California Health and Human Services Agency
Community Assistance, Recovery & Empowerment (CARE) Act
Working Group Meeting Minutes
May 13, 2026

Working Group Members in Attendance:

- **Amber Irvine** – San Diego County Behavioral Health
- **Beau Hennemann** – Anthem Blue Cross
- **Brenda Grealish** – Commission for Behavioral Health
- **Dr. Brian Hurley –** Substance Abuse Prevention and Control (SAPC), Los Angeles Department of Public Health
- **Ivan Bhardwaj** – California Department of Health Care Services, Behavioral Health
- **James Kwon** – Los Angeles County Department of Mental Health, Office of the Public Guardian
- **Jenny Bayardo** – California Behavioral Health Planning Council
- **Jodi Nerell** – Sutter Health
- **Dr. Katherine Warburton** – Department of State Hospitals
- **Lauren Rettagliata** – Family Member
- **Mark Salazar** – Mental Health Association of San Francisco
- **Monica Morales** – Yolo County Behavioral Health Services
- **Monica Porter Gilbert** – Disability Rights California
- **Nichole Zaragoza-Smith** – California Department of Housing and Community Development
- **Sarah Davis** – Judicial Council of California
- **Hon. Scott Herin** – Superior Court of Los Angeles County
- **Stephanie Regular** – Alameda County Public Defender Office
- **Stephanie Welch** – California Health and Human Services Agency
- **Susan Holt** – Fresno County Behavioral Health
- **Tim Lutz** – Sacramento County Health Services

Working Group Members in Attendance Online:

- **Bill Stewart** – San Diego County Behavioral Health Advisory Board
- **Dr. Clayton Chau**– National Healthcare & Housing Advisors
- **Jennifer Bender –** Riverside County Public Defender Office
- **Kent Boes** – Colusa County Board of Supervisors
- **Keris Jän Myrick** – Person with Lived Experience of Schizophrenia Diagnosis
- **Khatera Tamplen** – Alameda County Behavioral Health
- **Ruben Imperial** – Stanislaus County

Working Group Members Not in Attendance:

- **Harold Turner** – NAMI Urban Los Angeles
- **Herb Hatanaka** – Special Services for Groups

- **Ian Kemmer** – Orange County Health Care Agency
- **Meagan Subers** – California Professional Firefighters
- **Jerry May** – San Jose Fire Department, Local 230
- **Ketra Carter** – Homelessness Strategies and Solutions Department, City of San Diego
- **Roberto Herrera** – California Department of Veterans Affairs
- **Ruqayya Ahmad** – California Pan-Ethnic Health Network

Welcome and Introductions

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

Linkins went over the day's agenda.

Linkins reminded the group to speak slowly for the ASL interpreters. She reviewed virtual meeting guidelines for the members who joined via Zoom and members of the public. She also reviewed essential operations information for the Working Group.

Linkins provided a brief recap of the February 11th Working Group meeting, which consisted of the following agenda items:

- Presentation from Amber Irvine and Melody Culhane on San Diego implementation updates
- Presentation from the Neimand Collaborative and Working Group discussion on CARE Act communication strategies
- Presentation by Dr. Katherine Warburton and Working Group discussion on a potential framework from psychiatry subject matter experts on establishing a standard of care for CARE Agreements/Plans
- A presentation from Health Management Associates previewing the 2026 CARE Act Annual Report

Linkins introduced Stephanie Welch, Deputy Secretary of Behavioral Health at CalHHS, who welcomed the Working Group members.

CARE Act Updates

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, California Health and Human Services Agency

Deputy Secretary Stephanie Welch provided a snapshot of the latest available CARE Act data through March 2026:

- 4,409 CARE petitions had been filed statewide since CARE implementation began
- 1,097 CARE agreements and 41 CARE plans had been approved
- 4,887 diversions or redirections to county services had been reported
- In total, approximately 9,200 individuals have been reached or served statewide through CARE.

Deputy Secretary Welch acknowledged counties and local partners for their strong implementation efforts and the significant number of individuals engaged through the process. She shared key lessons from recent county site visits and meetings, highlighting promising practices, implementation challenges, and opportunities to strengthen services and supports. She thanked counties for their partnership and noted that site visit feedback helps shape ongoing training and technical assistance, as well as ongoing program improvements.

- In Riverside County, recent discussions explored opportunities to expand referrals through the county's crisis care continuum and first responder partnerships. The county also shared a story of a CARE participant who, through engaging in services through the CARE process, achieved sobriety, reconnected with her family, and now has a meaningful role in her grandchildren's lives.
- Ventura County demonstrated strong collaboration among the Sheriff's Department, courts, and behavioral health partners, with law enforcement playing an active role in filing CARE petitions.
- Orange County stakeholders emphasized ongoing challenges related to housing shortages and limited behavioral health resources.
- Santa Clara County highlighted significant investments in crisis services and housing, while exploring ways to strengthen CARE referrals and engagement.
- Discussions in Monterey County focused on implementing SB 27 and expanding CARE petitions for individuals involved in the criminal justice system.
- Visits to Behavioral Health Bridge Housing sites in San Bernardino and other counties reinforced the importance of stable housing and flexible lengths of stay to support recovery.
- Multiple counties highlighted ongoing challenges securing appropriate long-term housing placements for CARE participants.

Deputy Secretary Welch discussed new efforts to gather county BHSA and CARE Act implementation details through the Behavioral Health Services Act (BHSA) Integrated Plans, noting that existing CARE data often lags behind current implementation. Counties will be required to answer CARE-related questions as part of their BHSA Integrated Plan approval process. She described that these questions aim to capture:

- How counties will use new BHSA service components, such as FSP, ACT, FACT, and intensive case management, to support CARE participants.
- How CARE referral pathways are being integrated into broader behavioral health systems to improve engagement and connect individuals to appropriate services.
- How counties identify, redirect, and document connections to services for individuals who do not enter the CARE process.

Deputy Secretary Welch explained that these questions are in service of understanding whether CARE is driving broader system improvements and strengthening access to care. BHSA Integrated Plans are due by July 1, and the state plans to partner with the DHCS to analyze findings. Deputy Secretary Welch noted that some preliminary results may be available for discussion at the August meeting.

Deputy Secretary Welch provided an update on CARE Court Improvement and Coordination Unit (ICU) activities, emphasizing the state's efforts to strengthen implementation through targeted training and technical assistance.

- Following the Governor’s March announcement, the state expanded county-specific technical assistance to improve CARE implementation.
- Site visits have helped identify local strengths and challenges, revealing that in some counties, lower petition numbers may reflect strong diversion and referral processes rather than limited engagement.
- Counties receive individualized technical assistance plans focused on their specific needs, including petition quality, family engagement, data sharing, and CARE service models.
- A recurring challenge across counties is serving individuals with co-occurring stimulant use disorder and psychosis, particularly when housing and treatment options are limited.
- The state is using lessons from CARE implementation to identify broader behavioral health system gaps and opportunities for improvement.
- Training and technical assistance (TTA) remain available to all counties, with strong demand for strategic communications support due to ongoing staff turnover and community education needs.
- Counties have also identified cultural barriers, distrust of government systems, and concerns among immigrant communities as challenges to CARE engagement.
- The state is working with counties to maximize funding, strengthen resource coordination, and support long-term program sustainability.

Deputy Secretary Welch provided communications updates, emphasizing the importance of public education, accessible resources, and sharing personal stories that illustrate the impact of the CARE Act.

- The CARE Act website remains one of the most visited websites within CalHHS and has been designed to provide tailored resources for different audiences.
- The website includes information for the public, TTA materials, and personal stories that help explain the purpose and impact of CARE.
- The state continues to encourage individuals, family members, providers, and petitioners who are comfortable sharing their experiences to submit stories that can help educate others about the CARE Act. She highlighted an example of a story from Monterey County in which a public defender helped connect an individual with a history of state hospitalizations and criminal justice involvement to CARE services, leading to improved support and stability.

Deputy Secretary Welch invited Ivan Bhardwaj to share observations on county implementation and sustainability efforts.

- Bhardwaj noted that some counties, including Monterey County, have identified revenue and sustainability challenges.
- He highlighted opportunities to increase Medi-Cal reimbursement through participation in BH CONNECT benefits and other evidence-based practices that some counties have not yet adopted.

- Bhardwaj acknowledged that counties face competing priorities and limited capacity, which can make it difficult to implement new programs and benefits.
- He emphasized that investing time to adopt available Medi-Cal-funded services can strengthen long-term sustainability, expand services, and increase revenue to support behavioral health systems.

Deputy Secretary Welch concluded by noting that the state is documenting lessons learned from CARE implementation and related behavioral health initiatives to inform future efforts. She emphasized that these insights help the state provide targeted support to counties, strengthen local capacity, and improve services across the system of care for individuals with complex behavioral health needs.

Featured Topic: Families and Peers in CARE

Karen Linkins, Desert Vista Consulting
Keris Myrick, CARE Act Working Group Member

Karen Linkins reflected on Deputy Secretary Welch's and Bhardwaj's comments, noting that CARE implementation has acted as a catalyst for broader system transformation, helping build the conditions for the successful implementation of additional reforms. She highlighted several positive outcomes of CARE, including stronger alignment between family members and peers, which the Peers and Families focus group, chaired by Keris Myrick, is building upon.

