California Health and Human Services Agency
Community Assistance, Recovery & Empowerment (CARE) Act
Working Group Meeting Minutes
February 14, 2024

Working Group Members in Attendance:

- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Charlene Depner,** Director, Center for Families, Children & The Courts, Judicial Council of California
- **Deb Roth**, Disability Rights California
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, Cal BCSH
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control, LA Dept of Public Health
- **Dr. Clayton Chau**, National Healthcare and Housing Advisors
- **Dr. Katherine Warburton,** Chief Medical Officer, California Department of State Hospitals
- **Dr. Veronica Kelley**, Chief of Mental Health and Recovery Service, Orange County
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Herb Hatanaka,** Executive Director, Special Services for Groups
- **Hon. Maria Hernandez**, Assistant Presiding Judge, Superior Court of Orange County
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Ketra Carter**, Director, Homelessness Strategies and Solutions Department
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Matt Tuttle**, President, San Jose Firefighters Union Local 230
- **Monica Morales**, Office of Second District Supervisor for Santa Cruz County
- **Tim Lutz**, Director of Health Services, Sacramento County
- **Ruqayya Ahmad**, Policy Manager, CPHEN
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County
- **Tracie Riggs**, County Administrator, Tuolumne County

Working Group Members not in attendance:

- **Al Rowlett**, Chief Executive Officer, Turning Point Community Programs; Commissioner, MHSOAC
- **Anthony Ruffin**, Community Center Director 1, LA DMH Concierge Outreach Team
- **Lorin Kline,** Director of Advocacy, Legal Aid Association of California
- **Xóchitl Rodriguez Murillo**, Deputy Secretary, Minority Veterans Affairs, CalVet
- **Zach Olmstead**, Chief Deputy Director, Department of Housing and Community Development

1. Welcome and Introductions

Karen Linkins, Principal, Desert Vista Consulting, welcomed the CARE Act Working Group (WG) members, both those present in person and those who joined online. She mentioned that the group has now been meeting for an entire year, as the first meeting was last Valentine's Day.

Linkins asked all members to introduce themselves briefly, and for the new members to add a few sentences about why they joined the group. Members present in person went around and introduced themselves. New members included Ketra Carter, Ruqayya Ahmad, Dr. Clayton Chau, Dr. Brian Hurley, Tim Lutz, Deb Roth, Monica Morales, Ivan Bhardwaj, and Dr. Katherine Warburton.

Deputy Secretary Stephanie Welch introduced herself and said she was pleased by the large in person turnout from members.

Working Group members who joined via Zoom introduced themselves.

Deputy Secretary Welch acknowledged that showing up for quarterly in person meetings can be a challenge and not all original Working Group members have had the space in their schedule to continue the commitment into 2024. She thanked members who have stepped down for their contributions and for identifying new members from their organizations to join the Working Group.

2. CARE Act Implementation Update

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

California Health and Human Services Agency (CalHHS):

Deputy Secretary Welch shared photos from recent site visits to some of the Cohort 1 counties and said that this is the first Working Group meeting where members can learn and discuss how things have been going with CARE implementation, since the previous meeting in November 2024 was just a few weeks after the "go live" date in October. It is now possible to begin to evaluate how implementation is going in each county and identify areas for improvement and areas of success and creativity. She thanked the counties that have hosted site visits and provided examples of learnings from counties:

- Glenn County: Last week, state partners visited a Home Key site of 32 units of supportive housing in Glenn County that was stood up in partnership with Habitat for Humanity. Glenn has one active petition. Housing navigators were engaged in the site visit and explained how they have been able to engage people in a range of housing and supportive services through CARE and outside of it, emblematic of how CARE is one tool in a larger toolbox. For all new BH initiatives the current administration has rolled out, the dollars have been in counties for a couple years at most, and it is exciting to see how counties are putting them to use.
- Tuolumne County: Tuolumne renovated a property that was a skilled nursing facility and is now a low barrier interim housing site. It took a high level of community support and collaboration with the Board of Supervisors to get this project completed, as well as creative braiding of funding sources.
- Orange County: State partners saw a permanent supportive housing site that is getting ready to open its doors.

Deputy Secretary Welch said that a process evaluation will be developed from the information learned at site visits. Along with CalHHS, HMA and judicial partners have joined CalHHS at the site visits and their learnings will inform the TTA plan for Cohort 2 counties. With LA going live in December, the CARE process is now open in eight counties that collectively represent over half of the state's population. The latest update on petition numbers shared with CalHHS show that nearly a total of 300 petitions have been filed across the Cohort 1 counties + Los Angeles. Only 40 of these have been dismissed at prima facie, indicating that counties have done a good job educating communities on eligibility and ensuring that petitions filed are for people who are likely eligible. Deputy Secretary Welch shared additional themes that she observed across the site visits:

- Many counties are considering using CARE as a diversion or step down from conservatorship. This is great and one of the reasons CARE was developed.
- Counties are providing mobile vans and other methods of making remote court appearance accessible to clients, in addition to some plans for community based court proceedings outside of courthouses.
- Counties are testing different models of coordination between public defenders and BH staff to optimize engagement strategies. Strategies included leveraging traditional homeless outreach teams, additional BH staff, and coordinated outreach between counsel and outreach specialists.
- Counties are using creative methods and funding sources to acquire housing.
- Site visits were at least a day long, and while challenges came up that counties are facing, there were opportunities to discuss those challenges in depth and observe the solutions that counties are generating. For example, counties are addressing workforce challenges through leveraging existing staff with specialized expertise.
- Peers and family advocates are core members of the CARE teams in a number of counties.
- Deep system coordination has been a necessary component of counties' early successes, including regular collaborative meetings between courts and BH departments.
- Counties have conducted extensive community outreach through a range of methods, including town halls, centralized call lines, and radio spots.
- The ability to develop true ACT models has been essential for counties to be able to support this population effectively.
- Though data is very preliminary as of now, it seems that the people being petitioned are generally representative of county communities, though they skew more male, which was expected.
- Continued challenges include:
    - The petition itself is complex and difficult to fill out. Self-Help Centers have been providing support for petitioners and counties have done a great job getting the word out about that resource. Self-Help Centers also are providing referrals for other BH resources.
    - Accessing private health information consistent with confidentiality laws.
    - Deeply complex conditions of respondents, including co-occurring SUD and physical health conditions.
    - High acuity and needs of respondents.

Welch said these are the primary themes that stood out to her and expressed gratitude to be able to look at implementation clearly and have conversations about how to best move forward to meet the needs of communities.

