates a pathway for those who are subject to a petition to enter treatment and services that the county behavioral health agency provides, without a court order. In addition, individuals and counties notified of a petition for CARE Court can directly engage in a treatment plan, and then at the Initial Hearing may be found not to meet the criteria for CARE Court due to current provision of and engagement in treatment.

III. Court Process

1. On the court process, the initial CARE hearing is required no later than 14 days from the date of the petition being filed. In AOT, the requirement is within 5 days. Why are we almost tripling the timeframe for this proposal when we are dealing with the most severely mentally ill—given also that, the CARE process allows for various 14-day extensions before the 1-yr clock even starts?

The timing is a result of one of the key differences between AOT and CARE Court – individuals can file directly with the court. To elaborate, in AOT only a county can file and it often takes a county weeks, and sometimes months, to investigate, offer services, and examine the individual before a petition for AOT is filed, so the short time frame between the AOT petition and the first hearing is appropriate. In CARE court, the petition can be filed by a range of designated people, so the petition needs some time for review by the court and for engagement of the parties before proceeding to the Initial Hearing. In CARE Court, the steps of engagement and evaluation happen after petition, through notice and engagement of county behavioral health, the respondent, counsel,

and supporter, which occurs within 5 days of petition; the Initial hearing, within 14 days of petition; and the subsequent Case Management conference hearing.

2. If the respondent stabilizes at any point throughout the process of the petition, does the petition end? Likewise, if at any time during the 1-yr CARE treatment plan the respondent stabilizes, can they petition to have the court-ordered treatment end?

   The CARE plan will continue for up to one year to support long term stability of the participant and to provide sufficient time for the CARE plan goals to be realized and a graduation plan to be completed. The respondent may propose modifications to the plan and an earlier graduation.

3. For IST misdemeanants who otherwise are not eligible for mental health diversion, would it make more sense to mirror the new care court referral to what currently exists in the law for AOT or conservatorship referral?

   These provisions should be consistent.

4. Would there need to be a Riese hearing on capacity or is that wrapped up in the "Evaluation hearing?"

   There is no Riese hearing as part of CARE Court because no medications are forcibly administered. Additionally, CARE Court does not allow for a psychiatric hold where Riese hearings typically take place.

5. The timeframe for the process—stretching over many weeks—suggests there is no imminent destabilization or need for care, as compared to AOT/5150, which happens much more quickly. If the goal is to bring in destabilized persons, should the timeline be tightened up ?

   As discussed above, the timing of the CARE court process is more lengthy than the AOT court process because we are allowing a direct petition to the court to begin court supervision of services earlier. That said, alternative timeframes can be considered.

6. Should a CARE plan be specifically mentioned within a settlement agreement under section 5977 (c)?

   Yes. The settlement agreement should at a minimum include the required Care plan elements.

7. If an agreement is made under section 5977 (c) (3) are we basically skipping down to (f)? Does that need to be explicit?

We anticipate clarifying that the matter can be terminated after the 60 day hearing if both parties are participating in the settlement agreement.

8. Are there going to be hearsay issues given the *People v. Sanchez* (2016) ruling?

We would imagine that People v. Sanchez would limit an expert witness's use of hearsay in their testimony– as it has in LPS and AOT.

9. Is there a risk of abuse if a person can be brought in with just a petition and prima facie evidence of eligibility, especially because non-experts are permitted to file the petition? AOT requires a concerned person to go through the county and the county decides whether to bring the petition, does this provide better protections?

The petition requires both facts which support the petitioner's belief that the person who is the subject of the petition meets each criteria and supporting evidence, through either an affidavit from a qualified mental health professional that the person meets, or is likely to meet, the criteria or evidence that the person who is the subject of the petition had a section 5250 hold within the last 90 days. The petition shall be signed under the penalty of perjury. The court may dismiss a case with prejudice if finds that the filing was not in good faith.

10. There is no clinical evaluation until after the target of the petition is in the system and has been required to try to reach a settlement agreement. Should there be an evaluation earlier? How can there be a settlement agreement without an evaluation?

If the subject of the petition does not believe they meet the CARE Court criteria they may decline their option of entering into the settlement agreement and move to the evaluation.

11. Welfare and Insitutions Code section 5976 states that the target of the petition is entitled to counsel, but does not specify that counsel must be provided if they cannot afford it, as with LPS proceedings. Is the intent to provide counsel?

Yes. Section 5977 requires the court to appoint counsel in all cases, not based on whether the individual can afford counsel.

12. How does the settlement agreement work? Is it essentially a voluntary CARE court treatment plan? Could this be made clearer?

The settlement agreement is a treatment plan entered into by both the respondent and county behavioral health with court supervision, but not court orders.