Linkins shared highlights from the focus group's initial meeting in April:

- The first joint family and peer focus group revealed more shared perspectives than expected, grounded in participants' emphasis on dignity, recovery, trust, connection, safety, and the importance of providing care before crises occur.
- Families and peers both highlighted the value of person-centered, relationship-based engagement and the importance of voluntary pathways in the continuum of care.
- The group shares a common goal with other focus groups that have come out of the Working Group of helping individuals stabilize, recover, remain connected to their communities, and avoid repeated crises.
- Additional sessions will be held to continue gathering input and identifying emerging themes.

Myrick introduced the focus group background, thanked participants, and noted that she is reporting out as a Working Group member rather than from her personal perspective as a peer or family member. She explained that the group's first meeting on April 27 was convened to bring family and peer perspectives into ongoing discussions about CARE implementation.

- The focus group was formed to complement prior provider-focused discussions on establishing standards of care.
- While families and peers are sometimes viewed as having opposing perspectives, they largely have common goals and want opportunities to work together.
- The discussion focused on leveraging learnings from their lived experience and systems knowledge to generate collaborative and creative solutions to implementation issues.

- Like other CARE focus groups, they are not working to generate policy recommendations.

Myrick explained that the focus group examined three priority areas related to CARE implementation: improving integration of peers and families in the CARE process, strengthening supports for family members, and enhancing implementation of the voluntary supporter role. The discussion also covered broader themes around recovery, community support, and cross-system collaboration:

- Participants emphasized the needs of both individuals receiving care and family members providing support.
- Discussions highlighted the importance of moving beyond a purely clinical model toward a recovery-oriented approach that includes health, housing, purpose, community, and meaningful relationships.
- The group stressed the value of community-based supports, social connections, and belonging in recovery.
- Participants encouraged a cross-system approach, including leveraging resources outside behavioral health systems to better support CARE participants and their families.

Myrick emphasized that peer support is a critical resource for both CARE respondents and family members. The focus group discussed ways to strengthen peer involvement in CARE through workforce development, expanded court-based support, and greater integration of peer-led services:

- Participants stressed the need for specialized training and preparation for peers working with the CARE population.
- Expanding peer support in court settings was identified as a priority to help respondents and families navigate the process.
- The group highlighted the need for technical assistance to help counties recruit, hire, and effectively supervise peer staff.
- Participants noted the important role of peer-run organizations in planning and delivering services within the CARE framework.

Myrick said discussions highlighted the significant role family members play in supporting loved ones in CARE, particularly outside traditional business hours. Participants also explored ways to strengthen the voluntary supporter role through education, training, and a more person-centered approach.

- Families reported needing greater access to 24/7 support, community-based resources, and peer support networks.
- The group identified a need for clearer education on the voluntary supporter role and supported decision-making to address misunderstandings and encourage broader use.
- Additional training, resource guides, and practical engagement tools were recommended for supporters.
- The group noted that, in some cases, a non-family supporter may be the best fit for an individual's needs.

Myrick concluded by summarizing potential technical assistance topics identified by the focus group and outlining next steps. She noted that participants emphasized strengthening county

capacity to support peer involvement in CARE and ensuring family and peer perspectives continue to inform implementation efforts.

- Potential technical assistance topics included recruiting, hiring, supervising, and training peer staff for CARE-specific roles.
- Participants highlighted the need to prepare peers for supporting respondents and petitioners in court-based settings.
- The group discussed connecting respondents and families to community-based resources, housing supports, and other services beyond clinical care.
- Participants recommended expanding understanding of recovery, engagement, and support networks within CARE implementation.

Next steps include convening additional family and peer focus groups before the August Working Group meeting and developing concrete recommendations. Myrick suggested using a co-facilitation model for future meetings and exploring ways to integrate family and peer perspectives with provider-focused standards of care discussions.

Linkins thanked Myrick and noted an opportunity to incorporate these themes into discussions with judges, emphasizing that insights from the various focus groups can be integrated, as each offers valuable perspectives on the same issues. Linkins then opened the floor for questions and comments from the Working Group.

Q&A

Lauren Rettagliata thanked Myrick for the presentation. She emphasized that family advocates want CARE to succeed because it gives families the ability to petition for treatment and provide history of a loved one's illness. She stressed the importance of judges considering that history, which often reflects years of efforts by families to secure help.

Rettagliata also highlighted the need for Assertive Community Treatment (ACT) teams, stronger use of family coordinators and existing support structures, including NAMI, and careful consideration of living environments for CARE participants. She expressed concern that some individuals have been returned to settings that were not working for them. She concluded that families want to work together with peers and other partners, noting that collaboration between families and peers was key to advancing Assisted Outpatient Treatment (AOT) and should continue to guide CARE implementation.

- Linkins thanked Rettagliata for highlighting NAMI and noted that the state is working with NAMI California to help ensure support is available in communities that do not have a well-established local NAMI chapter.

Dr. Alyce Belford-Saldana of San Bernardino County thanked Rettagliata for her comments and noted that San Bernardino County is interested in strengthening its relationship with its local NAMI, including through technical assistance opportunities. She also suggested that integrating peers into legal aid teams supporting CARE participants could provide significant benefits by allowing peers to engage directly with behavioral health systems and support clients in ways attorneys cannot. She added that local legal aid partners in San Bernardino would be highly motivated to incorporate peer resources into their teams.

- Stephanie Regular of the Alameda County Public Defender's Office agreed that peers embedded within legal aid or public defender offices could be a helpful component. She noted that Alameda County's public defender office already has a community outreach worker who serves as a peer navigator, helping create a warm handoff between clients, attorneys, and behavioral health providers. Regular also emphasized the importance of training for peer staff and noted important distinctions between peer roles and the role of respondent's counsel, cautioning against blurring these roles in the CARE process.

Ruben Imperial, Behavioral Health Director for Stanislaus County, expressed interest in the buts and bolts of expanding peer integration in CARE, particularly how the group is distinguishing between clinical treatment services and the CARE Court process itself. He noted existing evidence on peer support improving treatment outcomes but asked for clarification on how peers engage differently in clinical care versus court involvement.

- Myrick noted the initial conversation did not go into that level of detail, but described the value peers can bring to court settings, emphasizing their ability to providing support when individuals feel scared, nervous, or apprehensive, which is especially needed for participants with prior criminal justice involvement. She emphasized that peers stay present and engaged even if someone steps outside the courtroom, ensuring they are not alone during the process. Myrick also discussed peers' roles in the clinical context as providing support as certified Peer Specialists. They also highlighted the parallel need for family supporters in court settings, where family members may be distressed by the court experience and lack someone to talk to about what they are feeling or what to expect.

Deputy Secretary Welch suggested that future focus group meetings should include more structured questions on how peers and family members can serve as navigators in the court process. She referenced Riverside County's collaborative court model, where family and peer advocates are present in court as part of the court team to support individuals and families, provide engagement, and help connect them to resources. She also shared observations from Sacramento County, where peers are present in court settings, and asked Tim Lutz to share more on their approach.

- Lutz thanked Deputy Secretary Welch and said her comments prompted a thought about connecting existing programs that interface with CARE in Sacramento. He noted that the Home Engagement and Response Team (HEART), focused on the unsheltered population, already embeds peers who accompany individuals to court, though their primary role has not been court navigation. He also shared that Sacramento County is working with the Public Defender's Office on a pilot to better support court navigation and resource linkage, and said the discussion highlighted an opportunity to align those efforts more intentionally within CARE.

Linkins shared a comment from Bill Stewart from the Zoom chat, who noted that the report-out was exciting because it reflects the ongoing effort to improve the CARE Act experience.

Deputy Secretary Welch asked members to help identify potential additional participants for future focus group meetings. She suggested leveraging broader networks, including organizations like MHA San Francisco, to help recruit representative peers statewide.

- Mark Salazar shared that MHA provides peer support for CARE participants in San Francisco County and expressed interest in participating in focus group efforts. He noted the value of CARE and emphasized the importance of continuing to improve the experience for both participants and family members.

Deputy Secretary Welch shared that Rettagliata will be joining future focus group meetings to provide additional family perspective.

Linkins asked behavioral health directors to help identify potential participants, emphasizing the need for individuals with direct experience in the CARE process rather than general awareness.

Rettagliata noted that, beyond NAMI, there are other family groups and partners that should be engaged and offered to help identify them. She suggested inviting representatives from insurance plans and hospitals, noting that many CARE-eligible individuals are being served outside the county system and their perspectives should also be included.

Linkins invited the Working Group to share ideas and connections to additional participants. She noted the intent to convene more than one focus group as part of a broader process and requested support in identifying and engaging more people.

- Susan Holt added to Linkins' ideas on how behavioral health directors could support focus group engagement, suggesting using structured gatherings to help generate local community input from peers and reporting findings back. She also suggested convening CARE graduates statewide in a focus group or celebratory convening to capture lived experience, including reflections on ideal family involvement and peer support models.

Linkins noted HMA's toolkit, "Understanding the Volunteer Supporter Role in the CARE Act Process: A Peer's Perspective," available on the CARE Act resource hub, and reminded members to take advantage of the additional tools and resources available there.