Questions from Working Group members:

- Monica Morales asked if there were any updates related to the budget.
    - Welch responded that the 24-25 Governor's Budget has a chart with what they believe the funding amounts will be, which she does not think has been adjusted. The total overall implementation budget for 24-25 is about $217M, which includes technical assistance and support to the judicial branch. Billing guidance for counties is forthcoming.
- In response to a question about workforce capacity, Deputy Secretary Welch described how counties are leveraging existing staffing to build out CARE teams.
    - Laura Collins of HMA said that the annual report will not include a section on workforce The independent evaluation may consider assessing workforce challenges, though it is not currently in the evaluation plan.
    - Ivan Bhardwaj added that he thinks workforce is an important consideration for the independent evaluation to take up, though there may also be paths to address it outside of data collection, such as through outreach from HMA's county liaisons whose observations could be worked into the evaluation.

Department of Health Care Services (DHCS):

Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health—Policy Division, presented updates on DHCS' training and technical assistance efforts:

- DHCS is under CalHHS and they report to Deputy Secretaries Welch and Buchanan on CARE Act activities
- DHCS is responsible for CARE training and technical assistance, consultation to support implementation, and data collection and reporting, which Health Management Associates has been contracted to assist with
- DHCS is also responsible for producing the independent evaluation and administering startup funds and ongoing mandated costs
- Three Behavioral Health Information notices have been published:
    - BHIN 22-059: General Uses for CARE Act Start-up Funding
    - BHIN 23-016: Guidelines to Delay CARE Act Implementation
    - BHIN 23-052: CARE Act Data Collection and Reporting Requirements Guidelines
- DHCS recently collaborated with CalHHS, the Judicial Council, and the State Bar to host the Cohort 2 kickoff on January 25, which provided an overview of the fundamentals of CARE, data collection and reporting, and available and upcoming trainings and technical assistance.
    - 275 participants joined, representing 47 counties.
    - Participants were made up primarily of administrators and managers and courts and counsel.
    - 38% of participants reported that their counties had begun implementation planning, which is a considerable percentage before any engagement from the state.
    - The most requested TTA from Cohort 2 counties are TTA on data collection and reporting, the CARE process and forms, and funding.
- The 2024-2025 TTA plan was developed in response to what DHCS and HMA have learned about county needs and best practices from Cohort 1. New trainings will include:
    - Outreach and engagement strategies
    - Assessment and treatment planning
    - First responders

    - Housing system and referral pathways
    - Strategies for the justice-involved population
    - Issues unique to rural counties
- Updates trainings, shifted based on lessons learned, will include:
    - Data collection and reporting
    - Eligibility
    - Family psychoeducation
- The above TTA lists are not complete and there is flexibility build into the plan to account for emerging county needs
- DHCS upcoming milestones include:
    - Finalizing KPIs for the annual report
    - Collaborating with RAND Corporation, the Independent Evaluation vendor
    - Publish guidance on claiming, which is in final review with DHCS leadership
    - Manage collection of first quarter CARE data, which is due March 1
    - Submit the Early Implementation Report, which is due to the Legislature by December 1

Bhardwaj took questions and comments from group members:

- Deputy Secretary Welch commented that the training available is excellent and worth exploring for stakeholders beyond BH

Judicial Council of California (JC):

Charlene Depner, Director for the Center for Children, Families and the Courts at the Judicial Council, thanked counties for their hard work to meet the needs of their communities. She presented Judicial Council updates:

- Court funding allocation methodology was approved in July and implementation funding has been distributed to all courts.
- Minor changes are being made to the rules and forms, which are moving forward in committees.
- Forms have been translated into Chinese, Vietnamese, Korean, and Spanish.
- JC is engaging with Cohort 2 in a number of ways and is grateful to all of the input provided by Cohort 1.
- Information resources are regularly updated in the JC website, in addition to dissemination through other channels.
- JC is on track for data collection and reporting timelines and are currently training Cohort 2 courts on data requirements.
- JC is encouraging Cohort 2 courts to begin building local relationships now to be ready for go live.
- JC has completed trainings related to eligibility, forms, legal roles, and services.
- JC is participating in state site visits to Cohort 1 counties.
- Self-Help center outreach and training for Cohort 2 Self-Help Centers is aggressively underway, and Self-Help Centers are proving to be great assets in Cohort 1.

The State Bar of California:

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

McConkey shared the following updates:

- The role of the State Bar is to administer funding and reporting for legal services, nonprofits, legal aid, providers, public defenders, and other entities involved in CARE implementation. For CARE, the LSTFC distributes funding for respondents' counsel.
- All CARE funds that the LSTFC distributed for this fiscal were allocated in the Budget Act of 2023, which determined that the minimum amount of funding that QLSPs and public defenders could receive is $20,400,000 and the maximum funding that could be distributed for legal training and technical assistance was $1,020,000.
- Two QLSPs applied for and received funding for the current fiscal year, both in San Francisco County.
- It is currently too early to announce a full timeline for funding determinations for the 2024-25 fiscal year.
- The LSTFC is currently working to determine funding allocations to Cohort one and two public defender offices and QLSPs for CARE representation for the next state fiscal year.
- No funding allocations can be finalized until the Budget Act of 2024 passes, which may be in late June.
- In the waiting period before the Budget Act is passed, the LSTFC may approve a Request for Proposals (RFP) in the spring, which will contain information on how and when funds would become available, subject to the Budget Act.
- The State Bar and LSTFC has been providing consistent technical assistance to cohort one counties via webinars and other avenues to support with data and expenditure submission, which the LSTFC is required to collect.
- The LSTFC has held virtual meetings and an in-person convening to facilitate peer support and resource sharing for cohort one and two counties.

Questions and Discussion:

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

- Lauren Rettagliata asked about coordination between the judicial system and county behavioral health directors. She said she heard a specific concern from someone in her county of Contra Costa. She asked if there was a way to find out if cohort two courts have been meeting with behavioral health departments.
    - Depner asked Rettagliata to contact her directly and said she will talk with colleagues from CalHHS.

3. Cohort 1 Updates on CARE Implementation

Linkins introduced panelists joining virtually from four Cohort 1 counties: Glenn, San Diego, San Francisco, and Stanislaus. She acknowledged that there are also representatives from Cohort 1 counties (Tuolumne and Orange) on the Working Group who would not be presenting today.

The following panelists presented:

San Diego:

- Claude Winship, BHS CARE Team Rep
- Adrianna Pratt, BHS CARE Team Clinician
- Chrissy Croft, BHS CARE Team Clinician

San Francisco:

- Jose Luis Guzman, Acting Director of CARE Court and Collaborative Courts, Adult/Older Adult System of Care, Behavioral Health Services

Stanislaus:

- Hon. Ruben Villalobos, Superior Court of California, Stanislaus County

Glenn:

- Joe Hallett, LCSW, Behavioral Health Director, HHSA Department
- Kristin Doyle, Program Manager, Adult Unit
- Zuheit Hernandez, Court Clerk

Linkins asked panelists how CARE is going in their counties and to what extent it is going as expected.

