California Health and Human Services Agency

Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes

August 12, 2026

Working Group Members in Attendance:

- **Dr. Alyce Belford Saldana** – San Bernardino County Department of Behavioral Health
- **Amber Irvine** – San Diego County Behavioral Health
- **Ashley Love** (for Ivan Bhardwaj) – California Department of Health Care Services, Behavioral Health
- **Bill Stewart** – San Diego County Behavioral Health Advisory Board
- **Dr. Brian Hurley** – Substance Abuse Prevention and Control (SAPC), Los Angeles Department of Public Health
- **James Kwon** – Los Angeles County Department of Mental Health, Office of the Public Guardian
- **Jenny Bayardo** – California Behavioral Health Planning Council
- **Lauren Rettagliata** – Family Member
- **Melissa Martin-Mollard** (for Brenda Grealish) – Commission for Behavioral Health
- **Monica Porter Gilbert** – Disability Rights California
- **Sarah Davis** – Judicial Council of California
- **Stephanie Welch** – California Health and Human Services Agency
- **Susan Holt** – Fresno County Behavioral Health

Working Group Members in Attendance Online:

- **Jennifer Bender** – Riverside County Public Defender Office
- **Dr. Katherine Warburton** – Department of State Hospitals
- **Kent Boes** – Colusa County Board of Supervisors
- **Keris Jän Myrick** – Person with Lived Experience of Schizophrenia Diagnosis
- **Nichole Zaragoza-Smith** – California Department of Housing and Community Development
- **Hon. Scott Herin** – Superior Court of Los Angeles County

Working Group Members Not in Attendance:

- **Dr. Clayton Chau**– National Healthcare & Housing Advisors

- **Harold Turner** – NAMI Urban Los Angeles
- **Herb Hatanaka** – Special Services for Groups
- **Ian Kemmer** – Orange County Health Care Agency
- **Jerry May** – San Jose Fire Department, Local 230
- **Ketra Carter** – Homelessness Strategies and Solutions Department, City of San Diego
- **Khatera Tamplen** – Alameda County Behavioral Health
- **Mark Salazar** – Mental Health Association of San Francisco
- **Meagan Subers** – California Professional Firefighters
- **Monica Morales** – Yolo County Behavioral Health Services
- **Roberto Herrera** – California Department of Veterans Affairs
- **Ruben Imperial** – Stanislaus County
- **Ruqayya Ahmad** – California Pan-Ethnic Health Network
- **Stephanie Regular** – Alameda County Public Defender Office
- **Tim Lutz** – Sacramento County Health Services

Welcome and Introductions

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

Linkins 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 asked that all Working Group members to attend the final Working Group meeting in-person on November 4, 2026.

Linkins provided a brief recap of the May 29th Working Group meeting, which consisted of the following agenda items:

- Families and Peers Focus Group Updates
- CARE Act Data Reporting and Evaluation Update
- Fresno County CARE Act Implementation Update
- San Bernardino CARE Act Implementation Update
- Working Group Discussion of 2026 Priorities

Linkins introduced Kim Johnson, Secretary of Behavioral Health, CalHHS, who greeted the Working Group members.

Secretary Johnson thanked the group for its work and diverse perspectives it brings to CARE implementation. She invited recommendations on how the State can do better in policy and learn from implementation so far. She said implementation is going well, with encouraging signs that the model is working as intended, and that as the program matures, greater results and benefits are emerging.

Secretary Johnson provided the latest Judicial Council CARE Act data through June 2026, which are publicly available on the Judicial Council website. She emphasized the importance of keeping the different data collection time frames in mind for the upcoming Annual Report discussion, as they can make data interpretation confusing.

- Since the statewide launch in October 2023, CARE has reached more than 10,000 Californians through formal pathways.
- As of June 30, there had been 5,484 petitions, 1,414 agreements, and 56 plans, with nearly 5,000 diversions or redirections reported through March 2026.

She highlighted the importance of understanding how people are connected to resources outside formal CARE pathways and noted that county visits have provided opportunities to learn from participants, families, and program administrators. She cited Los Angeles County's 85% increase in petitions from late 2025 into early 2026 and stronger coordination among community partners, mental health workers, and emergency teams.

Secretary Johnson emphasized that there is still room to improve implementation, support delivery systems, and strengthen coordination, and thanked the Working Group for its commitment to making CARE the best it can be for the people served. She also noted that Deputy Director Stephanie Welch was attending a legislative budget hearing and would rejoin when she could.

Implementation Updates

Linkins shared key updates on CARE Act implementation since the May Working Group meeting. She highlighted the May 29 Yolo County site visit, which provided CalHHS and state partners with an opportunity to observe CARE implementation and discuss local successes and challenges. At the site visit, state and county partners:

- Attended court hearings and met with the Judge, County Counsel, public defenders, and staff.
- Discussed funding and housing challenges.
- Visited a combined shelter, treatment, and housing campus funded through BHCIP, Homekey, and the City of Woodland.

She also highlighted a collaborative training with Governor Newsom's office, San Bernardino County, and the City of Victorville that brought local leaders together to educate the community about CARE implementation and services. More than 70 people attended.

Discussing statewide activities, Linkins highlighted the addition of three questions on CARE implementation to counties' BHSA Integrated Plans. County responses showed several consistent themes around service capacity, referral pathways, and redirections:

- A shared service backbone is forming around housing and ACT.
- Counties are prioritizing CARE, while service capacity continues to catch up.
- CARE is creating "no wrong door" referral pathways, with formal procedures and specialized portals in many counties.
- Redirections are working, with more people being connected to services before a petition or full CARE process, although documentation varies across counties.

Linkins concluded her presentation and transitioned to a discussion of the Annual Report.

CARE Act Data Annual Report

On behalf of Deputy Secretary Welch, Linkins acknowledged that pending legislation could affect CARE and said that more information will be available in November once the legislation is finalized and signed.

Linkins highlighted key findings from the unreleased Annual Report and accompanying recent implementation update, emphasizing CARE's role as a pathway to services, supports, and housing, with participants at the center of the process.