- Laura Collins of HMA noted that they have developed a new peer-specific toolkit and resource guide focused on the peer role in CARE, including engagement in the court process, outreach, engagement, and graduation.

Myrick closed the discussion by thanking the group and noting plans to expand participation. She reflected that earlier divisions between families and peers have shifted through shared dialogue, allowing space to better understand each other's experiences and needs and work collaboratively. She thanked Deputy Secretary Welch and the CARE Working Group and expressed appreciation for their continued engagement.

CARE Act Data: Reporting and Evaluation Updates

Representatives from Health Management Associates and the RAND Corporation

Linkins opened the discussion on data, explaining that the group would hear updates on the annual report presented by Serene Olin from HMA, then RAND would present updates on the independent evaluation.

Olin thanked Linkins and began her presentation by reminding the group of the distinction between DHCS' annual report and RAND's independent evaluation:

- DHCS produces the annual CARE Act report each year, while RAND is responsible for the independent evaluation.
- The annual report focuses on monitoring CARE Act implementation and primarily relies on data from county behavioral health departments and the Judicial Council.
- The report includes performance indicators and demographic information to support disparity-reduction efforts.
- RAND's independent evaluation will produce two reports, one preliminary report due at the end of this year and a final report in 2028, using a broader range of evaluation methods and research questions.

Olin provided context for the upcoming 2026 CARE Act Annual Report:

- The 2025 annual report covered the first nine months of implementation and included only the seven Cohort 1 counties and Los Angeles County.
- The 2026 report will include all counties statewide, representing approximately 21 months of implementation for Cohort 1 counties, 19 months for Los Angeles County, and about seven months for the remaining 50 counties.
- Data reflected in the report remains approximately one year behind current implementation.
- Legislation that took effect on January 1, 2025 significantly expanded county reporting requirements, including new data points on outreach and engagement efforts for petitioned and referred individuals.
- The report will include newly required information on service access between petition and first disposition, eligibility determinations, and referrals from key system partners, with approximately six months of data available for these newer reporting areas.

Olin reviewed county reporting progress on data points pertaining to petitioned individuals, CARE inquiries, and system referrals, noting that reporting capacity has improved over time:

- Counties showed stronger reporting performance over time, with fewer reporting gaps related to system, process, or workflow issues.
- Cohort 1 counties demonstrated greater reporting progress than Cohort 2 counties, reflecting their longer implementation period.
- All 58 counties reported on petitioned individuals, although nine counties reported receiving no petitions as of June 2025.
- 53 counties reported CARE inquiry data, with 18 reporting no CARE inquiries.
- 56 counties reported system referral data. Approximately half reported receiving no referrals from MIST, FIST, AOT, or LPS facilities as of June 2025.

Deputy Secretary Welch praised counties for their significant improvement in data reporting and thanked HMA for their technical assistance. She acknowledged the substantial effort required to collect and submit the data and expressed appreciation for everyone's hard work.

Olin acknowledged the significant volume of data counties are required to collect and report and emphasized the importance of understanding the limitations of a new and evolving initiative. She encouraged stakeholders to view the upcoming findings within the context of data quality challenges, reporting requirements, and implementation timelines.

Olin reviewed several data quality issues and key challenges that impacted county reporting:

- The revised CARE Data Dictionary, which incorporated new statutory reporting requirements, was not released until February 2025, requiring counties to adapt quickly and, in some cases, retrospectively report on new data elements.
- Missing and unknown data were not evenly distributed, with greater reporting challenges among individuals served outside CARE Court jurisdiction and in areas such as substance use disorder data, housing status, and inpatient stays.
- Cohort 1 counties demonstrated stronger reporting capacity and greater improvements in data quality, suggesting similar progress is likely as Cohort 2 counties gain more implementation experience.
- Due to reporting, processing, and quality assurance timelines, the report reflects a snapshot of early implementation and should not be viewed as a measure of current operations or overall program effectiveness.

Olin provided a preview of several new additions to the 2026 CARE Act Annual Report, noting that while the structure remains similar to the first report, the expanded data will offer a more comprehensive view of CARE Act implementation across the state:

- The report will include additional information on petitioned individuals referred to county behavioral health, reasons for dismissals, and expanded data on outreach, engagement, and services provided before petition disposition.
- New trend data will examine services and supports received while participants are on a CARE plan or agreement, along with outcomes such as graduations, reappointments, and exits from the CARE process.
- New sections will focus on system referrals and CARE inquiries, including referral to petition conversion rates, outreach efforts, reasons petitions may not be filed, inquiry sources, and county responses.
- The report will expand disparity analyses by examining county variation, petitioner type, and demographic differences among petitioned individuals to better understand factors influencing CARE Act implementation.

Olin concluded that the 2026 report will provide a richer and more detailed picture of statewide CARE Act implementation and thanked counties for their continued efforts to collect and submit data.

Q&A

Monica Morales asked whether additional data points, including housing, medication adherence, and peer supports, would also be captured.

- Olin responded that the report will include trends in access to services and supports provided through CARE agreements and CARE plans, including medications, social service supports, behavioral health treatments, and other related services.

Deputy Secretary Welch discussed plans for reviewing the annual report before the August meeting and asked whether the ad hoc Data workgroup would have an opportunity to review it in advance.

- Linkins noted that it would be unlikely that the group could preview the report before its release.

- Deputy Secretary Welch recommended providing members at least a week to review the report before the August Working Group meeting so they could come prepared with questions and engage in a more meaningful discussion.
- Olin agreed with the recommendation and noted that DHCS will release the annual report in July, giving members approximately a month to review the report before the August presentation and discussion.
- Deputy Secretary Welch suggested that the Data group meet in July to review the annual report in advance and develop a deeper understanding of its findings before the August meeting. She noted that this would help support a more informed discussion for members who may not have time to review the full report. Linkins agreed to coordinate the effort.
- Hennemann added that the Data group had previously conducted initial reviews and provided early feedback to help jump-start broader group discussions, and said a similar approach would be beneficial.

Dr. Belford-Saldana suggested examining whether individuals had received county behavioral health or Medi-Cal services before a CARE petition was filed. She noted that many individuals in AOT or CARE have no prior service history and suggested this information could help explain when diversion to services outside the CARE process might be appropriate.

- Olin agreed and said that the data is not included in the annual report but that related analyses using claims data may be underway.
- Linkins added that the state put out a survey completed by 26 counties, including San Bernardino, to capture this information. She noted that site visits and survey findings suggest CARE is helping identify individuals who were previously unknown to county behavioral health, an important part of the broader CARE story.

Brenda Grealish clarified that in relation to data points on medication, medication adherence is distinct from being prescribed medication or filling a prescription. She emphasized the importance of distinguishing actual adherence from prescription and claims data when interpreting the findings.

Jodi Nerell of Sutter Health asked whether counties would have an opportunity to incorporate findings from the Annual Report or from RAND into their Behavioral Health Services Act three-year planning process, given the timing differences between the release of the reports and counties' current planning efforts.

- Deputy Secretary Welch said the timing of the reports may not align with counties' current Behavioral Health Services Act planning cycle but agreed that using RAND learnings in future planning efforts makes sense. She noted that the integrated plan process encourages counties to use data to support planning decisions, including CARE data, survey findings, evaluation results, and local county analyses. However, she clarified that the upcoming report will not be available in time to inform current planning efforts and will not include county-level findings.
- Olin added that the data are not yet sufficient to support county-specific analyses in this year’s report.

Linkins transitioned the discussion to the presentation from RAND, and reiterated the distinction between the DHCS annual report and RAND's evaluation.

RAND Presentation

Labriola shared that she would provide a high-level overview of RAND's preliminary report, including key findings and methods, and reviewed the process and components of the independent evaluation:

- Today's presentation will cover an overview of the evaluation, including data sources, methods, key findings from the preliminary report, and next steps.
- RAND's evaluation maintains consistent approaches focused on documenting the theory of change, assessing implementation, evaluating outcomes and impact, and identifying lessons learned and recommendations.
- RAND is responsible for producing two reports, an interim report currently being finalized and a final report at the end of the evaluation period in 2028.
- The findings shared today represent a broad summary, with more detailed information forthcoming in the full report.

Labriola reviewed RAND's evaluation approach and methods:

- The logic model remains unchanged and lays out key implementation outcomes of interest, including service utilization, hospitalizations, arrests, and incarceration.
- Seven core questions guide the evaluation, supported by mixed methods including interviews with staff, participants, petitioners, analysis of administrative data, and an upcoming survey not yet fielded.
- Qualitative data is drawn from a sample of 12 counties representing variation in geography, population size, and implementation cohort, supplemented by state-level interviews with representatives from DHCS, HMA, CalHHS, and the Judicial Council.
- Quantitative analyses draw on multiple administrative datasets with differing timeframes, including CARE Act data (Oct 2023–June 2025), Medi-Cal claims (Jan 2022–Jan 2026), and substance use treatment records (Jan 2018–Jan 2026), with analysis comparing pre- and post-petition outcomes.
- At the time of reporting, qualitative data collection had been completed in five counties: San Mateo, San Diego, Stanislaus, Alameda, and Los Angeles, along with state-level interviews.

Deputy Secretary Welch noted some confusion between the interim report and the longer-term evaluation report.