13. Should the court order the settlement negotiations and the development of a treatment plan to run simultaneously? There seems to be a lot of time before the health department is figuring out what the target of the petition needs, or even before there's an evaluation.

    County behavioral health should begin engaging the subject of the petition as early as possible to offer treatment, including upon receipt of notice of a petition. If an individual is clinically stabilized in on-going treatment with the county behavioral health agency, the parties may no longer meet the criteria for CARE Court and the case may be dismissed at the Initial hearing; or they may more promptly enter into a settlement agreement at the Case Management Conference hearing.

14. The timeline for an adopted CARE plan is a status conference at 60 days after implementation, plus regular conferences set at least every 180 days. In a yearlong plan, this means the default is only two status conferences; should there be greater court oversight?

    The goal is to limit court involvement if the individual is doing well in the community and the county is providing services– which is why deference has been given to the court. That said, language should be added that clearly lays out how a hearing can be requested in between status conferences.

15. The bill requires notice to be provided to the respondent's counsel. How will the family member know who is the respondent's counsel?

    The court will be appointing counsel in every case–likely the public defender in the vast majority of counties. Information on service requirements, including addresses for the entities to be served, will need to be included in the court's self-help center.

16. Should we require the Judicial Council to develop forms – specifically for a petitioner who is a family member – to make it easier for them to know how to do this?

    Yes–the intent is to have the Judicial Council develop accessible forms.

IV. Psychiatric Advance Directive

1. How are Psychiatric Advance Directives currently working in practice? Consenting to care ahead of time that you may refuse in the moment is very

different from the inverse, which is more common for advance directives. Any info from the MHSOAC on their pilot?

U.S. Centers for Medicare and Medicaid Services clarified over 15 years ago that Psychiatric Advance Directives (PAD)s should be part of psychiatric care but only 27 states have enacted laws and policies recognizing PADS. Advance directives are commonly used for physical health conditions and efforts have been underway for over a decade to increase their use for psychiatric conditions. The National Resource Center on Psychiatric Advance Directives (NRC) provides the following definition, "PADS are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives are used to plan for the possibility that someone may lose the capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness".

PADs can help expand the use of Supportive Decision Making tools. PADs are not intended to be used to require on-going medication or involuntary inpatient care. A PAD allows a person in a mental health crisis to retain their decision-making capacity by choosing supporters to help advocate for their choices.

While California may not yet have specific legal statute regarding PADs there are efforts underway to develop what will work best for California. The Mental Health Services Oversight and Accountability Commission has a learning collaborative with several counties to study and develop standardized templates, training, technology and potentially enabling legislation to support accessibility and sustainability of PADs. The administration looks forward to further engaging in these efforts.

V. Respondent Placement and Housing

1. This proposal is silent, as is AOT, on this point, but where is the respondent throughout this whole process? Are they being held? Are they at an inpatient facility? Are they released? Provided with housing?

CARE Court does not include any locked or custodial commitments. Instead, it is an outpatient model that seeks to support housing stability. For participants who are unhoused, counties may utilize local, state, federal and other housing and homelessness funding to serve CARE participants. Additionally, the proposed $1.5 billion for Behavioral Health Bridge Housing funding would be prioritized to serve CARE Court participants per Sec 5983 (b).

2. Article Five requires the care plan to include a Housing Plan, with language specifying it includes the needs of the respondent and the resources considered in support of an appropriate placement. It goes on to say counties may offer appropriate housing placements in the region as "early as is feasible in the engagement process." Does the respondent continue to remain unhoused as they move through the Care COURT process depending on the resources available and the county's ability to identify an appropriate housing option? Could the respondent complete the care court process without their housing needs ever being met if there was a "housing plan" in place but not an actual placement made?

   In the 2021 Budget Act, the state made a $12 billion investment to prevent and end homelessness which included funding to create new community based residential settings and long-term stable housing for people with severe behavioral health conditions. While CARE Court does not create a right to housing, the legislation recognizes the importance of housing in finding stability and staying connected to treatment. To this end, the Governor's proposed 2022-2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which would fund clinically enhanced bridge housing settings that would be prioritized to serve CARE Court participants, per Sec 5983 (b).

3. Regarding the housing plan, what is a "region?" Counties are being permitted to offer appropriate housing placements "in the region." Does that mean that someone from Sacramento County may be placed as far east as Lake Tahoe?

   Individuals who are served by CARE Court will have diverse housing needs on a continuum ranging from clinically enhanced interim or bridge housing, licensed adult and senior care settings, supportive housing, to housing with family and friends. Housing placement should meet the individual needs of the CARE Court participant, including their geographic preferences to the extent possible. In order to support on-going connection to treatment, identifying housing that is near to treatment and other community resources will support the success of the participant. Particularly in rural areas of the state, the most appropriate and near placements may be in the region, but not the county.