- Nearly all ongoing services are provided through voluntary CARE agreements developed collaboratively, rather than through CARE plans.
- Counties continue to demonstrate strong teamwork, relentless engagement, person-centered approaches, and participant voice in service decisions.
- Reimbursement for outreach and engagement attempts is a core strength of the CARE Act and its impact offers an important policy learning for the behavioral health system.

The data shows steady increases in engagement and meaningful housing gains throughout participants' CARE journeys, while the mix of people petitioning has also evolved.

- Mental health service use rose from 77% to 87%, social service engagement from 50% to 64%, and medication use from 47% to 61% between months one and five.

- Nearly 60% of active participants received all three core recovery supports: medication, treatment, and housing.
- Participants who were housed increased from 53% to 71%, while those unhoused declined from 22% to 17% and those in institutional settings from 25% to 12%.
- System partner petitions increased from 25% to 61%, while family petitions declined from 67% to 26%, reflecting increased outreach and training.

Linkins emphasized that the findings are early promising indicators, not definitive long-term outcomes, as CARE implementation is still developing. She highlighted that the findings show CARE is largely working through voluntary participation, which is one of its strengths. CalHHS continues to support counties in strengthening implementation and reaching CARE's full potential.

Linkins concluded her presentation and turned it over to HMA to present an overview of the Annual Report.

Lauren Niles Whalen introduced herself and her colleague, Serene Olin, from HMA. She briefly reviewed HMA's role, which includes supporting DHCS with the Annual Report and CARE data collection and reporting efforts. She explained that their presentation will cover the 2026 Annual Report, data quality and limitations, key findings, takeaways, and opportunities to strengthen implementation.

Niles Whalen provided an overview of DHCS's CARE Act reporting responsibilities, including the annual report and independent evaluation.

- The annual report monitors early implementation and identifies opportunities for program enhancement and implementation improvement. The report includes outcomes, performance indicators, demographics, and county implementation experiences.
- The independent evaluation is being conducted by RAND, with reports to be published in years 3 and 5 of implementation. Data sources include county data submissions to DHCS, participant surveys, interviews, claims data, and other sources.

She highlighted several data elements that are new in the second annual report due to legislative changes, expanded reporting requirements and guidance, feedback, and increased data volume. The expanded data allowed for deeper analysis of CARE implementation, disparities, and county practices.

- Expanded data points provide more information on dismissal and ineligibility reasons, outreach and engagement, services, graduations, reappointments, and early exits.
- New analyses also examine CARE inquiries, system-referred individuals, referral sources, and county follow-up actions.
- Disparity analyses examine geography, petitioner type, service access, and demographic differences, along with county implementation exemplars.

Niles Whalen explained that the report should be viewed as a retrospective snapshot of early CARE implementation, with important limitations.

- The report covers October 2023 through June 2025, representing 21 months of implementation.
- Primary data sources included in the report were Judicial Council data and county behavioral health agency data on inquiries and CARE participants.
- Cohort 1 contributed 21 months of data, LA County contributed 19 months, and Cohort 2 contributed approximately seven months.
- The Data Dictionary changed in January 2025, with new definitions and reporting requirements reflected in the report.
- All 58 counties reported data on petitioned individuals; 56 reported system referrals and 53 reported CARE inquiries.
- The report reflects early implementation and is not a program effectiveness study; RAND's independent evaluation will address effectiveness.
- Data quality was affected by evolving requirements, missing and unknown data, cohort differences, and reporting lags, particularly for data points on housing, substance use, and inpatient stays.

Niles Whalen explained the pathways into CARE and how inquiries and statutory referrals can connect individuals to services before or without a CARE petition.

- CARE inquiries may come from families, friends, roommates, or county agencies and may or may not result in a petition.
- Statutory referrals come from specified courts and LPS facilities for individuals who may meet CARE criteria and also may or may not result in a petition being filed.
- The most common action following a CARE inquiry was connection to county mental health services, social services, or Full Service Partnership programs.
- About 1,800 CARE inquiries were reported during the first six months of data collection, though counties noted significant reporting challenges.

- Nearly 450 statutory system referrals were reported, with MIST courts and LPS facilities representing the largest sources.
- Among referrals with outcomes, roughly one-third resulted in a CARE petition, one-third were connected to county services without a petition, and one-third resulted in neither.
- The most common reason reported by counties for not petitioning a referred individual was that the individual was unlikely to benefit from CARE, followed by an ineligible diagnosis or need for a higher level of care.

She transitioned to the core section of the report, examining CARE petitions, dispositions, and dismissal patterns.

- About 2,200 CARE petitions were filed statewide in the reporting period, with petition volume increasing over time.
- The statewide rate was 5.6 petitions per 100,000 residents, with higher rates among Cohort 1 and rural counties.
- County behavioral health agencies received about 2,000 petitions from courts representing 1,960 unique participants.
- Among participants with an initial disposition assigned by the court, 43% received a CARE agreement or plan, while 57% were dismissed.
- The most common dismissal reason reported by counties was diagnostic ineligibility, followed by nonparticipation, transition to a higher level of care, and inability to locate the participant.
- The median time to initial disposition was 76 calendar days, with significant variation across participants and counties.

Niles Whalen explained that the report provided new insight into what happens while participants wait for an initial CARE disposition, including outreach, engagement, services, and county investigation.

- Counties reported more than 4,000 outreach attempts and nearly 13,000 two-way engagements across 53 counties.
- Counties were developing processes to engage participants as early as possible and build trust and rapport. San Diego reached individuals within two weeks of petitioning and included family and other supports when appropriate.
- About 60% of petitioned individuals who had not yet been assigned a disposition received county services or supports, including mental health services, medication, and housing assistance.

The report examines who was petitioning to CARE, how outcomes varied by petitioner type, and the demographic and housing characteristics of CARE participants.