- Guzman (San Francisco) said that their process is going well, though differently than expected. He said that because of the three separate avenues into CARE (external petitioners, BH petitioners, conservatorship stepdown), there have been varied levels of engagement around CARE plan development. They are currently in the development stages with several respondents, which is going better than anticipated. It has been helpful for clinicians and outreach workers to be able to engage respondents and their council in some pre-planning before a court hearing.
- Hon. Villalobos (Stanislaus) said that now that they are several months into implementation, they are getting a better sense of the process. Like many counties, they expected a deluge of petitions, which did not happen. This gave Stanislaus time to get their systems in place. They now have 23 or 24 petitions that have been filed. They have done everything they can to proceed with each petition. Most are on their way to CARE agreements or plans and only a few have been dismissed.
- Hallett (Glenn) said things started off slower than expected, even though they knew there would not be many petitions in their small county. Currently, one petition has been filed and two more are on the way. Outreach and engagement has gone well and some people have engaged and gotten into treatment before a petition even had to be filed. Challenges have included figuring the process out as they go and navigating additional requests for information from the court.
- Doyle (Glenn) added that the second petition was just filed. Their first court hearing will be held this week. They are adapting processes as they go based on what is working and not working. They have a small team but they are incredibly collaborative.
- Hernandez (Glenn) said that their neighboring Butte County is providing case management support. With their support, the Glenn court was able to process a petition with no errors. Because of their small size, all clerks have been trained to process petitions. Currently, lead clerks are working to iron out kinks in the process and set up workflows for data reporting. The county is working closely with justice partners and the level of collaboration has led to a smooth rollout.
- Winship (San Diego) said San Diego has 73 petitions and 21 CARE agreements. He said there has been challenges, but they are working them out and getting more comfortable with the process. Building relationships with courts, public defenders, and community partners has been invaluable. It has been important to come to the table with an open mind to see the types of referrals that come in. Judges in San Diego have been fairly liberal with prima facie determinations because a lot of petitioners do not have mental health or legal backgrounds and access to all the required information. As long as families can accurately speak to symptoms they have observed, the Judge will send petitions to BH for investigations.

- Pratt (San Diego) said she has been part of the team since October. She said CARE is a new way for people to be able to refer for treatment which has been positive. She shared that she has enjoyed working so closely with families and that family members are in need of a lot of support.
- Croft (San Diego) added that there has been great collaboration with all stakeholders, including with respondents and the Judge, which has contributed to their success. She said the clinicians and frontline workers have gotten good at explaining the process to respondents and petitioners.

Linkins asked what counties have been doing to make it easier for families and other types of petitioners to file petitions.

- Winship (San Diego) said that early on, they made the determination to use the term "CARE Act" as opposed to "CARE Court," due to people's negative associations with court. To make court less intimidating, the Judge has been allowing virtual appearances and other accommodations. When BH receives the petition, they are already thinking about a potential CARE agreement and working on getting buy in from the respondent through prioritizing the respondent's goals. BH is actively educating community members to clarify what CARE is and is not.
- Hon. Villalobos (Stanislaus) said that to make it easier for petitioners to file, the court and BH have been spreading information through partnering with various community groups. They have also taken a flexible approach to assessing petitions by appointing counsel, looping in BH, and delaying full review when a petition does not contain sufficient information so the petitioner can receive help assembling more information. The petition is a very difficult form to fill out, especially for petitioners in emotional distress.
- Guzman (San Francisco) said that they set up email and phone consultations to assist family members with finding the right information and filing. Through this process, they also connect family members to behavioral health services. Consultation is also available for other types of petitioners, such as first responders.
- Hallett (Glenn) said that the Self-Help Center in the court has been a great partner, though no family members have filed a petition. The documentation is difficult to gather, particularly getting an affidavit from a behavioral health provider in a small county. Since the BH department provides the majority of services, referrals will come to them and they will determine if it makes sense to petition or connect a person to another avenue of services.

Linkins asked how petitioners are using the Self-Help Centers and what assistance is being provided.

- Hon. Villalobos (Stanislaus) said that their Self-Help Center has partnered with the Public Defender and Behavioral Health and the three refer people to each other. Services are co-located in the court so the PD does office hours within the Self-Help Center.

Linkins asked how counties have staffed for their CARE teams.

- Winship (San Diego) said that their staffing model was based on their projected number of respondents. They staffed the team with 2 Program Managers, 10 Clinicians, 2 Clinical Psychologists, 2 Case Management Assistants, Peer Support Specialists, and a legal support team and analysts. They have been blessed to have passionate staff come on board. Staff is out in the field within 24-48 hours after they receive a petition.

- Hallett (Glenn) said that they brought on one dedicated Case Manager, one Clinician, and Analysts for data reporting. Those staff were moved from other positions which they have not yet re-hired for.
- Doyle (Glenn) said that their county is small so they felt they could handle the caseload without hiring new staff. In addition to the positions Hallett listed, they also have a Program Manager and peers at the drop-in center. Their Case Manager is bilingual in Spanish and additional interpreters are available.
- Guzman (San Francisco) said that they mirrored their staffing on their AOT model. They have a Program Manager who was an internal transfer, two Clinicians, and two Health Workers. They have Spanish language capacity on the team and access to staff with other language capacity.
- Hon. Villalobos (Stanislaus) said the BH department has a phenomenal team in place.

Linkins asked counties to share what outreach and engagement strategies have been successful.

- Croft (San Diego) said what has been most effective for them is being able to connect people rapidly to resources, even before a CARE agreement is in place. For respondents who are unhoused, it is challenging to keep track of where they are located, so getting them immediately into a shelter or short-term housing option makes ongoing engagement possible and increases buy-in. There is a shortage of housing in San Diego, but they are working hard to immediately meet respondent needs.
- Pratt (San Diego) said that collaboration with petitioners, pre-existing outreach teams, and community partners has been crucial in the process of locating respondents. There have been several petitions in an area of the county that are quite far from the BH office, so it helps to use all available community resources. Once respondents are located, they work to build rapport and prioritize respondents' service desires, while sprinkling in clinical skills and motivation to engage in additional services.
- Guzman (San Francisco) said that what the San Diego representatives shared is consistent with what they are doing, and SF has the added benefit of having active BH outreach teams in the small geography that they mostly focus on. Most respondents are just 15 minutes from their office.
- Doyle (Glenn) said that they have dedicated housing navigators who have done some initial referrals, and they are partnering to collaborate on outreach and engagement to facilitate warm handoffs.