- Labriola clarified that the findings being discussed are from the interim report, with a separate final report to follow in 2028 that will include updated data, learnings from additional qualitative interviews, and the survey findings. She noted that the current interim report includes outcomes on mental health service utilization, medications, housing, substance use treatment, emergency department visits, and inpatient stays.

Labriola presented findings on county readiness to implement the CARE model, drawing on qualitative interview data from multiple implementation partners:

- Implementation required extensive cross-sector collaboration and trust-building among behavioral health departments, courts, public defenders, service providers, and individuals with lived experience.
- Counties reported that 6 to 12 months of planning time was important, though many still experienced staffing and interagency coordination pressures leading up to and following launch.
- Counties leveraging existing AOT or collaborative court infrastructure had a relative advantage but still needed to adapt systems to meet CARE requirements.
- Implementation required development of new workflows, templates, and notification systems across implementation partners to operationalize the CARE Act.
- Community engagement was consistently identified as a critical component of successful implementation.

Labriola provided findings regarding the petitioning process and trends among petition sources, respondent demographics, and petition outcomes:

- The CARE petition process was described by all petitioner types as more labor intensive in practice than it appears on paper.
- Administrative data showed an increasing share of petitions from professional pathways, reflecting growing awareness of CARE among service providers, alongside a continued flow of family-initiated petitions.
- Eligibility determinations were shaped by engagement, ability to locate individuals, and alignment between individual needs and available resources.
- Counties leaned toward favoring CARE agreements over plans. CARE agreements were generally preferred for supporting participant ownership and engagement, while CARE plans were sometimes viewed as a last resort with limited enforcement mechanisms and lower buy-in.
- Analysis of county data indicated Black individuals were represented at higher rates and Hispanic individuals at lower rates compared to several reference populations.

Labriola shared findings on factors influencing CARE effectiveness and perception, drawing on interviews and Medi-Cal claims data:

- Implementation partners described CARE as effective for filling gaps between levels of care, providing more support than voluntary outpatient services alone without the level of restriction of conservatorship.
- Many implementation partners noted meaningful impacts for participants and families in the CARE process.
- Views on the court's inability to compel treatment were mixed, seen by some as protecting rights and supporting trust, while others viewed it as limiting effectiveness for higher-need individuals.
- Community perceptions often framed CARE incorrectly as a pathway to conservatorship, shaping both strong support and strong opposition, and complicating family understanding of the process.

- The “black robe effect” was viewed differently across interviewees, with some citing improved accountability and others noting concerns about intimidation or confusion in court settings.
- Medi-Cal claims data showed increased engagement in outpatient mental health services, medication use, and housing stability among CARE participants, alongside decreases in homelessness and institutional placement.

Labriola discussed findings on whether CARE participants increased engagement in services, drawing on both qualitative interviews and claims data:

- Implementation partners reported increased engagement in outpatient and supportive services, particularly among active CARE participants supported through intensive outreach and connection efforts.
- Stronger engagement was most notable in outpatient service utilization among active participants.
- Claims data showed increased hospitalizations in the months immediately before and after petition filing, suggesting a crisis period.
- Hospitalization rates declined approximately six months after petition, indicating reduced acute service use over time.

Labriola reviewed findings on whether access to services through CARE is equitable, drawing on interviews and available comparative population analyses:

- Some implementation partners reported observing bias directly in local trends, though most were not systematically tracking data to measure inequities and some noted low counts made detection difficult.
- Interviewees expressed caution about drawing strong conclusions from small numbers and limited implementation-level tracking of disparities.
- Comparative analyses indicated racial and ethnic differences in CARE participation, consistent with earlier findings across similar reference populations.

Labriola shared findings on whether CARE participants experienced increased recovery and empowerment.

- Partners reported gradual improvements in recovery, including gains in stability, communication, confidence, and self-awareness.
- Participants were generally viewed as having improved health, stability, and satisfaction with services.
- Key barriers included system distrust, medication reluctance, housing challenges, and difficulty with engagement and community reintegration.

Labriola noted that the evaluation research question on whether CARE participants experienced increased mental health recovery and empowerment equitably could not yet be fully answered due to current data limitations. She added that the final report will incorporate additional data sources, updated information, survey results, and continued interviews to more fully address all seven evaluation questions.

Labriola outlined next steps for the RAND evaluation, noting that the interim report was submitted to DHCS on May 1 and is undergoing multiple rounds of review before being submitted to the Legislature in December 2026. She added that qualitative interviews will

continue with additional counties, participant and petitioner surveys will begin in June, and interviews with participants and petitioners will follow later in the summer. Quantitative analyses will also continue. The final RAND report is due to DHCS in September 2028, with submission to the Legislature expected in December 2028 after additional review cycles.

Labriola concluded her presentation by introducing Nicole Eberhart and Stephanie Brooks Holliday, Co-Principal Investigators with RAND, who would support the Q&A discussion. She noted that the team works closely with DHCS Quality and Population Health Management (QPHM) and provided contact information.

Q&A

Linkins opened the floor for Q&A

Deputy Secretary Welch thanked the presenters and noted that, since the original evaluation design, additional data sources may now be available, including data collected through the BHSA integrated plan process. She asked whether DHCS had discussed updating the evaluation's data sources to incorporate these additional inputs.

- Labriola noted that the team has primarily focused on data sources included in the original evaluation plan but acknowledged the suggestion and indicated they would follow up with DHCS to discuss incorporating any additional available data.

Deputy Secretary Welch emphasized the importance of including peers and other implementation partners in interviews and surveys. She also noted the sensitivity of collecting participant experiences, stating that even after graduation these topics can be difficult to discuss. She asked how the evaluation team is addressing these sensitivities in a responsible way when capturing information.

- Eberhart clarified that interviews include peers, while surveys are more targeted, including a brief petitioner survey and a broader mandated survey of CARE participants. She described a multi-step outreach approach led by the survey research team, noting engagement challenges due to respondents' geographic instability and hesitancy. Their strategy includes advance notice through county teams, email and mailed letters, followed by phone outreach and, in some counties, in-person engagement by experienced field staff. She noted that the contact information they have for respondents is incomplete, which limits the sample, but multiple follow-ups are planned to build familiarity and trust and encourage participation.
- Brooks Holliday noted that qualitative interviews include peers in professional roles at the county level, as well as peers from state-level and advocacy groups, along with individuals who have gone through the CARE process in the 12 study counties. She explained that recruitment for participant interviews will be conducted through county partnerships, while surveys will use available contact information to reach a broader participant population. She added that interviews are designed to be flexible and responsive to potential participant distress, with the ability to adjust questions or stop at any time, and noted that members of the qualitative team include clinical psychologists and community-facing practitioners.
- Deputy Secretary Welch suggested an offline conversation to better understand the interview selection process and noted that the approach appears labor intensive,

emphasizing the importance of considering appropriate support or recognition for participants' time.

Deputy Secretary Welch requested clarification on elements of the evaluation logic model.

- Labriola clarified that the red boxes in the logic model represent the items included in the current interim report based on available qualitative and administrative data, while non-highlighted items will be addressed in the final report once additional data sources, including the survey, are available. She explained that the model flows from the seven evaluation questions on the left through CARE strategies and implementation activities to implementation outcomes and then key outcomes, such as the three-legged stool, ED visits, and hospitalizations, which appear in the far-right column.

Deputy Secretary Welch thanked the presenters for the clarity and noted that the two-part evaluation was intended to support actionable recommendations for improving CARE implementation. She emphasized the importance of equity and disparities as a focus of the RAND evaluation and asked what types of recommendations may be included to support continued implementation improvements.

- Labriola noted that the report includes a structured set of recommendations, primarily outlined in the executive summary, linking key findings to corresponding recommendations and responsible entities. She gave an example of community engagement findings, noting recommendations such as continued investment in community education and efforts to dispel misconceptions, with both counties and the state identified as responsible parties. She added that the report includes approximately 20 recommendations in total.

Linkins shared a question from Jennifer Brya, who asked whether analysis of Medi-Cal claims data could be extended further back than 2022, considering the SUD claims data goes back to 2018, to better capture longer-term patterns.

- Labriola acknowledged the differing time frames as an important question and noted uncertainty about why Medi-Cal claims data begin later than other datasets, indicating the question would be clarified with their quantitative lead.
- Eberhart noted that the team requested Medi-Cal claims data going further back but were not able to obtain it in time for inclusion in the interim report.
- Ye Ji Kim from DHCS responded that SUD claims data was extended back to 2018 to capture longer-term substance use and treatment history for CARE participants. She noted that Medi-Cal claims and eligibility data could potentially be extended further back if needed and indicated DHCS would coordinate with RAND on additional data availability, while deferring to RAND on the methodological approach.
- Eberhart noted that the claims data analysis focused on service utilization and comparisons across similar reference periods, typically examining the year prior to and following key events. She acknowledged the suggestion for further consideration.

Deputy Secretary Welch shared an anecdote from a CARE graduation in Sacramento, describing an individual with multiple prior hospitalizations, incarcerations, and felony and misdemeanor charges who had achieved stability, housing, and medication adherence. She emphasized the importance of longer historical data to fully understand participant trajectories

and assess if the intended impact of CARE is being achieved, while noting the need to balance data collection feasibility with capturing the full scope of outcomes.