- System partners accounted for the largest share of petitions at about 45%, closely followed by personal petitioners (i.e., family members or roommates) at 43%.
- Petitions from system partners and self-petitioners had the highest rates of CARE agreements and plans.
- First responder, mobile crisis, and outreach petitions had the highest rates of dismissal without service connections.
- Petitioner sources varied by race and ethnicity, with personal petitions more common among Asian and Hispanic participants and system partner petitions more common among Black and white participants.

HMA reviewed service and support access among CARE participants with CARE agreements or plans, showing strong engagement with mental health treatment, social supports, medication, and specialized programs.

- Nearly 90% accessed mental health treatment, 74% received social services or supports, and nearly two-thirds received stabilizing medication.
- About half of those receiving medication accessed a long-acting injectable.
- Nearly 90% accessed a specialized program, most commonly FSP's, with access varying by county size and density.

HMA reviewed housing access, service trends, recovery supports, acute events, and housing stability among participants with CARE agreements or plans.

- About one-quarter received a CalAIM housing service or support.
- 42% received housing services or supports funded through county, state, or federal programs.
- Mental health service access increased from 77% to 87% during the first five months of CARE participation.
- Social service and support access increased by nearly 14 percentage points, as did stabilizing medication use.
- 60% received all three key recovery supports, while nearly 30% received two of the three.
- Just under 60% experienced an acute medical, psychiatric, or law enforcement-related event, most commonly criminal justice involvement.
- Participants in temporary or permanent housing increased from 53% to 71%, while unhoused and institutionalized participants declined.

Niles Whalen provided early insights into how participants were exiting CARE, including graduations, reappointments, and exits before completing a full year.

- As of June 30, 32 participants had graduated after a median of 13 months in CARE. Another 26 participants were reappointed for an additional 12 months at their one-year status hearing.
- Participants exiting before 12 months spent a median of six months in CARE, with reasons for termination including inability to locate, long-term incarceration, or transition to a higher level of care.

She discussed elective clients, who were dismissed from CARE Court but continued receiving services and supports outside court jurisdiction.

- Nearly 200 participants were diverted to county services and supports outside CARE Court jurisdiction.
- Missing and unknown data were widespread, limiting confidence in findings about this population.
- More robust data collection could help assess the role of court oversight in engagement and identify potential gaps in CARE implementation.

Niles Whalen concluded her presentation by highlighting key takeaways from the findings, including early service engagement, housing gains, and opportunities to strengthen consistency and equity across CARE implementation.

- Initial dispositions took time and varied by county, with a median of 76 calendar days.
- About 60% of participants received services and supports while awaiting disposition.
- Participants increasingly accessed mental health treatment, social services, and stabilizing medications.
- Nearly 60% received all three foundational recovery supports: medication, psychosocial treatment, and housing.
- CARE appeared to support housing stability through increased access to housing services and creative county solutions.
- Dismissals without subsequent county services highlighted potential gaps in continuity of care.
- Variation in petitioner outcomes, referral practices, county capacity, and system coordination presented opportunities for improvement. Opportunities include improving timeliness, service engagement, housing access, data quality, referral pathways, eligibility screening, equity, and cross-system coordination.

Q&A

Linkins, Niles Whalen and Olin took questions from Working Group members.

Dr. Katherine Warburton indicated that the findings on reductions in homelessness and institutionalization were encouraging and asked about racial differences in outcomes and how comprehensive community services were defined.

- Niles Whalen commented that the team had examined racial and demographic differences among participants and had not found significant differences in service access, though they would continue to examine this. She noted that the same analysis had not yet been conducted for changes in housing status. She explained that psychosocial community-based services encompass a combination of mental health treatment and social services.

Deputy Secretary Welch encouraged the Working Group to provide specific recommendations on how the data could be further analyzed to improve CARE implementation. She also asked specifically about the capacity to identify access to substance use disorder services, highlighted the need to better understand what happens to participants who are dismissed, and noted that it would be valuable to understand which participants experienced incarceration while in CARE.

Secretary Johnson emphasized the importance of ensuring that annual report metrics captured the full CARE story, including diversions and other outcomes beyond petitions. She also highlighted the need to account for changing local capacity and the growing availability of housing and integrated behavioral health and substance use supports in future reports.

- Niles Whalen explained that SUD data were not included in the presentation because one-third were missing. She noted that about 20% of participants were reported as receiving SUD services, but the level of missing data made the finding difficult to interpret confidently.
- Olin added that several data points presented opportunities for improvement and that the team could work with RAND to use claims data to strengthen gaps, particularly where counties had difficulty accessing certain information.

Keris Myrick thanked the team for the report and raised several areas for further examination. She encouraged disaggregating incarceration data to identify potential disparities and recommended clearly noting legislative changes that occurred during the reporting period, as they may have affected petitioning and eligibility. She also emphasized the importance of meaning, purpose, belonging, and community as critical components of

recovery and encouraged examining whether participants were supported in these dimensions. Finally, she highlighted the underutilization of clozapine and encouraged examining changes in its use among CARE participants.

- Niles Whalen explained that the Data Dictionary does not identify specific medications such as clozapine, while RAND's independent evaluation would address broader definitions of recovery, including meaning, purpose, and belonging. She also noted that legislative changes were clearly documented in the report, including changes to definitions, reporting requirements, services and supports, outreach and engagement, and statutory system referrals. Additional legislative changes since the report period would be reflected in the next Annual Report.
- Olin flagged that the most recent legislative changes would not be reflected in the 2027 CARE annual report. The 2028 report would provide an opportunity to better understand the impacts of expanded CARE eligibility, recognizing that implementation and data collection take time.

Myrick raised the need to better understand how CARE addressed participants' significant health and disability needs.

- Olin explained that disability data were collected but had a high level of missingness.

Lauren Rettagliata emphasized that hospitalization should not necessarily be viewed as a negative outcome, particularly for individuals who have experienced prolonged homelessness. She noted that hospitalization can provide an opportunity for psychiatric evaluation, appropriate medication, and psychotherapy, and distinguished short-term hospitalization from long-term state hospital commitment. She recommended examining what happens to participants during hospitalization and whether they are subsequently connected to services.