Linkins asked what counties are doing to make it easier and less intimidating for respondents to participate in court proceedings.

- Hon. Villalobos (Stanislaus) said that redefining what participating in court proceedings means has been central to their strategy. Some respondents don't want to come to court at all, so he works to figure out ways to use court to motivate respondents to access services. He will set court dates but then tell respondents that if they engage in services, they don't have to come, even though they don't have to come anyway. He also works to ensure that court is as welcoming as possible through coordinating with bailiffs and other court staff and trying to be available whenever a respondent is willing to engage.
- Winship (San Diego) said that they are legally obligated to give all paperwork filed to respondents, which poses challenges, especially for respondents who are unhoused. If the BH team feels that it will not be safe for the respondent to keep the paperwork where they are, they will go over it together and then store it securely, which they have discussed with the Public Defender. Court paperwork is a challenging way to begin a process of trying to get someone help. Virtual options for court are available and they

are also working to support respondents who have fears of technology. Everything is done on a case-by-case basis.

- Pratt (San Diego) said they have clinicians at court hearings that is present to support the respondent.
- Winship added that they also must educate petitioners about the court process, a large portion of whom are elderly parents. CARE staff has had to wear many hats to support and educate all people in the process. BH informs petitioners that respondents will get a copy of the petition. They are also working with NAMI to support families.
- Hallett (Glenn) said that the treatment team provides a high level of support to the client and while they don't yet have a virtual option, they will provide transportation to respondents and be a supportive presence. The Public Defender is a strong advocate and works to prep their client fully. Some clients have opted to receive service electively to avoid the court process.
- Guzman (San Francisco) said that the respondents' counsel has been very flexible and goes out to meet clients in the field.

Linkins asked what the most effective housing supports are for this population and what housing options they have under development.

- Winship (San Diego) said that as with any new program, some resources have been delayed. They have been able to utilize short term hotel and motel options and are working to develop relationships with independent living facilities. They leveraged some of their CARE start up funding for board and care beds. Most respondents will need a high level of care, at least initially. Some respondents are living with family and friends, though they want to support participants in finding a path to independence if that is a goal of theirs. They have found that it is challenging to convince individuals to leave short term hotel housing placements to transition to longer term group settings.
- Doyle (Glenn) said that they have a new 32 unit PSH complex, build by Habitat for Humanity. Aside from that, there are very limited options in the county and many services are provided out of county. They work closely with housing partners to develop creative options, like short term hotel stays. Sometimes individuals will initially need higher levels of care. They are investigating building a regional facility or board and care in the county. Funding issues are persistent, but they are exploring all options.
- Guzman (San Francisco) said they have a mix of housed and unhoused respondents. For housed respondents, they work with them to maintain their housing, which the two QLSPs who represent respondents have extensive experience with. For unhoused respondents, many have been unhoused for a long time and it is challenging to transition them to county options, which are mostly SROs and some congregate settings.
- Hon. Villalobos (Stanislaus) said that 25% of respondents were housed with family or friends at the time the petition was filed, though some of those situations are tenuous. The county works to provide support in these cases. He shared an anecdote of a respondent who was released from custody and was placed in a congregate housing setting, though was on the verge of being kicked out. He was able to coach the respondent on appropriate behavior for the housing setting.

Linkins invited Dr. Kelley and Hon. Hernandez from Orange County and Tracie Riggs from Tuolumne County to add to the conversation.

- Dr. Kelly said that Orange has received 53 petitions, 30 of which have been sent to BH. Most petitioners were filed by family members, followed by hospitals and self-petitions by people in custody. Most petitions have received continuances so the county has additional time to engage the respondent, as it can be challenging to

locate them. 19 respondents out of the 30 referred to BH have been unhoused. 1 CARE agreement has been signed. There is some tension between the PD and clinicians stemming from balancing what the respondent wants with what is clinically appropriate. About half of respondents so far are completely new to BH. A lot of respondents are not interested in the housing offered, which is a housing placement attached to a FSP. It takes time to develop rapport before individuals are open to accepting housing and other services.

- Hon. Hernandez said that the Self-Help Center has been quite helpful in getting people assistance, and they have placed kiosks around the county to increase access to Self-Help services.
- Riggs said that Tuolumne continues to focus on housing as a first step. BH has received 8 referrals so far. They are collaborating with the court on early engagement and the court has been a great partner. There are challenges with accessing all necessary records, but otherwise the process has been going well. She echoed Dr. Kelley's statements about the need to build trust.

Linkins invited questions from Working Group members.

- Bill Stewart asked about what the data counties are collecting is revealing about who is being petitioned and who has CARE plans or agreements. He also asked about how CARE teams in counties are staffing with attention to culture and equity.
    - Hon. Villalobos said that most respondents are male, though there are some women. Because they have a sample size of less than 30, it is difficult to say if it is representative of their community in terms of race and ethnicity. Their court, PD, and BH teams are very diverse.
    - Guzman said that their CARE staff is diverse in terms of cultural identity, racial identity, and gender identity, which was intentional. SF County has a large population of API resident, which are underrepresented among people who access BH services, which has been mirrored in the petitions they have received.
    - Dr. Kelley said that demographic information is required to be collected in the CARE Act Data Dictionary. The county is keeping an eye on this data to monitor if any communities are over or underrepresented. The CARE team staff represents the communities that they serve, including some staff having multi-lingual capability and lived experience.
    - Winship said the petitions received have been representative of San Diego County's racial demographics and their CARE team staff is ethnically diverse and also diverse in terms of backgrounds and specialties.
    - Pratt added that San Diego has Arabic and Spanish speaking staff and that the clinical team is highly representative of the cultures in the county, though the clinical staff leans female.
- Keris Myrick asked how many respondents are commercially insured, since the counties said that a significant portion of respondents are new to them. She also asked if any peer support for families is being offered, beyond just psychoeducation, since they are experiencing significant trauma. She said she thought a panelist said they were looking at paperwork to determine a diagnosis, which concerned her, and asked for clarification. She added that she is incredibly sad that the rapport that is being built required a court process and was not instead prioritized in a way that would allow people to engage voluntarily. She said that trusting relationships are the most important aspect of recovery, and it is sad that a court process had to be established to get to the point of trust building. She said while she appreciates the judges, this is not supposed to be the kind of work they are doing. She added that she does not agree that CARE should not be called CARE Court, because it is dishonest to obscure the court element.