- Eberhart suggested developing a more descriptive profile of individuals entering CARE to reflect their longer histories. She distinguished this from pre-post outcome analysis, noting that extending retrospective timeframes could create issues with comparability and missing data. She indicated that the team would consider ways to capture longitudinal participant context separately from evaluation comparisons and would follow up on the best approach.

Linkins noted that the anecdote shared by Deputy Secretary Welch reflected patterns seen across multiple site visits, including individuals with extended periods of homelessness, incarceration, and hospitalization.

Linkins thanked the RAND team for the preview of the upcoming report and emphasized interest in continued discussion.

Training and Technical Assistance Updates

Linkins introduced Collins to present on training and technical assistance (TTA) updates.

Collins provided an update on peer-focused CARE TTA activities, highlighting new resources to support peer integration into county CARE teams and implementation:

- A new county toolkit is available, focused on the integration of peer roles across outreach, engagement, court, treatment, and graduation processes.
- The toolkit includes staffing guidance on recruitment, retention, supervision, and peer career pathways within CARE roles.
- Companion resource tools support hiring and onboarding, including job descriptions and interview questions, and examples of partnerships with local peer organizations.

Collins acknowledged Working Group contributors including Keris Myrick, Bill Stewart, and Khatera Tamplin, as well as peer support specialist Edward Poche from Sacramento County, and Painted Brain for their contributions to the resources. She noted that the toolkit and companion materials are available on the CARE Act Resource Hub.

Collins summarized recent technical assistance activities since February, noting continued monthly office hours focused on county-to-county learning and collaboration:

- Topics included preparing CARE participants for court, whole-person care supports, and leveraging resources available through Medi-Cal managed care organizations, including enhanced care management and community supports benefits.
- Additional sessions addressed hospital and LPS facility referral and petition processes to strengthen coordination and improve consistency across system partners.
- Training updates included eligibility guidance reflecting SB 27 changes and ongoing support for graduation planning, identified as key areas of need for counties.

Collins highlighted additional CARE resources, including a video on the volunteer supporter role narrated by Tristan from Painted Brain, paired with a discussion guide to support CARE participants and potential supporters. She also noted ongoing technical assistance to counties

and stakeholders through regular communications and newsletters, which feature examples of county successes such as referral pathway development in Ventura, a graduation in Kern County, and a recent video released by Merced County.

Collins outlined upcoming Quarter 2 activities, including guidance on collaboration across the housing continuum, clarification on ACT and FACT models in relation to CARE, and continued engagement with the Department of State Hospitals to improve understanding of referrals and operational processes.

- Ongoing office hours on data collection and reporting will continue on a biweekly basis.
- Upcoming trainings include psychiatric advance directives (PADs), developed with Painted Brain, along with updated guidance on administrative claiming and justice system partner collaboration.
- Data collection and reporting trainings will incorporate Data Dictionary revisions and updates related to the annual report.

Collins concluded her presentation.

Q&A

Morales asked whether the trainings are being recorded, with specific interest in the administrative claiming training.

- Collins confirmed that a training is already uploaded and is being refined into a more detailed “how-to” format, alongside an updated brief outlining CARE administrative claiming requirements. She noted the session will focus on internal tracking of claiming activities using a worksheet tool, addressing common county challenges, and confirmed the training will be recorded and uploaded.

Rettagliata asked whether family coordinators are being integrated into the CARE process, noting that families often benefit from coordinated support and that some individuals involved in petitions are receiving services in private hospital settings where family coordinators are already in place. She emphasized the potential role of family coordinators in supporting communication, guiding families, and improving coordination with counties, and raised concerns that counties may not always be aware of these supports.

- Collins noted that resources are available on the resource hub aimed at supporting the family member role in CARE, including a robust guide and training, and welcomed additional input.
- Rettagliata asked whether these materials were shared with NAMI affiliates.
- John Freeman with Desert Vista Consulting noted that NAMI California has made digital binders available to counties and has also developed materials that incorporate content from HMA resources. He added that NAMI is aware of HMA-produced materials and is sharing them with affiliates, though there may be a need for a refreshed effort to ensure continued awareness and distribution.
- Collins suggested a review of the materials to identify any gaps in guidance, emphasizing that the resources are intended to support the different ways family members can participate in CARE, including as possible volunteer supporters.

- Rettagliata noted that individuals working with family coordinators in hospital settings may not be fully aware of NAMI's resources, and indicated she would follow up with NAMI to better understand how these resources are being distributed and shared with affiliates.

San Bernardino County Implementation Update: Data, Outcomes, and Best Practices

Dr. Alyce Belford-Saldana, Deputy Behavioral Health Director, San Bernardino County Behavioral Health

Linkins introduced Dr. Alyce Belford-Saldana, Deputy Behavioral Health Director for San Bernardino County Behavioral Health, who presented to the group on CARE implementation in San Bernardino. She thanked Susan Holt of Fresno County and partners in Alameda, Orange, and Riverside Counties for their ongoing collaboration and assistance.

Dr. Belford-Saldana noted that her presentation was developed in February and does not include the most recent updates. She described the extensive planning and collaboration involved in San Bernardino's early implementation:

- State implementation resources and technical assistance provided significant support throughout the process.
- Planning efforts included close collaboration across multiple county agencies and partners who met regularly to develop petition workflows, forms, and service pathways.
- Key implementation partners included the courts, public defender, probation, public guardian, hospitals, law enforcement, and outreach teams. Legal Aid joined later in the implementation process, creating some initial alignment challenges.
- Ongoing collaboration has strengthened partnerships and improved implementation efforts.
- Implementing a standardized process across a 20,000-square-mile county with multiple court locations required ongoing coordination and flexibility.
- CARE launched in San Bernardino in December 2024, with the first petition received in January 2025. Court operations have since expanded from one day to two days per week.
- Regular collaboration among Department of Behavioral Health (DBH), County Counsel, Legal Aid, and the court supports case planning and court preparation.
- Court partners increased access and awareness through a mobile court van and self-help kiosks in rural communities.

Dr. Belford-Saldana outlined San Bernardino County's service delivery model for CARE participants:

- CARE participants are connected to established county programs, with engagement teams playing a central role in outreach, trust-building, and connecting individuals to court and services.
- The county shifted portions of its engagement model to contracted community-based organizations under BH CONNECT while continuing to directly provide intensive case management support.

- Ongoing collaboration with courts, Legal Aid, and other justice partners helps refine referral pathways and improve participant engagement.
- Multiple behavioral health, housing, crisis, outreach, and residential programs support CARE participants, including specialized teams embedded with law enforcement and community response programs.
- Innovative outreach approaches and multidisciplinary teams help engage individuals who are difficult to locate or connect with services.
- The county is transitioning toward ACT-level services and developing a dedicated team to prioritize CARE referrals, requiring significant administrative and service delivery changes.

Dr. Belford-Saldana discussed lessons learned during the first year of CARE implementation:

- 76 petitions have been received to date, indicating an increase in monthly volume compared to the first year of implementation.
- One key step in increasing volume was addressing clinicians' reluctance to file petitions, shifting the view of CARE petitions from a last resort to a tool that promotes engagement, accountability, and service coordination.
- Strong partnerships with the Department of State Hospitals (DSH), Department of Corrections and Rehabilitation, and regional providers have improved referral processes, care coordination, and transitions for eligible individuals. Most referrals have originated from the Department of State Hospitals.
- Conversations following Governor Newsom's letter prompted cities across the county to become more engaged and seek opportunities to support ongoing CARE implementation and petition filing.
- The county is providing CARE Act and petition process training to city partners and developing workflows to streamline referrals and petition submissions.
- Internal trainings have also been launched for behavioral health staff, including psychiatry teams, to increase awareness and encourage appropriate use of CARE Act petitions.

Deputy Secretary Welch acknowledged that behavioral health systems have long focused on outreach, engagement, and meeting people where they are. She noted that the CARE process provides the additional support, structure, and accountability that some individuals need to successfully engage in services. While not appropriate for everyone, she suggested that many providers can think of specific individuals from their experience for whom that extra layer of support and accountability could have made a meaningful difference.

Dr. Belford-Saldana agreed that the primary value of the CARE process is not necessarily a "black robe effect." Instead, she noted that CARE participants often become empowered once they understand the process and realize they have a voice and a choice in their care. She emphasized that, unlike many collaborative court models, CARE is truly participant-centered, allowing individuals to play an active role in decisions about their services and goals.

Deputy Secretary Welch agreed, noting that participants act as the "CEO of their CARE plan," with the court process providing support, accountability, and a structure that helps ensure their goals and choices guide service planning and delivery.

Dr. Belford-Saldana connected Deputy Secretary Welch's comments on the value of CARE to the ongoing RAND independent evaluation. She suggested that if RAND focuses on questions centered on empowerment and participant choice, compared to questions focused on the black robe effect, a different story of value could be explored. She emphasized that CARE may be better understood through the ways participants feel supported, heard, and empowered in directing their own care.