4. If courts are not required to order and counties are not being required to provide housing, doesn't that negate this whole CARE proposal? Isn't the purpose to ensure a respondent has a care plan, a supporter, and appropriate housing?

   While CARE Court does not provide a right to housing, the 2021 Budget Act made a $12 billion investment to prevent and end homelessness which included

funding to create new community based residential settings and long-term stable housing for people with severe behavioral health conditions. In addition, the Governor's proposed 2022- 2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which would fund clinically enhanced bridge housing settings that would be prioritized to serve CARE Court participants, per Sec 5983 (b).

5. Does this structure mean the individual has to comply with stabilization medication and specialty mental health treatment to access housing? If so, how does this align with housing first principles as currently defined and practiced?

   CARE Court holds the county and the individual accountable to a CARE plan and supports connection to housing as described above. Counties may leverage local, state, federal, and philanthropic resources to support housing placements for CARE Court participants. Nothing in the statute makes housing contingent on CARE Court participation.

6. Does it change the prioritization of limited housing resources available? Would someone be more likely to access housing if they go through CARE Court than other county/city/continuum of care processes?

   The Governor's proposed 2022- 2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which would fund clinically enhanced bridge housing settings that would be prioritized to serve CARE Court participants per Sec 5983 (b). This is the only fund source that would statutorily require prioritization of CARE Court participants, though other funds sources for housing are available to serve this population and may also be prioritized at the local level as applicable.

7. If someone does to access housing early on in the CARE court process but then struggle with their treatment plan and fall of their medication, do they lose their housing?

   Nothing in the statute makes housing contingent on CARE Court participation.

VI. Post -Hearing Process

1. What happens when a respondent has had two consecutive CARE episodes and they still have not improved? Likewise, if at any time during the first or second year the treating mental health provider does not believe the respondent will improve, what happens?

CARE is a new approach and is designed to provide meaningful connection to treatment and services for up to 24 months. If, at any time during the proceedings, the court determines by a preponderance of evidence that the respondent is not participating in CARE proceedings, after the respondent receives notice, or is not adhering to their CARE plan, the court may terminate the respondent's participation in the CARE program. The court may utilize existing legal authority pursuant to Article 4 (commencing with Section 5200) of Chapter 2 of Part 1, to ensure the respondent's safety. The subsequent proceedings may use the CARE proceedings as a rebuttable presumption that no suitable community alternatives are available to treat the individual.

2. What happens if after one year (or even two years), a respondent improves and is doing well, but they know that without CARE they will not be able to maintain stability, even with targeted outpatient treatment?

   Upon successful completion and graduation by the Court, the participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery. A PAD can remain in place for any future crises.

3. At the 11-month review – what does "successfully completed participation" mean?

   This is an evidentiary status hearing. The CARE participant, supporter, counsel, and county behavioral health agency can present evidence, and the court will hear recommendations from the county behavioral health agency. The participant may request graduation or reappointment to CARE court process. If the respondent requests to be graduated from, or times out of, the CARE court process, the court will officially graduate the respondent and terminate its jurisdiction with a graduation plan which successfully completes participation.

4. Where is the authority to reappoint for an additional year if someone is unsuccessful?

   A clear standard as to when the program can be extended needs to be added to the language.

5. Should CARE court be limited to the one year, not extended, unless the person chooses to do so voluntarily after successful completion? If they do not succeed at the one year or fail earlier, they would be returned to criminal court for continued proceedings. Rationale is because under regular diversion a misdemeanant's term in a program is a maximum of one year and similarly if a person serves a term in custody the max is anywhere from 6 months to a year.

Since this would be attached to a criminal case, the maximum terms should be the same.

CARE Court should allow for an additional 12 months. This issue may be addressed by terminating the criminal case once the individual is accepted into the program– as is currently done for AOT.

6. What happens if a person is complying with treatment but is not showing progress or considered "successful?"

We consider participation in treatment success. To the extent that the individual has a subsequent mental health crisis, a PAD may be relied upon, or the court may utilize existing legal authority pursuant to Article 4 (commencing with Section 5200) of Chapter 2 of Part 1, to ensure the respondent's safety.

7. What is the plan for someone who has not complied with a CARE plan but has not destabilized to the point of needing 5150 care, and who did not participate as part of a diversionary program? Is there a basis for imposing consequences?

CARE Court does not create new standards or change existing legal authority pursuant to Article 4 (commencing with Section 5200) of Chapter 2 of Part 1. The county should continue to engage any patients who are terminated from CARE Court and are not subject to existing legal authority.

8. What happens if a CARE court participant moves jurisdictions, or becomes homeless? Is there a possibility of allowing a court to order housing, if the lack thereof is what has kept the person from stabilizing in the past?