    - Hon. Villalobos said that in regard to evaluating eligibility, the statute requires certain paperwork be submitted and assessed. In addition to complying with the law, the court still has meaningful conversations with people and does not make determinations based on paperwork alone. In regard to the role of judges, he said that he believes this work is very much what judges are meant to do and is why he became a judge. CARE is one of the few areas of the law where nobody is accused of having done anything wrong. Instead, the court acts as a convener to figure out how people can provide and access services better.
    - Myrick thanked the Judge and added that respondents' must also be made aware that they have a right to all the services from the county that are laid out in their CARE plan.
    - Croft thanked Myrick for her comments. She said that regarding language about court, clinicians in San Diego are never lying about the presence and role of the court, they just are not leading with it in their engagement strategy. They go through a fact sheet about CARE with every respondent to ensure that they understand the full process and understand that it is voluntary. BHS views the court aspect primarily as accountability on the county. She said that in her understanding, all information related to the petition is sealed and would not interfere with participants' future employment prospects, though most respondents have already had interactions with the justice system. For respondents who have just come from incarceration, they are working to get them housed immediately and change the role of court in their lives. She agreed that it should not take a court process for the system to function, and they do the same types of relationship building through other BHS programs, though CARE provides extra support for clinicians to be successful.
    - Winship said that peer support is an incredibly valuable part of the CARE process, though San Diego has been unable to hire for those positions so far. Support is falling to the supporter role, which is most often taken on by family members. They are working to keep families in the process to the extent that a participant desires. He emphasized that CARE is a voluntary process with court oversight and there are no legal consequences for respondents, just for BHS. The court accountability piece for the county is an effective mechanism to improve service delivery. He added that 78% of the petitions in San Diego have been Medi-Cal eligible, 19% have been uninsured, and a small portion has had private insurance, one or two of which have moved forward in the CARE process. Regarding eligibility determinations, he emphasized that licensed clinicians conduct assessments for all respondents. Courts are not mental health professionals, so they leave the diagnostic determination to the county. Courts will provide continuances for investigations when necessary. If a respondent is ineligible, they will recommend dismissal and connect the individual to appropriate services.
- Ruqayya Ahmad thanked the presenters and echoed Myrick's comment about terminology. She said that without changing the legislation to remove the court component, calling it CARE Act instead of CARE Court feels misleading. She said it should be clearly communicated in the name and any discussions that court is central to CARE in the interest of transparency and maintaining the public's trust.
- Lauren Rettagliata said that CARE is for people who are seriously mentally ill and unresponsive to offers of services. She asked at what point counties recommend that an LPS conservatorship process be started in order to help people, because there are so many family members who she works with that have had loved ones who have died on

the street. She also asked if law enforcement will help locate respondents and consider them missing persons.
    - Winship replied that CARE has not changed anything about the conservatorship process and there is no direct avenue to conservatorship through CARE. The only way that CARE could support a conservatorship investigation is if someone had entered into a CARE agreement and is not successfully engaging, in which case the court may elevate them to a CARE plan, and if they are unsuccessful in their plan and are then hospitalized, their lack of engagement in CARE could be brought up during a conservatorship investigation, though all the same standards for conservatorship must be met.
    - Hon. Villalobos added that as a Judge, he does not talk about conservatorship at all in CARE proceedings. CARE is a "carrot-based" program and he is intentional about not raising the topic of possible conservatorship. Conservatorship is an entirely separate pathway. He said that there are times when a LPS conservatorship is needed to save someone's life, but it is independent of CARE.
- Dr. Chau asked how many petitions have been received in languages other than English. The answer was none. He said that he reads multiple languages and the translated forms in Vietnamese and Chinese are confusing and incredibly difficult to fill out. He added that he was contacted by Korean families of mixed legal status who want services for their loved one but are too scared to file a petition in court. He shared that he has a family member who meets CARE criteria and is living on the street, but the form was too difficult to fill out for the parents. The petition asks for a mental health declaration, but he has heard from families that mental health providers have refused to provide a declaration. He reiterated that the petition process is too challenging for non-English speaking and mixed status families.
- Dr. Warburton asked if the therapeutic alliance that clinicians are establishing with respondents is also occurring with prescribers.
    - Doyle responded that as a small county, they only have one psychiatrist for the adult population, so clients have consistency in who they see and can develop a relationship.
    - Winship said that San Diego BHS tries to ensure that if a respondent already has a provider, they like they can stay with that provider. He said that through the contracted case management agency, there are several prescribers available. Once a respondent enters into a CARE agreement, clinical evaluations take place within a week.
    - Tami Mariscal, Tuolumne County BH Director, spoke from the public audience and said that Tuolumne County has psychologists on staff who work closely with prescribers and there are physicians onsite several times a month. Telehealth is also available. They ask physicians to provide consistency and education for participants. One CARE participant has agreed to long acting injectables.

Linkins thanked the panelists and released the group for a lunch break.

4. Independent Evaluation Updates

Linkins introduced Andy Potter, Program Evaluation Section Chief at DHCS, to open the portion of the meeting on the independent evaluation of CARE.

Potter announced that RAND will be the Independent Evaluator for the CARE Act. He said that DHCS chose to work with RAND because of their depth of experience at the intersection of justice, housing and homelessness, and behavioral health, particularly in California. They

demonstrated a thoughtful approach to evaluation, including equity considerations, and demonstrated expertise in reaching hard to reach populations for surveying.

Potter offered clarification between RAND's role and HMA's role:

- RAND is not involved in annual reporting.
- RAND will be developing a logic model that lays out the CARE Act's theory of change.
- RAND is responsible for fielding a participant survey.
- RAND is responsible for a causal analysis and for assessing disparity reduction.
- RAND's core role is to determine if CARE participants are doing better than they would have in the absence of CARE.

Potter said that today's session is meant to open the conversation between RAND and the Working Group, which will be ongoing. He added that RAND may use some data from the annual report as well as other data sources. He said that RAND is still new in this role and in the process of developing their workplan.

Potter introduced Nicole Eberhart from RAND.