Dr. Belford-Saldana continued her presentation and discussed key implementation challenges and lessons learned, highlighting efforts to improve outreach, housing coordination, family engagement, and cross-system collaboration:

- San Bernardino's large geography has made participant engagement and follow-up difficult across the county's large service area. To navigate this challenge, the county embedded teams in underserved regions to improve access and outreach.
- Departments are collaborating to build a more coordinated housing continuum and expand housing inventory.
- Family education and support remain critical when participants choose to decline services.
- Greater coordination is needed with neighboring counties as participants frequently cross county lines.
- Conservatorship step-down processes need to be further refined to prevent financial and service challenges for participants.
- Interagency care coordination and bureaucratic processes can delay service delivery and require ongoing streamlining efforts.
- Partners recognized the need for better communication and tracking of outreach activities across systems.

Dr. Belford-Saldana highlighted a recent community-based engagement event:

- A recent Joshua Morongo outreach event drew 37 community members.
- The event resulted in the filing of a CARE petition and a same-day prima facie determination through the mobile court unit.
- Legal Aid, Superior Court staff, judicial officers, outreach teams, and Self-Help Center staff participated in the event. Community partners, including the Joshua Tree City Manager's Office and High Desert Medical Center, were also represented.
- DBH provided mobile behavioral health and substance use disorder services on-site.
- The county identified food banks and other community resources as important partners for future outreach events.

Dr. Belford-Saldana emphasized the many behavioral health initiatives currently underway and the opportunities to align CARE Act implementation with broader system transformation efforts. She expressed optimism about the future of behavioral health and the lasting impact these changes will have on service delivery.

- CARE is being integrated with initiatives such as CalAIM, BHSA, BH CONNECT, and justice-involved programs.
- The county views these efforts as opportunities to strengthen coordination across systems and services.

- Expanding outreach to cities, hospitals, and community partners has been a major focus.
- A key lesson learned was the need for greater training and education for internal staff.
- The county is working to increase understanding that CARE petitions can be a supportive tool and align with engagement-focused practices.

Dr. Belford-Saldana concluded by noting ongoing efforts to strengthen community partnerships, address system alignment issues, and expand training:

- Collaboration with local NAMI is being explored, with plans to expand their role through technical assistance.
- SUD services within BHSA were identified as not consistently recognizing CARE Act participants as a priority population, creating a gap in coordination and access.
- Strong emphasis was placed on the need for continued training to better integrate behavioral health and legal teams within court settings.

Q&A

Linkins opened the floor for questions

Irvine thanked Dr. Belford-Saldana for her presentation and asked for clarification on the data slide, specifically why dismissals are broken down into unable to engage and unwilling to participate, and what nuance distinguishes the two categories.

- Dr. Belford-Saldana explained that unable to engage refers to individuals who could not be located or could not be successfully connected despite outreach attempts, while unwilling to participate refers to individuals who were contacted but declined to move forward with the court process, though some may still be open to engaging in services outside of CARE.

Dr. Hurley shared that the upcoming American Society of Addiction Medicine (ASAM) criteria 4th edition will require co-occurring capability as a core component of substance use treatment. He emphasized that counties need to invest in program capacity, noting that challenges arise when systems rely on licensed clinicians and integrated assessments without clearly structured clinical program supports.

- Dr. Belford-Saldana emphasized the complexity of building fully integrated care teams, noting that while SUD counselors have long been part of county FSP teams, the current requirements involve a much deeper level of integration. She highlighted ongoing challenges around federal privacy rules, billing structures, and information sharing across systems. She also noted efforts to incorporate standardized tools within ACT development and to align procurement processes so CARE participants are identified as a priority population. She further explained the need to streamline assessments within electronic health records to avoid duplicative processes.

Deputy Secretary Welch asked Ivan Bhardwaj where additional support or resources might exist to advance SUD and mental health integration, noting that this need is consistently raised during site visits. She asked whether BH CONNECT and BHSA training resources could serve as a foundation or whether there are other centers of excellence or supports that counties could leverage to strengthen integrated care capacity.

- Bhardwaj responded that centers of excellence are typically organized around specific evidence-based practices, such as FACT or other community treatment models, and they do address co-occurring disorders within those frameworks. However, he noted that there is not currently a single comprehensive center of excellence focused broadly on large-scale behavioral health integration. He added that a consolidated list of existing resources could potentially be developed to support counties in accessing relevant guidance and information.
- Deputy Secretary Welch noted that she will continue to reflect on the issue, emphasizing a responsibility for high-touch involvement in advancing behavioral health integration and committing that the group would continue working on it collaboratively.

Linkins concluded the discussion.

Fresno County Implementation Update: Data, Outcomes, and Best Practices

Emma Rasmussen, Deputy Director, Fresno County Department of Behavioral Health

Dr. Emma Rasmussen, Deputy Director of the Fresno County Department of Behavioral Health, introduced herself. She shared appreciation for Dr. Belford-Saldana's presentation, noting commonality between the two counties in their CARE implementation journey. Having now operated CARE for a year and a half, Fresno has encountered many of the same lessons and challenges discussed by Dr. Belford-Saldana.

Dr. Rasmussen provided context on Fresno County and their approach to CARE implementation:

- Fresno County spans approximately 6,000 square miles and serves a population of just over one million residents, with 51% enrolled in Medi-Cal.
- In 2025, the county served more than 30,000 individuals through behavioral health services.
- As a large county with many rural communities, Fresno has gained valuable insights during its first year and a half of CARE Act implementation.
- Fresno has prioritized extensive community outreach and education, recognizing early the need to revisit and reinforce messaging as implementation progressed.
- The county used a variety of educational approaches in the lead-up to launching CARE, including virtual, in-person, small-group, and large-group presentations, and developed recorded trainings for ongoing staff education.
- County outreach efforts included engagement with law enforcement, hospitals, LPS facilities, internal access teams, and local colleges, helping identify community knowledge gaps and strengthen awareness of the CARE Act.

Dr. Rasmussen described Fresno County's first year of CARE Act implementation as a period of learning, data-driven improvement, and course correction. Before its site visit and ICU designation, the county had already identified challenges and begun implementing changes to strengthen program performance. She shared that Fresno County used its 2025 data to identify implementation gaps and establish priorities for 2026. The findings informed targeted outreach, education, and partnership efforts to strengthen CARE Act referrals and engagement.

Dr. Rasmussen outlined the following details on the county's improvement efforts:

- Fresno launched an internal review of eligibility and dismissal trends, with weekly data reviews that helped identify common reasons for dismissals.
- Analysis showed a lack of referrals from internal behavioral health teams, highlighting the need for additional staff education and engagement.
- Referrals from LPS facilities were minimal, helping the county identify additional outreach opportunities.
- Law enforcement submitted the county's first four petitions, but referrals later declined. Discussions with law enforcement revealed their uncertainties about participant outcomes and the referral process.

Dr. Rasmussen reported significant improvements in 2026, stemming from the learning that successful implementation requires effective analysis, ongoing collaboration, problem-solving, and support beyond public education and one-time trainings.

- Collaboration with the Department of State Hospitals (DSH) and the Department of Corrections has improved communication, care transitions, and referral processes.
- Internal referrals increased after staff were engaged in discussions that addressed concerns, clarified roles, and improved accountability.
- Fresno worked closely with its conservatorship team to develop workflows and build confidence in making CARE Act referrals.
- Referrals from facilities increased from one in all of 2025 to 18 by the second quarter of 2026.
- Direct engagement with frontline staff proved more effective than relying solely on leadership-level presentations. Ongoing communication, training, and feedback helped providers better understand eligibility requirements and improve referral quality.

She highlighted how Fresno County's 2026 data reflects the impact of targeted outreach and process improvements. Comparing a few months of 2026 to all of 2025, the county has already seen meaningful increases in referrals and engagement:

- Internal referrals increased from zero in 2025 to three in early 2026, demonstrating greater staff awareness and confidence in the CARE Act.
- Family outreach and discussions about CARE Act resources contributed to increased community awareness and inquiries.
- Fresno received its first self-petition from a CARE respondent, marking an important milestone in program engagement.
- Referrals from LPS facilities increased significantly, reflecting the success of targeted education and outreach efforts.
- Fresno County is preparing for its first CARE Act graduation, highlighting strong collaboration among partners and a shared commitment to participant success.

Dr. Rasmussen outlined Fresno County's projected 2026 petition numbers, noting a forecasted year-end total of approximately 130 petitions.

- Fresno recorded 25 petitions in Q1 and 15 so far in Q2, with expectations of reaching 30 petitions by the quarter's end.
- The county projects 35 petitions in Q3 and 40 in Q4 based on the current trajectory.

Dr. Rasmussen emphasized key implementation pivots that improved access, participation, and system responsiveness. Early lessons showed the need to adapt CARE processes to meet participants where they are, reduce barriers, and strengthen coordination across providers and other partners.

- Fresno implemented a virtual court option to reduce anxiety barriers and improve participation for individuals unable to attend in person.
- Contracted provider DART West supported flexible court access, including virtual participation, office-based options, and field-based engagement.
- Transportation support was added to address rural access challenges and reduce delays for participants traveling to court.
- Initial court appearance incentives included a welcome backpack with basic necessities and participant-selected gift cards to encourage engagement.
- Housing capacity was expanded through Behavioral Health Bridge Housing partnerships.

Dr. Rasmussen described Fresno County's development of structured workflows with its conservatorship teams to better integrate CARE consideration into step-down planning.