- Niles Whalen agreed that hospitalization should not automatically be framed as a negative outcome. She said the team would review the report's framing and, as more data become available, examine hospitalization patterns to better understand when they may indicate a need for further review.
- Rettagliata emphasized that for individuals experiencing psychosis, multiple hospitalizations may occur before stabilization and should not be quickly interpreted as a failure.

Bill Stewart raised the importance of collecting and analyzing data on family support throughout the CARE process.

- Niles Whalen explained that the team collected information on volunteer supporters throughout the CARE process and on psychiatric advance directives (PADs). She noted that PADs use remained very limited and fewer than 5% of all participants had a named volunteer supporter, increasing to under 20% among those with CARE agreements or plans.
- Stewart suggested that the low numbers of volunteer supporters might indicate a need for stronger outreach or training around the supporter role.
- Niles Whalen and Olin agreed that additional training or information could be an implementation improvement, noting that some counties had successfully engaged family caregivers and other supports. Olin referenced the PADs Working Group's ongoing work and suggested sharing HMA Resource Hub toolkits to help support implementation.

Monica Porter Gilbert expressed frustration that the report had not been provided before the meeting, noting that it limited the opportunity for a robust discussion. She requested an update on the report timeline and next steps.

- Ashley Love, on behalf of Ivan Bhardwaj, explained that the team was working with the web team to have the report posted within the next day or two.
- Porter Gilbert asked for more detailed information on the types of mental health services and supports participants received, including case management, peer support, and crisis stabilization. She also requested more detail on the time it took participants to access services, particularly in early months of CARE participation.
- Niles Whalen explained that the report provided more detail on specific services and supports beyond the high-level data presented. She noted that time to service connection is not in the report, although it identified reasons for delays, including administrative barriers, service availability, and participants declining services.
- Linkins said that she would send the slides to Working Group members and provide a link to the report once it was posted.

Susan Holt asked that future reports include age distribution to better understand outcomes. She also recommended examining how many participants were previously unknown to county behavioral health versus those who had been known but disconnected from services.

- Niles Whalen explained that the report included some information on dispositions by age but did not examine services and supports by age. She noted that this could be considered for the next Annual Report.

Dr. Alyce Belford-Saldana highlighted the overrepresentation of males among CARE petitions and recommended further disaggregation of the data. She suggested examining gender, age, race, and ethnicity among individuals who were not connected to services or whose petitions did not proceed to court, as well as differences in petitioner types. She also recommended disaggregating housing outcomes to help identify populations that may benefit from targeted outreach and implementation strategies.

- Niles Whalen noted that the report included comparisons between petitioned participants and the general population using Census data. She also noted that the independent evaluation would provide additional insight into these areas.
- Olin emphasized that the relatively small volume of data limited the ability to make detailed county-level comparisons. She encouraged counties to use the statewide findings as a benchmark and compare their own age and sex distributions in the context of their communities.

Deputy Secretary Welch apologized for the report not being provided to the Working Group in advance of the meeting. She committed to rescheduling a data ad hoc meeting so members could have an opportunity to thoroughly review the report and provide feedback that could be incorporated into future reports. She also emphasized the group's commitment to examining CARE's impact on different populations. Finally, she suggested using upcoming regional convenings with county teams to help counties look more closely at their own data and proposed making this a focus of a fall breakout session to support meaningful local implementation insights.

Linkins thanked the Working Group for their engagement and confirmed that the Data Ad Hoc would be convened to allow for further review and discussion. She then ended the presentation.

Housing Overview

Linkins welcomed Glenn Tsang, Policy Advisor for Homelessness and Housing, DHCS, to present on housing for CARE participants and the broader housing landscape.

Tsang thanked the group for having him and introduced himself, explaining that his work at DHCS focuses on major housing initiatives related to housing and health care. He explained that his goal for his presentation was to provide information on the department's housing and homelessness resources and current initiatives.

Tsang shared a story of one Medi-Cal member, illustrating how housing stability can improve health outcomes. He described the individual's experience of chronic homelessness, illness, and frequent emergency service utilization. After a hospitalization, she was referred to recuperative care, where she received medical support and a stable

place to recover. Through Enhanced Care Management, she was connected to a housing navigator and other supports, including transitional rent, which helped her move from interim to permanent housing. The member is now stably housed and receiving Housing Tenancy and Sustaining Services to help maintain her housing and support her health.

Tsang explained how CalAIM's Medi-Cal transformation uses health care resources to address housing as a driver of health, with a focus on services that can improve health outcomes and reduce costly emergency and inpatient care:

- Enhanced Care Management (ECM) provides a lead care manager to coordinate clinical and non-clinical needs, including housing, food, income, and other services.
- Community Supports include housing navigation, Housing Tenancy and Sustaining Services, and recuperative care, offering alternatives to episodic emergency care by addressing housing needs directly. Transitional Rent, the newest Community Support, went live at the beginning of the year and helps cover rental assistance to stabilize members in housing.
- Early results include improved health conditions, reduced emergency department and inpatient visits, and health care savings.

Tsang highlighted the housing-related Community Supports available through the CalAIM policy guides:

- Housing Transition Navigation: Provides individualized support to locate housing, complete applications, and develop a housing support plan.
- Housing Deposits: Covers one-time costs such as furnishings and other items needed to help make a new residence a home.
- Housing Tenancy and Sustaining Services: Helps people remain housed through case management, landlord communication, lease support, move-in assistance, and independent living skills.
- Day Habilitation: Supports people in becoming acclimated to their living environment and developing daily living skills, including using public transportation.
- Recuperative Care: Provides a stable place to recover from illness or injury for people without a home, similar to the support someone might receive through home health care. It can also help prevent hospital admissions, not only support recovery after discharge.

Tsang provided detail on Transitional Rent, emphasizing that the benefit is currently focused on the behavioral health population and is being implemented in phases:

- Transitional Rent provides up to six months of rental assistance through Medi-Cal managed care plans.
- Members must meet criteria in three areas: clinical risk factors, homelessness or risk of homelessness, and qualifying transition circumstances. Qualifying transitions can include leaving incarceration, residential or institutional settings, recuperative care, shelters, or unsheltered homelessness.
- Unlike other Community Supports, Transitional Rent is the first mandatory Community Support for plans.
- There is ongoing need to address the "Month 7" gap and ensure members do not return to homelessness when the six months of assistance ends.