Eberhart thanked Potter for his introduction. She introduced her colleagues who were also calling in. She presented the following information about RAND and their plans for the independent evaluation:

- RAND is a non-profit research institution headquartered in Santa Monica.
- RAND's overarching goal is to help improve decision making through research, evaluation, and analysis.
- Melissa Labriola, Nicole Eberhard, and Stephanie Brooks are the leads on the CARE project. They all have relevant expertise to apply to evaluating CARE and also have a broader team assisting with additional expertise.
- RAND has robust legal and mental health evaluation experience in California. Previous evaluation methods have included stakeholder engagement, participant surveys, and analysis of various court and mental health data sources.
- The goals of the evaluation are to:
    - Document the theory of change of the CARE Act.
    - Evaluate the program implementation, outcomes, and impact.
    - Document lessons learned.
    - Make recommendations for ongoing implementation.
- Evaluation methods will include:
    - Stakeholder engagement with a range of stakeholders (including county BH agencies, racial justice experts, and more).
    - Logic model development, which will summarize the resources needed to operate CARE, the key program activities, and the expected outcomes.
    - Survey of program participants, which will be developed collaboratively with stakeholders, in order to understand the outcomes experienced by CARE participants.
    - Analysis of implementation and outcomes using a variety of data sources, which will work to determine the relationship between CARE activities and outcomes for participants.
    - Equity oriented analysis, which will look at both implementation and outcomes to determine if disparities were reduced.
- RAND has a dedicated and experienced survey research group that has experience surveying hard to reach populations.

- They have developed a preliminary timeline that includes deliverables between 2024 and 2028.
- Key deliverables include RAND's workplan, evaluation plan, a draft preliminary report due in 2026, and a final report due in 2028.
- Immediate next steps include finalizing the workplan and evaluation plan, beginning stakeholder engagement, including through participation in groups like the Working Group, and developing the participant survey.
- RAND Health Care and RAND Justice Policy Program are the branches engaged in this work.

Linkins thanked Eberhart and invited questions from group members.

- Deputy Secretary Welch asked what the Working Group can expect to see from the evaluation by the end of 2026, as that is when the group sunsets. Specifically, she asked what the difference is between the preliminary and final report.
    - Eberhart responded that the preliminary report will leverage the data available up to that point and will present initial findings. The preliminary report will provide an opportunity for feedback.
    - Potter added that 2026 will come fast and there will be limited data across the 58 counties in the preliminary report, which will be more robust in the final report. The reports will likely be structured similarly.
- Deputy Secretary Welch said this group will likely want to provide input into the evaluation. This group has a lot of systems level experts who want to help ensure all necessary data is available to the evaluators. She said that since the goals of CARE are to prevent incarceration, hospitalization, and conservatorship, it would be good to track those outcomes in real time and be able to adjust implementation accordingly. In the Behavioral Health Task Force, there was recently a presentation on the rates of incarceration over the years for people with SMI. Even though multiple interventions have been made at the state level, the number of people incarcerated has increased. She said she wants to avoid that outcome. She asked that RAND help manage the expectations of the group regarding what they will be able to see.
    - Eberhart responded that they are not currently set up to provide real time data. The evaluation timeline includes a long process before findings are published. The annual reports may be a more useful avenue for this. She added that it is important for RAND to continue to engage with this group and other stakeholder bodies and will see if it is possible to do interim briefings.
- Herb Hatanaka said that it sounds like RAND has been assigned outcomes to track, but that is not how the evaluation should be approached. He said that a lot of the positive outcomes being achieved are happening outside of just CARE plans and agreements. He said there are currently very few CARE agreements in place, and there is good reason why. He suggested that the secondary outcomes focused on process metrics should perhaps become primary outcomes. This level of outreach and engagement to get people to access services and counties' commitment to serve people, whether it results in a CARE agreement, is a large benefit and may not make it into the report, which would be a shame.
    - Eberhart clarified the question with Hatanaka. She said he is correct that the infrastructure work and the work being done with people who do not enter into CARE agreements are not currently planned to be captured. She will discuss with her team if it is possible to expand to include this, but their contract lays out a specific scope.
- Stewart asked for more detail on the stakeholder engagement process.

    - Eberhart responded that this process is still being determined.
    - Holliday added that they currently have planned for bi-annual stakeholder engagement throughout the court of the project. She acknowledged that stakeholders is a very broad category and it will include consumers and family members in addition to county and state officials. Methods may include convening advisory boards and various forms of community engagement.
- Dr. Chau said that the reports are a long ways away. He asked if there could be a summary report on lessons learned from Cohort 1 to inform Cohort 2 implementation.
    - Deputy Secretary Welch said there is something like this under development, but it has not yet been determined if it will be internal or public, since it is primarily intended to be a TTA tool. CalHHS published quarterly reports, which could be a good vehicle to inform the public about some of these learnings. She asked Laura Collins to explain HMA's reporting duties.
    - Dr. Chau suggested interviewing people in Cohort 1 counties to solicit ideas. He emphasized it is urgent to do this soon to improve the process.
    - Collins said she does not think they are waiting on reporting to adjust TTA. HMA has liaisons that talk with each county to determine what is working and not working and ensures successful strategies are shared.
    - Dr. Chau asked if HMA will also interview families and participants.
    - Serene Olin from HMA said that HMA is looking at the data submitted by counties on a regular basis, including in their Data Governance Workgroup. They are looking for opportunities to learn from this internal data and share early learnings. They will work with RAND on how to shape stakeholder interviews to spotlight successes and understand challenges. She said that part of learning from the program is talking to a variety of stakeholders to get a more holistic view, including people who may not initially be coming to the table. She emphasized that HMA and RAND are collaborating closely.
    - Dr. Chau said that he is wary of data from participant surveys because it does not include the experiences of people who do not engage. He asked if the community will be surveyed, including petitioners and people who were unable to file petitions, so the process can be improved for Cohort 2. He said that otherwise, petition numbers will stay low.
    - Eberhart said the participant survey will only include people who engaged in the CARE process; however the stakeholder engagement process can seek feedback from families and the community. She added that in her experience evaluating new programs, there is a slow ramp up period. Slower starts have been helpful to counties, and she warned against drawing conclusions too soon.
    - Collins said that they are hearing from families and other stakeholders through their email and are assisting them with questions about petitioning. HMA also has a training on petitioning coming up at the end of the month.
    - Deputy Secretary Welch said that it is part of CalHHS' role to have ongoing engagement with all stakeholders, including people with lived experience and families.
- Dr. Warburton said that DSH has been running a diversion program for the felony incompetent to stand trial population, which has a similar premise to CARE and seeks to get people stabilized with wraparound services. They have found that they cannot simply ask "does IST diversion work?" but instead must ask if diversion that is implemented in a way that provides services matched to patients' needs works, because often the services are insufficient which leads to poor outcomes. She asked if their methodology will analyze if the content of a CARE agreement is appropriate and if a participant is getting all the services it lays out.