- Fresno is aligning deputy conservators and community teams to improve coordination during LPS step-down planning from locked facilities to community placements, including planning for transitions to CARE.
- Current priority work centers on strengthening conservatorship team processes, particularly for determining appropriate step-down decisions.
- Future CARE reporting is expected to reflect increased LPS to CARE referrals as workflows are fully implemented.

Dr. Rasmussen concluded her presentation by emphasizing that Fresno County's progress has been driven by sustained collaboration across partners and consistent engagement over time, allowing challenges to be addressed quickly and collectively. She also highlighted the county's growing emphasis on using data not just for reporting, but for understanding the story it tells and using those insights to guide ongoing improvements and system changes.

Linkins congratulated Dr. Rasmussen and her team on their work before opening the floor for questions.

Q&A

Amber Irvine thanked Dr. Rasmussen for the presentation and asked about Fresno's relatively low percentage of family petitioners compared to San Diego. She asked whether the county has considered additional strategies to engage and involve families.

- Dr. Rasmussen responded that Fresno County has a strong relationship with NAMI but recognizes the need to further strengthen family engagement. She invited ideas on strategies that have worked in other counties to better reach and involve families.
- Irvine suggested expanding outreach through community library presentations. She also praised Fresno's court incentive approach using gift cards, noting its alignment with contingency management, and expressed interest in adopting a similar model. She asked for more information on Fresno's bridge housing sites.

- Dr. Rasmussen explained that bridge housing is a time-limited shelter model, but Fresno County begins immediate transition planning upon entry to move participants into more permanent housing. While stays are limited, extensions can be made to support successful placement. She added that some participants leave earlier than expected, often transitioning to family homes or independently securing housing while awaiting longer-term options.

Brenda Grealish commended Dr. Rasmussen and Dr. Belford-Saldana for their presentations and acknowledged the complexity of the work. She highlighted the challenges families face navigating systems and emphasized the importance of identifying barriers as a first step toward solutions.

Susan Holt shared appreciation, expressing pride in Dr. Rasmussen and the Fresno County team's dedication and passion. She thanked partners for highlighting and celebrating county efforts, noting that recognizing the work of staff and allowing them to shine is one of the most meaningful aspects of her role as Behavioral Health Director.

Deputy Secretary Welch commended the counties for their transparency and commitment to continuous improvement, noting the importance of openly reviewing data to support real-time adjustments. She highlighted their significant progress achieved in a short period and emphasized the value of technical assistance efforts, including development of toolkits such as those supporting LPS step-down processes.

- James Kwon from the Los Angeles Office of the Public Guardian shared comments on LPS step-downs, noting that individuals in conservatorship or institutional settings represent a key opportunity for structured transition planning given the availability of complete clinical information. He emphasized that while these care transitions may appear straightforward on paper, they require careful coordination to avoid creating additional trauma for individuals stepping down. He also highlighted feedback from Public Guardians expressing interest in boosting CARE Act referrals, while noting barriers such as limited CARE team capacity and unclear referral pathways, underscoring the need for clearer guidance and stronger coordination between CARE teams and conservatorship systems.

Dr. Hurley emphasized the importance of innovation and person-centered approaches in CARE Act implementation. He highlighted broader system challenges, particularly the limited access CARE participants often have to substance use disorder services within the DMC ODS system of care, and the difficulty of integrating specialty mental health and substance use treatment in practice. He underscored workforce and billing constraints as key barriers and suggested the need for clearer county guidance on how to better connect and integrate specialty mental health and SUD services to improve access and care coordination for this population.

- Deputy Secretary Welch asked for clarification on how specialty mental health teams serving CARE participants can incorporate medication assisted treatment within their clinical practice and service delivery.
- Dr. Hurley clarified he was referring to medications for addiction treatment and broader evidence-based SUD practices, and asked how specialty mental health teams can incorporate these into CARE participant care.

Dr. Kate Warburton emphasized the need for true integration of substance use, primary care, mental health, peer support, intensive case management, and legal services, noting that while counties understand the value of an integrated model, funding and billing structures do not fully support it. She recommended that 2026 priorities focus on helping counties develop sustainable financing approaches aligned with BHSA and BH CONNECT, particularly to support individuals with complex needs transitioning from conservatorship or state hospitals.

Kwon raised concerns about the complexity of co-occurring substance use and mental health needs among individuals stepping down from conservatorship, noting that a significant portion may still be actively using substances, which can contribute to recurring system involvement. He asked whether counties are tracking detailed care coordination and discharge planning data from hospitals, beyond referral counts, to better understand what services and placements are being initiated. He also highlighted ongoing gaps in hospital and facility awareness of CARE referral pathways and emphasized the need for stronger education and coordination with hospitals and statewide partners.

- Deputy Secretary Welch noted that hospitals and systems operating under workforce and reimbursement constraints often face limitations in taking on unfunded responsibilities, which affects implementation. She acknowledged that this remains an unresolved challenge and emphasized the importance of using data to better understand outcomes and costs, including potential cost offsets from CARE participation. She added that the state is interested in working with counties to explore these analyses.
- Kwon asked what alternatives hospitals are using if they are not referring to CARE, and suggested that understanding hospital decision-making could clarify whether CARE may be a more effective long-term option than other pathways such as FSP referrals.

Linkins asked Dr. Rasmussen to elaborate on how Fresno County increased LPS facility referrals, specifically what messaging or engagement strategies helped overcome provider burden and resistance, and what approaches were effective in driving higher petition and referral rates from frontline staff.

- Dr. Rasmussen explained that Fresno's approach focused on helping providers understand the consequences of not referring individuals to the appropriate level of care, including repeated cycling through services. She emphasized shifting the conversation toward shared responsibility for determining the right interventions, including CARE and other options. She described how internal data review, including analysis of billing patterns, helped identify individuals with a history of high service utilization, which prompted cross-team collaboration and improved communication between the county and facilities.
- Linkins shared that trainings have been conducted through the California Hospital Association and related partners, and noted that Dr. Rasmussen's approach reflects the type of more targeted, practical training needed at the local level. She emphasized that the focus should go beyond general petition guidance toward more specific, meaningful problem-solving that directly supports implementation.

Linkins closed the discussion. She noted that due to time constraints, the next agenda item, a discussion of Working Group priorities for 2026, would need to be skipped. She encouraged members to submit comments on priorities for future meetings via email.

Closing Thoughts

Stephanie Welch, California Health and Human Services Agency

Deputy Secretary Welch encouraged Working Group members to reach out at any time with suggestions, questions, and updates, including to share about CARE graduations or other milestones in their counties. She noted the strong work underway across the state, which CalHHS and state partners are not always close enough to capture.

She reiterated the availability of ongoing, responsive technical assistance for counties and other partners. She encouraged counties with technical assistance needs, including follow-up items from the discussion such as using hospital data to identify individuals who could be served through CARE, to reach out via email.

She closed the meeting by thanking everyone for the productive and engaging conversation and expressing appreciation to all participants.

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.

- Melissa Cortez introduced herself as a family member and shared that her brother died in December 2025 while in a restorative rehabilitation setting in Riverside County. She spoke about her brother's experience in the CARE process, which began in May 2025. Cortez said that her brother was a person living with schizophrenia who needed treatment, protection, dignity, and real support. She explained that brother's death involved acute Clozapine intoxication and that to her understanding, he did not have independent access to his medication. Cortez shared that her family's experience raises serious concerns about how CARE is functioning in practice. She said that while it may appear a full care team is in place, in her brother's case it seemed the case manager was the only person trying to do everything while the rest of the system lacked clear coordination, oversight, and accountability. Though he had a public defender and a whole team, there was no clear assignment of responsibility for ensuring concerns were investigated. She explained that he was deemed incompetent by a court psychiatrist, and expressed concerns that this did not result in closer monitoring or stronger safeguards, and that family warnings were not treated as urgent safety concerns. Cortez requested the Working Group examine the gap between how CARE is designed on paper and how it functions for families in crisis. She also requested a review of Riverside County CARE implementation, including how safety concerns are handled, how family warnings are documented and escalated, how medication is monitored, and how responsibility is assigned when multiple agencies are involved.
- Kaino Hopper thanked the group for the work being done and offered condolences to Cortez, echoing her comment about listening to, documenting, and escalating family concerns. She noted a written public comment submitted last week, which was understood to be shared with the minutes. She raised concern about how outcome reporting is framed regarding whether a family agrees to take a person back into their home, emphasizing several considerations for both participants and family members that may impact the appropriateness or feasibility of living at home. She stressed that family

needs and safety requirements must be honored before placement decisions are made. She cautioned that asking whether a person is welcomed home may be a misrepresentation of whether the placement is appropriate, including considerations such as caregiver capacity and age.