Tsang explained that DHCS intentionally launched Transitional Rent with the behavioral health population to strengthen coordination between Medi-Cal managed care plans and county behavioral health systems. He emphasized that both systems have housing resources and that greater coordination can help members access the full range of available supports.

Tsang outlined key state investments and initiatives aimed at building out the broader behavioral health housing and treatment continuum:

- Behavioral Health Transformation recognizes housing as part of treating behavioral health conditions, with major investments in treatment beds and services.
- The Behavioral Health Services Act requires 30% of county BHSA dollars be directed to housing and 50% of those housing dollars to be focused on people experiencing chronic homelessness, particularly those living in encampments.
- Medi-Cal housing resources through managed care plans are intended to be used first, with BHSA housing intervention dollars serving as a backstop.
- DHCS has $4.4 billion in competitive grant funding to build, enhance, and expand behavioral health treatment settings, which is already underway.

Deputy Secretary Welch underscored the goal of leveraging Medi-Cal to grow housing capacity, particularly as Behavioral Health Bridge Housing dollars expire. She noted that CARE participants had been prioritized for those funds and that the latest annual report showed greater housing stability once individuals entered CARE. She said that with the loss of BHBH funds, counties have questions on how to fund the significant housing supports that CARE participants need. She asked Tsang to speak to how counties can stretch Medi-Cal dollars further.

- Tsang thanked Deputy Secretary Welch for raising the sunset of Behavioral Health Bridge Housing and emphasized the need to pivot toward other funding for CARE

participants. He said connecting participants to managed care plans is essential, as Transitional Rent is available for participants that meet the clinical, homelessness, and transitioning criteria. After Transitional Rent, BHSA housing interventions and rental subsidies can potentially offer additional support.

- Deputy Secretary Welch said that counties were reporting that working with managed care plans to utilize the Transitional Rent benefit for CARE participants has been extremely difficult.

Tsang concluded his presentation by emphasizing DHCS's effort to braid resources so they work in conjunction. He highlighted the flexible housing subsidy pool model, an administrative approach that combines funding sources to ensure members' rent is paid without requiring landlords or others to navigate whether funds come from Transitional Rent, BHSA, local, or HUD resources. Tsang noted that 12 counties were currently participating in the Flex Pools TA Academy, with some pools already housing members and others expected to do so later in the year.

County Strategies: Fresno, San Bernardino, San Diego, Tuolumne, Stanislaus

Linkins transitioned to a response panel of county representatives and housing providers to share additional local insights.

Deputy Secretary Welch elaborated on her earlier mention of county-reported challenges with the timing of working with managed care plans to use the Transitional Rent benefit for a vulnerable, high need population. She said county site visits had highlighted the need for flexibility, as CARE participants might move between settings, creating challenges when different entities were responsible for housing.

Linkins introduced Marcus Dillard, Chief of Homelessness Services for San Bernardino County, who is partnering with the county to build out its continuum of care and overseeing the county's homelessness and housing intervention system, including Transitional Rent, Community Supports, and BHSA Housing Interventions. She also introduced Katie Wilbur, Executive Director of RH Community Builders in Fresno County, a housing and service provider operating shelters, Behavioral Health Bridge Housing (BHBH), master leasing, and other housing services, while developing permanent supportive housing.

Linkins framed the discussion as an opportunity for the group to identify assumptions within state policies that might affect local implementation or not bear out as expected. She also invited feedback on what could be improved, as well as technical assistance, resources, or policy guidance that would be helpful.

Wilbur highlighted several issues and lessons from local implementation:

- At the federal level, HMIS reporting and data raised concerns, particularly that exits to substance use treatment should not be recorded as a negative outcome. She views this as a positive outcome for people in low barrier shelters and said negative reporting hurts housing providers.
- Coordinating Behavioral Health Bridge Housing (BHBH) with CARE teams has been a learning experience. Their BHBH program is built with a full team on site, and determining roles and responsibilities across teams has required ongoing fine tuning.
- The CARE participants they house are often transient, so being flexible enough to keep a bed open, close it, and reopen it several times has been needed.

Dillard added challenges and learnings from San Bernardino County:

- Onboarding of contracted service providers has been challenging, as they have not always had the necessary clinical knowledge.
- Better coordination is needed on Transitional Rent and the eventual transition to BHSA.
- State guidance is needed on developing housing support plans. He noted that providers sometimes do the bare minimum to get a plan approved rather than the work necessary to stabilize the individual and move them into housing. Because there is little guidance on how the relationships should work, the county has had challenges making sure providers do the necessary work to connect individuals to housing.

Deputy Secretary Welch asked Dillard to clarify whether the managed care plans are working with providers who might not yet be trained or ready to serve the CARE population.

- Dillard responded that one provider in the area did not have a clinician on staff. He said the concern is whether individuals are receiving the necessary stabilization during the six months they are connected to Transitional Rent. Dillard emphasized the need to ensure the right supports are provided during that period so individuals can become stabilized and successfully move into housing.

Dr. Belford Saldana shared additional insights from San Bernardino County:

- San Bernardino is taking a unique approach by partnering with the Office of Homeless Services to provide Transitional Rent and shifting about a third of its BHSA housing intervention dollars to that office for management and oversight, which requires significant collaboration between behavioral health and housing systems.