    - Eberhart responded that there are several ways they could go about analyzing this, including looking at claims data and asking participants about the services that they received. She acknowledged the complexity of this metric.
- Myrick said she recently read a critical assessment of street teams in New York that claimed that they were unsuccessful because they were not achieving certain outcomes, though there were many factors that were not considered. She said that measuring medication adherence is very tricky and the evaluation should ask what it means when someone adheres or does not, not just if they are adhering, because that shift is critical to understanding if CARE changes the relationship people have to medication. She acknowledged that the statute lays out some specific outcomes, but there are many nuances that are critically important to determining what worked and what did not.
    - Eberhart said they are hoping to learn from participants what is important to them in their care and recovery through the participant survey. She thanked Myrick for the suggestion.

Linkins thanked Eberhart and Potter for their participation in this meeting and in a previous ad hoc meeting.

5. Updates on Time Limited Ad Hoc Sub-Groups

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

Tracie Riggs and Jodi Nerell of the Services & Supports group provided a summary of their January meeting:

- Representatives from Riverside and Tuolumne Counties provided updates on implementation.
- Co-chairs asked members what they hoped the group would accomplish. Responses included measuring success from the respondent's perspective and developing a list of a standard suite of services provided through CARE.
- There was some discussion of data, and they want to ensure they aren't duplicating the efforts of the Data group.
- Tami Mariscal recently presented on various aspects of the county BH service landscape to their Board of Supervisors, which she will share with the ad hoc in a future meeting. Riggs said BH is the most complex system of all county systems.
- The group discussed how to assess what is working when there are so many differences between counties, which they will continue to talk about.

Linkins opened the floor for questions from WG members.

- Deputy Secretary Welch said she was unable to attend but asked if the group is talking about strategies to serve people with co-occurring SMI, SUD, and physical health issues. She specifically suggested they talk about engagement strategies for people using intense substances and said ideas from the ad hoc could inform future trainings.
    - Riggs said they are still early on, but they have been discussing where there are gaps in the system and what is working well. She said she will bring Deputy Secretary Welch's suggestion to the group.
- Rettagliata said that a member of the public asked in the Services and Supports meeting if there will be a discharge plan upon graduation from CARE.
    - Riggs said that a transition plan is part of the plan in Tuolumne.
    - Deputy Secretary Welch said that the statute requires a graduation plan, which is essentially a discharge plan.

- Ketra Carter said that a lot of medications are not allowed in SUD treatment facilities, and it means that people cannot access all the services they need simultaneously. She asked that the group consider this along with other system gaps.

Linkins encouraged Working Group members to continue making suggestions for ad hoc group focus areas.

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

- The group was tasked with developing a client journey tool, which they discussed in depth. Group members suggested that additional pieces of paper for respondents may not be helpful. In response to this, they are soliciting insights from people on the ground in Cohort 1 counties to inform the development of this tool. Cohort 1 counties suggested a short video may be a better medium.
- There was a presentation from HMA about technical assistance and training that is available and in development. They also walked the group through enhancements to the website.
- Co-chairs facilitated a discussion around what additional stakeholder groups should be targeted for trainings, and which groups should contribute to trainings.

Jennifer Brya said that she has been working with Cohort 1 BH Directors to identify people doing respondent engagement work who would like to assist with the development of the client journey. This will include identifying what questions they commonly receive from respondents that could be addressed through a short video. These county representatives are also interested in using this as an opportunity to learn what engagement strategies are working well in other counties. These best practices will be captured and turned into a tool that could help Cohort 2 counties.

Linkins invited questions from the group.

- Ahmad asked about the training related to strategies for working with justice involved populations. She asked who will be creating and providing this training, given the impacts of the justice system on communities of color. She asked how the trainers will be equipped to address the needs of this population without perpetuating trauma.
    - Linkins responded that this is a great topic to bring to the ad hoc, which HMA is a part of.
    - Collins responded that this topic is an element of the training plan for 2024. A trauma informed lens is applied to all trainings.
    - Welch asked if the TTA ad hoc group could look at the training. She said this training is required in statute.
    - Holt responded that this topic should be taken up by the TTA ad hoc and there should be a review of each training with an equity lens and provide recommendations for changes as necessary. She said they also want to be leveraging insights from participants once people have gone through the process to inform future trainings.
    - Collins added that the training on the justice involved population came from a suggestion from the Working Group. There are placeholders in the TTA plan for topics suggested by stakeholders.
- Myrick said journey mapping should happen collaboratively with respondents, because other people won't experience it from their perspective.
    - Holt responded that as more participants move through CARE, they will be recruited to help develop this and other tools, so they are person-centered.

Keris Myrick and Beau Hennemann of the Data Collection, Reporting & Evaluation sub-group provided the following summary of their January meeting:

- RAND presented a similar presentation on their background and evaluation plans.
- Members discussed the components of the Data Dictionary.
- Members discussed various considerations related to stakeholder engagement and fidelity to the model.
- Members asked excellent questions.

Linkins invited questions.

- Carter asked if there has been discussion of information sharing between medical and social service components, because the homeless population has inadequate access to these services and a CARE plan can be derailed quickly if service providers are not aware of the full plan and working within different systems.
    - Hennemann said this has not yet been discussed, but that level of data sharing will be critical to success. He asked Linkins if this topic falls into the purview of the Data workgroup or the Services and Supports group.
    - Linkins responded that it could fall in both but should certainly be addressed in the Services group. She emphasized the importance of data sharing and said it would be useful for multiple groups to offer their perspectives.
    - Dr. Chau said it was brilliant to include people from health plans in the Working Group, particularly in terms of thinking about sustainability of the model. He discussed the new benefits being rolled out through CalAIM, which most CARE participants will qualify for. He suggested that local CARE teams work with health plans to connect participants to services, including housing navigation.

Linkins asked if any other members had suggestions for topics that should be taken up by ad hoc groups.

- Myrick suggested that either the Data or Services and Supports group take up the topic of internal staff shifts within BH departments and how those shifts may impact other people currently receiving or seeking services outside of CARE.
- Roth said she is not highly knowledgeable about CalAIM, but it seems that CARE will be serving people with severe needs, though the CARE process may move them into the mild to moderate category. She said she does not know how people move from one bucket to another.
    - Hennemann replied that people receiving county services can still be enrolled with a health plan, the difference between the buckets is just about which entity is responsible for providing the services. People are typically bouncing back and forth and there is coordination between health plans and counties. As health plan members, respondents will be eligible for additional wraparound services and supports.
    - Deputy Secretary Welch added that the CARE population has complex needs, often including physical health conditions. Health plans are important partners in addressing these needs, especially for unhoused respondents. She said that there is a broad lack of understanding of the role of health plans within the behavioral health world. This topic will be the focus of an upcoming Behavioral Health Task Force meeting.
- Hatanaka said that the best use for evaluations is to inform stakeholders how to improve processes, and the CARE evaluation will also include the legislature as an audience, whose motivation has always been to get people to agree to treatment. This group understands how complicated the process is to get people to agree to services, which