WIC 5982 outlines that counties may offer appropriate housing placements in the region as early as feasible in the engagement process but, as currently drafted, does not allow the court to order housing or to require the county to provide housing.

If a person moves jurisdictions, existing rules for behavioral health services continuity should apply.

VII. Support Person

1. Will the supporters be trained in engaging with people with MH/SUD conditions? Likewise, if a respondent decides on a supporter not provided by the Dept of Aging, shouldn't that supporter receive some kind of training if they will be guiding the respondent through court proceedings, meetings, etc.? Is the Dept of Aging the correct entity to train supporters?

Supporters will be trained in strategies to engage individuals with severe mental illness. A key department responsibility will be to effectively train supporters on supported decision making with individuals who have behavioral health conditions and on the use of psychiatric advance directives. As Welfare and Institutions code 5980 describes this training will be developed with input from peers, family members, disability groups, providers, and other relevant stakeholders.

Self-direction is a critical element of CARE. Welfare and Institutions code 5980(c) explains that if a respondent chooses their own supporter, that person may serve as a supporter without compensation. Volunteer supporters will be provided with required, accessible training that includes, at a minimum, a description of their role, expectations, and conflicts of interest. Respondent may also choose not to have a supporter.

With a focus on individual empowerment and access to services in the home and community, California Department of Aging (CDA) has long focused on person-centered advocacy and support programs for older and disabled adults, including the Long-Term Care Ombudsmen program for residents of nursing homes and assisted living facilities, the Friendship Line for behavioral health support, and, more recently, the Office of the Patient Representative that represents the wishes of incapacitated individuals in long-term care facilities. In July, subject to final budget approval of the Governor's January budget proposal, CDA will be hiring a Conservator/Public Guardian liaison that will work with local Public Guardian/Public Conservator offices to help strengthen probate conservatorships for adults with diminished capacity to make financial and personal care decisions. The supporter program compliments CDA's focus on advocacy and empowerment of older and disabled adults.

2. If the supporter is required to assist the respondent with understanding the entire CARE process, shouldn't the supporter be <u>required</u> to attend court proceedings rather than just being allowed to attend?

   The supporter <u>should</u> attend and that clarification in the language would be helpful

3. Why the Department of Aging? Would the office of patient's rights in DHCS make more sense? Will CDA decide the contract specifications if the role is contracted out? Is a competitive process envisioned?

   As stated above, CDA has expertise in managing person-centered advocacy and support programs with expert community-based organizations that effectively

serve vulnerable older and disabled adults, including preserving the rights of unrepresented and vulnerable people. They are the appropriate entity to develop and administer a State Supported Decision Making program, in partnership with expert community-based organizations. The Office of Patients' Rights within DHCS has the responsibility to ensure that mental health laws, regulations, and policies for the rights of mental health service recipients are observed in licensed mental health facilities.

As Welfare and Institutions code 5980 outlines CDA may enter into a technical assistance and training agreement to provide trainings either directly to supporters or to the contracted entities who will be responsible for hiring and matching supporters to respondents. CDA will seek stakeholder input on contract specifications and contract award criteria. The Supporter program contracts shall include labor standards.

4. If supporters are being bound to "existing obligations and prohibitions," who is ensuring that a supporter not trained/provided by Dept of Aging knows all this?

   As the program is developed, that will be incorporated into the training envisioned for volunteer Supporters.

5. For the supporter, if someone does volunteer, should there be some written commitment to serve in this role like in 5350(e) (2)?

   As the program is developed, that will be incorporated into the training envisioned for volunteer Supporters.

6. Who sets the qualifications and compensation? Who is the employer? What about possible conflict of interest?

   Welfare and Institutions Code section 5980 outlines that CDA will develop the Supporter program and will do so with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. CDA intends to contract with community-based organizations at the state, regional or local level who will serve as the employer of the supporters. CDA will be responsible for addressing any potential conflicts of interest for CDA funded supporters or contracted entities.

7. The language allows contracted entities to "match" the supporter and has the court appointing a supporter within 5 days of filing. Does CDA or the contractor provide name(s) to the court or to the respondent first? Does the respondent have a choice?

Self-direction and choice are critical elements of CARE Court. Reasonable and feasible strategies will be employed to provide Supporter choice to the respondent, recognizing limitations due to the immediate need to have a supporter available in the 5-day period and in every county in California. Respondents can also decline a supporter.

VIII. Evaluation and Accountability

1. Like we are seeing with LPS, we need specific and robust reporting requirements, should those be included here for technical assistance piece.

   A robust data collection, evaluation, and accountability framework will be added to the legislation. This will include demographic data to mitigate against and remedy racial, ethnic, and other inequities in behavioral health and housing.