- The county's three managed care plans have had a slow rollout with inconsistent workflows, while the Transitional Rent amount does not come close to covering the cost of serving individuals with serious mental illness. Adult residential facilities, for example, can require rates of up to $300 a day, compared with roughly $30 a day through Transitional Rent. The county therefore has to coordinate internal referrals, confirm eligibility, work with the Office of Homeless Services, and then coordinate with the managed care plan because Transitional Rent must be used first.
- More than 500 shelter beds are shifting under an RFP, and providers will need to offer Transitional Rent and BHSA-funded housing. She expressed concern that the county could lose providers due to the insufficiency of current rates for clients with high needs.
- The county is working through how to braid BHSA with Transitional Rent, while also managing frequent client movement that requires repeated certifications and tracking.
- HUD and HMIS requirements also present challenges, as many providers are small "mom and pop shops" and will need substantial technical support to meet the requirements. More than 1,100 individuals in BHBH-funded beds need to move by June 30, but the county does not have enough permanent supportive housing inventory. They are developing temporary solutions while recognizing that this will also reduce interim housing capacity.

Amber Irvine shared insights from San Diego County:

- The Transitional Rent process varies significantly by managed care plan, creating confusion and requiring separate workflows.
- Most CARE participants reside in adult residential or independent living facilities, which cannot use Transitional Rent in part because of the costs involved.
- San Diego faces a significant housing inventory issue. Affordable housing and single-room occupancy units that could be covered by Transitional Rent are often not located in recovery-friendly environments, creating barriers for individuals ready to transition to independent living.
- CARE participants experience periods of destabilization and are sometimes kicked out of residential settings. It is not clear how Transitional Rent works when an individual needs to be relocated multiple times during the six-month period.

Susan Holt spoke to challenges and learnings from Fresno County:

- The administrative complexity and workload associated with implementation require significant coordination, time, and resources.

- Transitioning from MHSA to BHSA requires Fresno to move existing housing investments, including FSP housing and master leasing, into the new housing category, clarifying that the 30% allocation is not all new housing funding.
- Fresno expanded its master leasing contract to operate Transitional Rent and is preparing to launch a Flex Pool. To address limited housing inventory, the county is using up to 25% of BHSA funds for capital projects, including approximately $6 million for a project expected to create 41 beds.
- The promise of Transitional Rent and BHSA coordination is strong, but implementation is extremely difficult.

Dr. Belford Saldana tied the discussion back to the CARE process:

- There is a perception among participants, families, and attorneys that entering CARE means housing will be provided. Individuals may expect a single room in a specific area, but that housing is not always available or clinically appropriate, which can create tensions in court.
- There is a misconception that the county will pay for housing even when individuals have Social Security or other funding sources. These expectations create significant challenges during engagement and contribute to a misalignment between what participants expect and what is realistically available.

Irvine echoed Dr. Belford Saldana's points and added context from San Diego:

- Prioritizing CARE participants for housing also creates misconceptions around what CARE provides. Some individuals already receiving ACT services self-petition because they believe CARE provides special housing, when in reality they are the same housing options available through their ACT teams.
- San Diego used BHBH funds to expand adult residential and board-and-care capacity, but these facilities do not prioritize CARE participants. Providers often select individuals who are stable, medication compliant, and already connected to treatment. She added that adult residential and independent living facilities can provide important social connectedness, including master-leased homes where CARE participants receive onsite groups and social activities.

Deputy Secretary Welch asked how the state and counties can address the challenge of finding providers able to serve high need CARE participants. She questioned why county contracts would allow providers to remove individuals because of challenges such as substance use or medication adherence. She asked whether the state can provide guidance or other support to help counties establish stronger relationships with providers and prevent CARE participants from losing housing.

- Holt said the solution is ultimately inventory. When inventory is limited, the county needs every housing provider and every available bed, even while seeking providers willing to serve people with the greatest needs. The county maintains minimum housing standards and will end contracts for substandard housing, but similar challenges exist in other parts of the system, including psychiatric hospitals that may decline individuals who are more difficult to serve. Holt said that with more inventory, the county could structure its contracts differently.
- Wilbur noted that, as a provider, finding the right balance is important. She said no one should be homeless because of difficult behaviors, but staff, including peers, also need a safe work environment. Sometimes moving someone to another location can be appropriate, while recognizing that providers need to be able to accept people back and move past challenges.
- Dr. Belford Saldana emphasized that mitigation dollars are critical because clients can cause thousands of dollars in damage to housing. Providers in San Bernardino are generally very tolerant and flexible, but violence, substance use, or dealing drugs can affect the broader housing environment. The county tries to intervene and move individuals to a different setting, but when that does not lead to improvement, it may indicate that the individual's acuity requires a higher level of care.

Linkins asked Tsang whether he had anything to share based on the discussion.

- Tsang acknowledged the feedback and said many of the challenges raised are on DHCS's radar and are being addressed with county and plan partners. He emphasized that this is difficult work, particularly in deploying resources to house members with the most complex needs.
- He highlighted technical assistance on funding sequencing and encouraged establishing referral workflows so counties and plans can determine when transitional rent or BHSA funds are appropriate. He encouraged counties to reach out to DHCS for case-by-case clarification. He said the first year will involve many hurdles and learnings, and that the feedback will help DHCS refine implementation.

Working Group Discussion and Q&A

Holt thanked Tsang and emphasized that state and local partners are on the same team. She acknowledged the tension between the immediate needs of people who require housing and support and the need to build sustainable systems and use quality improvement to strengthen implementation over time. Holt also expressed concern about workload, burnout, and the impact of ongoing challenges on the workforce.

Lauren Rettagliata said that the Housing That Heals model is essential to the CARE process and that providers such as those in Fresno and San Bernardino have demonstrated how to braid funding streams to support this model. She said the funding gap for people with serious mental illness in adult residential facilities is significant and a legislative fix is needed. She flagged that BHCIP funding does not support adult residential facilities, even though these facilities serve people with serious mental illness and additional health needs, while temporary housing for people with substance use disorders is supported.

Linkins acknowledged that Wilbur needed to leave and thanked her for her participation.

Dr. Belford Saldana expressed caution about additional legislation and emphasized that timing is critical. She said the behavioral health system is undergoing a pivotal period with several initiatives being implemented simultaneously, creating significant demands on staff and providers. Many behavioral health providers did not enter the system to manage housing, yet are now being asked to handle HMIS, rents, and mitigation. She thanked the state for the opportunities and support and stressed that implementation will take time, allowing counties and providers to build sustainable systems and focus on services while working through the remaining challenges.