- Jann La Pointe, introduced herself as the family liaison at NAMI Contra Costa, a clinician in training, a family member to a person living with schizoaffective disorder, and someone living with invisible disabilities, noting this intersection of lived experience, professional knowledge, and experience supporting families with CARE petitions. She discussed how most pathways to treatment are initiated by mental health professionals, mobile crisis workers, or peace officers, while CARE provides families a pathway to initiate help through a petition and is often perceived by families as the last chance for loved ones to get needed help. La Pointe named two common breakdowns in the CARE process: inability for individuals to engage voluntarily due to high acuity leading to dismissal without referral to a higher level of care, or dismissal due to inability to locate the individual. She referenced the need to address these gaps and noted a prior case involving a young man in San Francisco who died after dismissal from CARE, urging the state engage in a proactive rather than reactive system review. She recommended judges order evaluations under Welfare and Institutions Code 5200 when individuals do not engage voluntarily, stating dismissal without a step-up referral is a failure that endangers individuals and families. She urged improved efforts to locate respondents, noting statutory time limits may be insufficient given the time required for outreach, trust building, and engagement. She asked the group to reexamine gaps in the CARE process so families can effectively help loved ones access care and individuals can receive needed treatment.
- Jay Calcagno, representing the California Behavioral Health Association, explained that CBHA represents community-based behavioral health providers statewide that collectively serve over two million Californians across the lifespan. CBHA supports a vision of continuous improvement of the CARE Act that centers autonomy and dignity of individuals with complex behavioral health conditions and adequately supports providers serving this population. They shared several recommendations for ongoing implementation. First, they urged the standardization of electronic health record documentation requirements across counties to ensure streamlined and efficient processes. Second, they recommended the state provide adequate county support to assist providers with outreach and engagement to CARE respondents. Next, they suggested leveraging the 2026 annual report and preliminary independent evaluation data to improve referral pathways, identify best practices for outreach and engagement, and address barriers to implementation across Cohort 2 and rural and frontier counties with limited data. They also suggested increasing non-English outreach and engagement through translation of materials to reach marginalized and underserved communities. Lastly, they recommended increasing local engagement with behavioral health boards, commissions, and providers.

Linkins thanked all Working Group members and members of the public. She adjourned the meeting and announced that the next meeting will be held on August 12, 2026.

Appendix: Working Group Member Suggestions for Future Meetings Submitted via Email

Comment submitted 5/15/26 by Lauren Rettagliata:

Hi Karen,

These are the pathways to treatment that are part of the CARE Act and the CARE Court proceedings that can be used to help those who need treatment and either do not meet the requirements to use CARE Court or who refuse to accept treatment voluntarily.

Intersection of CARE and Section 5200 / LPS

- Evaluation Order upon Dismissal: Under the California Legislative Information guidelines, a CARE Act petition form allows petitioners to request a Section 5200 evaluation if a respondent is unable or unwilling to participate due to severe mental illness.
- Involuntary Referral Pathway: If a court terminates a person's CARE plan due to non-participation, the judge can use Section 5200 to mandate an involuntary LPS evaluation.
- 72-Hour Evaluation Detentions: When a Section 5200 order is triggered via CARE Court, the respondent is taken to an LPS-designated county facility for a 72-hour treatment and evaluation hold.
- Legal Presumption for Conservatorship: If a person fails to complete their CARE plan and later faces an LPS conservatorship hearing within six months, the court will consider their CARE Act non-compliance as evidence of grave disability. [1, 2, 3, 4, 5, 6]

I am sorry that I have used AI--but it does succinctly make this point.

Getting needed medical and psychiatric treatment for someone because of the very nature of their illness and psychosis cannot volunteer needs to be addressed. Psychosis is deadly both for the person who is in a psychotic state and at times for the loved ones who are trying to care for them. We cannot leave people on the streets or in encampments because it endangers everyone. The toll on our inner cities and rural encampment areas fosters disease. People left in these states are preyed upon by both drug and sex traffickers.

We need a session that asks -- What happens to those who CARE Court cannot reach. Every county that has made a presentation has asked this question?

Please forgive the haste in which I have put this together. I wanted to get this to you quickly as requested.

--Lauren Rettagliata

Appendix: Public Comment Submitted via Email

Comment submitted on 5/5/2026 by Kaino Hopper:

To: CARE Act working Group: 5.13.26: public comment—topic: Family and Peer CARE

Hello Members of the CARE Act Working Group,

I have followed your vital and vivid work since the first meeting in February 2023. Thank you for your collaboration and cooperation as well as for candid sharing of improvements, ideas and parts that are going well.

My letter today is for the topic: Families and Peers in CARE.

I was a CARE Petitioner in June 2025. My Petition was immediately reviewed, met criteria, and outreach workers contacted me on how to find my daughter who was homeless after exiting 18+ months in a branch of the state hospital system for being found incompetent to stand trial. She had refused all of the many re-entry services that would have led to immediate housing and supports like reinstate SSI, apply EBT, attain a phone. This was not who she is typically when she is stable.

During her days on the streets in Sacramento she rejected CARE outreach worker services, but she did accept services from family. I checked with the Sacramento County Behavioral Health Director of CARE Act services and was reassured that any family work would be valued as parallel work that would have been given by CARE workers if they had been able to establish trust.

In the courtroom on Sept 2, 2025, during the CARE Petitioner update time, I mentioned the many hours and types of services delivered by family, and the county director's promise, however, these were not considered because Sacramento County Behavioral Health CARE Act assessment claimed she had accomplished all these events independently. There is currently no allowance for new evidence because the Family Petitioner is not entitled to speak further. Unfortunately, the County Workers did not fact check any of the self-reports, and since our reports differed from our daughter's, she would not allow us to speak.

This is evidence of the condition of anosognosia, documented by her doctors. We knew she was not telling a mis-truth, she firmly believes she is not sick and does not need help, and she believes that asking me to deliver support services is still her doing it herself. She did look good that day, we were proud of her. But, we tried to present the fact that she seemed functioning due to the high level of services family was providing. We tried to point out that we are aging parents, were told to be the bridge of trust and the county would honor our work, and our efforts would not prevent the Petition moving forward. Yet the Petition did not move forward, it ended.

Within weeks she was unhoused, lost CA ID, lost EBT, and SSI was stalled because she would not choose a mailing address, and these sad situations continue today. I filed an AOT referral, met criteria, outreach workers tried to find and build trust, this also failed.

Our family was faced, once again, with the old dilemma of delivering life sustaining care, or do nothing and wait until she completely decompensated. So, I gave up. I have still given up.

She is cycling through Emergency rooms, psychiatric hospitals, streets, and back to emergency rooms. Currently 7 times since late January.

So, my report to you is to hire workers who believe in CARE Act, who have training to look for signs of anosognosia, grandiose thinking, and train them to investigate all self-reports--call them

confirmed reports if you must. The workers need to be treated well, paid well, trained well to do better assessments and to interview anyone in the Respondent's sphere who is delivering any services and to quantify those services as vital ones that prove a need for CARE services, not to use those to say the Respondent is independent, unless there is evidentiary proof.

I add here that in Feb 2023, my daughter publicly spoke in support of CARE Act as a hopeful way to prevent incarcerations like the one she'd just exited. She is a delightful, spunky human when she is stable.

I want to continue to support CARE Act as a step below conservatorship, however, it needs to continue to be improved. My experience is that those implementing it need to believe in the program and have much deeper training if it is going to reach people like my daughter.

With Hope,

Elizabeth Kaino Hopper of Carmichael ekainohopper@gmail.com

Comment submitted on 5/18/2026 by Kaino Hopper:

Hopper Public Comment about CARE Act Working Group mtg 5.13.26/Wednesday 1215 O Street, Sacramento, CA 95814 | Allenby Conference Room 110 /May 18, 2026

Dear Chair Stephanie Welsh, Moderator Karen Linkins, and all Members of the CARE Act Working Group,

Families consistently hear that our connection helps loved ones recover, and most of us are wanting and welcoming to have that connection when the person is stable enough to engage.

So, when I heard at the beginning of the CARE Act Working Group meeting on 5.13.26, a report from a site visit, that a "CARE Respondent exiting a state hospital was ‘not welcomed home’ and then the public defender had to work really hard to secure housing” I decided to write and say how harmful those types of statements are to families and to the Peer who needs housing. It is not the job of families to be the housing. It is not the fault of the Peer if placement in family housing is not the most appropriate to meet their functional daily needs. Securing housing is part of the paid work for discharge planners and other helpers who should be prioritizing the appropriateness of the housing placement by presenting the housing details as separate from family readiness to be welcoming of relationships.

Some family homes are too small or have too many roommates already, some are strapped for income, some have senior citizens whose needs may be a mismatch for the independent needs/desires of the Peer seeking housing. Some may have rules and requirements such as Medication management, Release of Information (ROI), health record sharing that the Peer does not wish to be part of, or even relapse prevention plan requirements. Some families live in areas with no ability to secure a medical transport in a mental health crisis, like Sacramento County, thus unable to secure medical assessments in times of extreme psychosis.

There are a multitude of reasons that housing placement with family has nothing to do with the welcoming home for visits or phone calls or relationships.

It is not OK for CARE Act workers or any behavioral health workers at any level , to say a family is/was unwelcoming because unless it is a direct quote with permission, it is gossip, hearsay, assumption, and stigma. “Nothing about me without me” is also true for families. Please train all workers ask about housing without pressuring, coercing, or stigmatizing, families. Respect the Families; respect the work we do.

Sincerely,

Elizabeth Kaino Hopper, Marvin W Hopper, parents of an adult living with SMI/ SUD,
Carmichael, CA ekainohopper@gmail.com