will not change dramatically in the next six months, so there will not be a high number of CARE agreements for the evaluation to assess. One of the successes of CARE is getting counties to expand their outreach and engagement efforts through a multi-disciplinary approach. The court involvement makes a large difference, which is also used in diversion programs in Los Angeles, which have a high participation rate. He said that he is not convinced that the evaluation will capture the key elements worth studying to demonstrate CARE's impact. He shared that in his work in LA, there are many instances where people won't agree to a formal suite of services, but through continued engagement they will receive some services. He said that CARE is a fairly low cost model for the successes it may generate.
    - Deputy Secretary Welch said that Dr. Kelly has repeatedly said that the most interesting stories are of the people who never end up needing a CARE agreement or plan, and they are actively thinking about how to capture and tell that story. She said one of the central purposes of CARE is to direct attention and resources to a specific high needs, high risk population. She emphasized that CARE is one tool in a broader landscape of new behavioral health initiatives that all support one another, including supporting health plans in serving the mild to moderate population so that people can be better supported and not need to move into the specialty system. She said that counties are highly motivated to tell the full story of what they are implementing, and the state is highly motivated to hear it.
- Dhakshike Wickrema suggested a joint meeting between the Data and Services ad hoc groups to discuss how to leverage data, beyond data sharing, to help influence and shape service delivery and housing options. She said that while the CARE agreements are important, the goal is to get people into housing and services. There has been outreach happening for decades, but there is now additional momentum, and additional data should be brought in to support that. She discussed Glenn County's Home Key development and how that leverages other funding to support CARE participants.

Linkins thanked members for their suggestions. She shared the dates of the remaining three working group meetings in 2024, which will be May 15, August 21, and November 6. She said that the three ad hoc groups meet each month that the Working Group does not meet, and all dates are posted on the website. She transitioned the group to public comment.

6. Public Comment

Linkins opened the Public Comment period and requested that participants limit their comments to 2 minutes. She explained that comments can be made verbally in person or via Zoom and in writing in the Zoom chat or via email.

- A member of the public introduced himself as a father to a daughter with schizophrenia. She is currently homeless and is in danger, though does not have the awareness that she is in danger. He shared that it is frustrating for families when HIPAA prohibits information sharing to families who want to know where their loved ones are. He asked the group to seek input from families, who are often the de facto support system for their loved ones.
- Kaino Hopper thanked the group and said she was thankful for the extensive resources available on the website. She said she was calling in as a family member and wanted to ensure that the group was aware of concerns from families related to if they will be able to have input in the court process. She said she has heard fears that family members will use the petition process as a form of abuse and there is a widespread belief that families

should be left out of care, which ignores the fact that there are healthy families and in the majority of cases, family involvement improves chances of recovery.

- Jennifer Gray said that her son started showing symptoms of schizophrenia in his freshman year of college. He did not think anything was wrong and so she could not get him connected to services. He left school and bounced back and forth between California and Massachusetts, with periodic hospitalizations. He ended up living in his car and was hit and killed by a truck two years ago. Families are often powerless to help their loved ones. She said that her son was incredibly gifted but there was nothing he or his family could do. She asked that families be included in the CARE process.
- Tanya Fedek said she petitioned the court for her son in San Diego. She asked that there be service provider accountability and records of engagement attempts, better information sharing, and audits of cases before they are dismissed. She asked that participants and petitioners both be surveyed. She said her son's case has been closed and he never received services or was offered appropriate housing. The LCSW that was assigned to him did not have the proper knowledge to address his case. He is now hospitalized. She asked that somebody reach out to her and look into this case and see what caused her son to slip through the cracks. She said the patients should not suffer just because the process is still being ironed out.
- Samuel introduced himself as a disability attorney and person with lived experience. He said he supported Myrick's comments dissuading the group from rebranding CARE Court as CARE Act. He said he was concerned that the coercive aspects of CARE were glossed over in the meeting. He stated that this is a controversial law for a reason and failure to comply with a CARE plan triggers an automatic referral for conservatorship, which makes this a coercive process. It is important for participants and petitioners to have a clear understanding of what CARE is, and it does not provide any services that are not also available to access voluntarily. Trust from the disability rights community is at an all-time low because of the expansion of forced treatment.
- Claire Canestrino said she is a student at UCLA Law and she is currently doing research about CARE with a professor. She thanked the group for their discussion and said she is especially interested in data from the early phase of implementation. She said if there is more information available, she would appreciate being pointed toward those resources. She also invited anyone interested in talking with the researchers to email patel@law.ucla.edu.
- Alison Monroe said her daughter died of a fentanyl overdose last year and today is her birthday. She said she is celebrating her birthday by continuing to fight for people like her. She stated that the job of the system is to keep people alive with a chance of recovery. The system kept her daughter alive for years but failed last year. She was not getting an adequate level of support and deserves to still be alive. It is not acceptable to throw people away because they are unable to understand they are ill. She said she is very interested that CARE allows family members to petition the court, be heard by a judge, and be a supporter. She said that conservatorship should be leveraged by a judge when necessary to keep people alive.
- Laurel Benhamida from Muslim American Society Social Services Foundation in Sacramento and REMDCO said she is concerned that the state is getting behind on the project of translating documents with quality control. She said that the quality control is not present, as evidenced by the member who spoke today, and that the state should set a timeline to get this done. She emphasized that this work cannot wait and should be done by the state. She said that nonprofits such as the ACLU should be involved. She thanked the ASL interpreters.

- Anita Fisher said her heart goes out to the moms who shared that they lost family members. She said her son is currently a CARE participant and so far she is disappointed with how the process is going. She asked that the evaluators survey petitioners and that they add a research question focused on how participants ended up needing CARE in the first place. She said the system that requires people to seek care voluntarily does not care for those with the most serious symptoms.

Linkins adjourned the meeting, thanked everyone in attendance, and reminded the group that they can email with questions and suggestions. She invited everyone in attendance to come to the ad hoc meetings.

Appendix I: Public Zoom Chat

CARE Presenter:

Good morning all. Our apologies but we are having some tech issues

CARE Presenter:

We are having challenges with the room feed so the video is coming from individual computers

CARE Presenter:

We are going to change zooms to deal with our technical issues. Please leave this meeting and rejoin the following:

CARE Presenter:

https://www.zoomgov.com/j/1610211048

Dial In: +1 669 254 5252

Meeting ID: 161 021 1048

CARE Presenter:

Please leave this meeting and rejoin:

CARE Presenter:

https://www.zoomgov.com/j/1610211048

Dial In: +1 669 254 5252

Meeting ID: 161 021 1048