Deputy Secretary Welch asked Tsang whether there is an equivalent to the Behavioral Health Centers of Excellence on the housing side, noting a need for tailored support and cross-county learning.

- Tsang said DHCS does not have a specific Center of Excellence for housing but does offer technical assistance through the TA Marketplace and Flex Pools, including support specific to transitional rent and BHSA policies. Tsang also said DHCS is learning from communities that have successfully used these resources to house people and will continue sharing best practices through other mechanisms.

Deputy Secretary Welch noted that the Behavioral Health Commission may be able to support counties as they transition from MHSA to BHSA, particularly around housing.

Secretary Johnson expressed appreciation for the conversation and acknowledged the challenges of implementing multiple transformational initiatives at once, noting that counties have different capacities and circumstances. She emphasized the importance of identifying what is working operationally, particularly among providers successfully serving CARE participants, as well as their policy, funding, and workforce needs. As Co-Chair of the Interagency Council on Homelessness, she committed to bringing these issues into the Council's discussions and strengthening coordination across systems. Secretary Johnson noted that solutions may involve removing barriers or increasing flexibility rather than

creating new legislation or policy, and reaffirmed the commitment to continue working with counties and providers to address implementation challenges and workforce needs.

Dillard thanked the group for the opportunity to learn and emphasized the value of working together to build a system that works for the people they serve.

Tsang thanked the Working Group for the feedback and encouraged members to reach out with questions, clarifications, or additional needs to help translate the policies into practice.

Focus Group Updates: Peers and Families; Public Defenders

Peers and Families

Linkins introduced Lauren Rettagliata and Monica Porter Gilbert to present a set of recommendations for ongoing CARE implementation developed by the Peers and Families focus group.

Porter Gilbert explained the two overarching themes of the group's recommendations:

- Center health, home, purpose, and community alongside services, ensuring person-centered processes and impact measures.
- Expand resources and opportunities for family and peer involvement throughout the CARE process.

Porter Gilbert and Rettagliata walked through the specific recommendations aimed at strengthening training and technical assistance:

- Expand guidance on recovery-oriented, community-based approaches within CARE that emphasize social connection, community participation, and natural supports alongside clinical services.
- Ensure CARE teams, including peers and court personnel, have access to clinical guidance and best practices for working with fluctuations in insight and decision-making capacity, such as LEAP training and Recovery-Oriented Cognitive Therapy. Guidance should also include strategies for adapting engagement approaches and revisiting participants' goals throughout the process.
- Support expanded access to LEAP training for families and volunteer supporters.
- Develop guidance for counties and providers on when and how peer support should be introduced and how to integrate and leverage peer staff in FSP/ACT teams.
- Identify the competencies and training needed to prepare peers and family peers to effectively support participants and families through court proceedings.

- Provide counties with best practices for hiring, training, and supervising peer staff, including guidance on billing for peer and family peer services.
- Develop CARE-specific training and recommend existing training for paid peer support staff and family peers focused on the specific needs of the CARE-eligible population and of families navigating the CARE process.
- Expand education for counties and courts on family involvement, including guidance on recognizing the diversity of family circumstances and avoid assumptions about families' capacity to provide housing, caregiving, or ongoing support.
- Encourage individualized, ongoing conversations with CARE respondents/participants about family involvement and the information they wish to share with family members, rather than treating consent as a one-time yes/no decision
- Supplement existing training resources for counties and courts on the volunteer supporter role to expand guidance on discussing the option of a volunteer supporter with CARE participants and leveraging existing support networks.

Porter Gilbert and Rettagliata reviewed recommendations aimed at structuring county teams and local processes:

- Clarify the existing and potential roles for peer support in the CARE process, including outreach, court appearances, treatment engagement, and graduation planning, with guidance distinguishing the roles of paid peer specialists and natural peer supports.
- Expand roles for paid peer staff, including paid family peers, across the CARE process, with particular focus on embedding peers in outreach, FSP, and ACT teams to support early engagement and trust.
- Integrate peers into the court process and public defender teams.
- Support access for all families to family/parent partner peers.
- Support greater use of community-based peer organizations to provide peer services where feasible, recognizing their expertise in peer hiring, supervision, and recovery-oriented practice.
- Advance system-level changes to reduce barriers that prevent peers with lived carceral experience from obtaining jail clearances.
- Explore opportunities to integrate family peers and family coordinators as core members of CARE teams to support family members and facilitate communication and connection between participants and family members, when appropriate.

Porter Gilbert and Rettagliata outlined recommendations to expand resource connections and supports:

- Expand access to family peer specialists and family-to-family peer support through NAMI and other networks.
- Provide counties with strategies to expand participant and family resource connections and support families outside traditional business hours, including connections to peer respites, community-based organizations, and other resources outside of the traditional service system.
- Support counties in helping participants build broader networks of support, rather than relying on a single supporter, to strengthen long-term recovery and community connection.

Porter Gilbert and Rettagliata highlighted recommendations to strengthen evaluation metrics and processes:

- Develop person-centered measures of impact for peer and family involvement, including participant and family activation, autonomy, connection to supports and relationships, and wellbeing.
- Ensure outcome measurement extends beyond system goals to also measure CARE team support of participants' stated goals as a core outcome of interest, recognizing the importance of creating ongoing space and support for participants to express and evolve their goals throughout the CARE process.
- Provide opportunities for all participants to share honest feedback about their experiences with the CARE process to inform ongoing implementation and improvement efforts.

Porter Gilbert summarized additional recommendations for specific frameworks and trainings.

- Consider LEAP, recovery-oriented cognitive therapy, and crisis response peer certification training to support CARE's goals.
- Highlight the "Reaching the 95%" initiative and Dr. Brian Hurley's work as a valuable model for engaging people who are not otherwise connected to services.

Porter Gilbert thanked Ruby Spies, John Freeman, Karen Linkins, and the rest of the Desert Vista Consulting team for facilitating the focus group process, and all focus group participants for their contributions. She then opened the floor for questions.

Q&A

Deputy Secretary Welch praised the recommendations and noted that they aligned with other input from peer leaders across the state. She said CalHHS is developing broader recommendations to support peers and families in behavioral health and is reviewing training opportunities the next year of CARE implementation. She requested clarification on crisis response peer certification training and how it differed from the certified peer support specialist training provided statewide.

- Keris Myrick clarified that Crisis Response Peer Training was a subspecialty training for certified peer specialists, not a separate certification. She explained that, similar to the family and youth subspecialties, certified peer specialists could receive the crisis subspecialty as part of the state's training.
- Deputy Secretary Welch said CalHHS is looking more closely at how to ensure peers receive appropriate training as part of their certification. She noted that the Behavioral Health Services Act workforce component prioritized training, particularly for peers and others already working in the field, and emphasized the need for more peers to be supported in crisis service settings.

Deputy Secretary Welch asked counties how the state could support implementing the recommendations in a way that reached the right people at the local level.

- Susan Holt thanked Deputy Secretary Welch for the question, emphasizing the importance of involving counties in shaping workforce and training investments.

Hon. Scott Herin asked for clarification on the term "family peer."

- Porter Gilbert clarified that "peer" generally referred to someone with lived experience in common with a CARE participant, while "family peer" is someone with lived experience similar to that of a participant's family member or loved one.

Bill Stewart thanked Rettagliata and Porter Gilbert for their presentation and highlighted stigma as an ongoing challenge. He emphasized that training could help address the stigma and strengthen peer support.

Myrick thanked the group and the state for bringing people with lived experience and family members together, noting the progress toward working better together around recovery. She highlighted that peer-run organizations can also train and support family members and suggested identifying organizations that provide both services. Myrick recommended Dr. Pat Deegan's medication empowerment training to support deeper conversations about medication as part of recovery and offered to share Los Angeles County's training plan, including medication empowerment, personal medicine coaching, and recovery-oriented cognitive therapy, to help counties implement similar approaches.

Secretary Johnson thanked the group for developing clear recommendations and offered state support to help counties implement them. She highlighted the recommendation for a lighter-touch way to gather feedback from families and participants and offered to work with the group on sample questions and formats that could be used locally.

Public Defenders

Linkins turned the presentation over to Jennifer Bender, Riverside County Public Defender Office.

Bender reported on the initial meeting of the CARE Public Defenders focus group.

- The group includes representation from Cohort 1 and 2 counties and had met to discuss implementation challenges and successes, with plans to reconvene.
- Initial discussion focused on collaboration with county behavioral health providers and the strain from increasing caseloads as more petitions are filed.
- The group was examining how to address strained resources and differences between counties, including population and geographic challenges.

Bender outlined several possible strategies discussed by the group to address implementation challenges and strengthen support for CARE participants:

- Develop a more uniform CARE agreement template.
- Begin permanent supportive housing planning early, given the limited duration of CARE agreements and plans.
- Allow CARE proceedings to be stayed when hospitalization or criminal proceedings prevent meaningful participation, rather than dismissing the petition.
- Expand outreach to people in custody approaching discharge or the conclusion of criminal proceedings to support a warm handoff into CARE.
- Encourage flexible court appearances, including remote appearances from locations where participants feel more comfortable.
- Adjust funding structures to better reflect the work being done by respondent's counsel and legal service providers, including criminal case representation for CARE clients.

Bender shared additional discussion highlights:

- One county developed a motion to seal CARE cases after proceedings, which helps protect client privacy.
- They highlighted the lack of funding for outreach and engagement activities, including meals and other supports that help build trust with hard-to-reach clients.

- They also noted the need for funding to recognize and celebrate clients' CARE graduations and support meaningful transitions.

Bender and Linkins opened the floor for questions.

Q&A

Dr. Alyce Belford-Saldana asked whether county counsel and legal aid organizations involved in CARE proceedings had been included in the discussion.

- Bender explained that public defenders and QLSPs collaborate through a shared listserv to discuss challenges and successes, though QLSPs were not part of the focus group discussion. She added that county counsel have their own group, although the groups had not yet connected.
- Dr. Belford-Saldana emphasized the importance of including legal aid representatives in CARE discussions and recommendations, particularly in counties where they represent CARE clients.
- Bender agreed that legal aid brings a unique perspective and noted that her office had collaborated with San Bernardino County Legal Aid and its public defender.
- Linkins explained that the group had met only once for its initial meeting and that additional meetings would provide opportunities to broaden representation across counties. She agreed that different perspectives should be represented and said the county counsel issue would be discussed with the Judicial Council to determine the best way to include those voices.

Rettagliata noted the important role of public defenders in CARE in Contra Costa County. She described their five-person team dedicated to CARE, which includes a peer. She recommended examining Contra Costa County's model at the state level and learning from the work of Joni Spears and her team.

James Kwon asked whether public defenders and legal aid groups across counties shared similar collaborative approaches, particularly in counties where respondent's counsel also handled other civil proceedings such as AOT or LPS.

- Bender acknowledged that collaboration varied across the state. She said that CARE was ultimately about collaboration with service providers to ensure clients received the services they needed. When counsel encounters barriers, they try to work collaboratively to develop creative solutions rather than rely on sanctions, noting that, to her knowledge, no one had reached that point because they were actively working to resolve challenges.

- Kwon added that, while the state had provided significant technical assistance to counties, there may be an opportunity to provide additional support to legal partners to promote greater process consistency.

Deputy Secretary Welch agreed that there was significant diversity across the state in how legal partners supported CARE. She said the state had more work to do with the Judicial Council, the Office of the State Public Defender, and the State Bar to address these differences. Deputy Secretary Welch also noted that County Counsel had been engaged primarily through the counties rather than specifically in their role as attorneys.

Deputy Secretary Welch added that the state budget included new one-time resources to support public defenders. She also noted that CalHHS received new one-time funding to support training for first responders, street medicine teams, and other outreach and engagement teams working with unhoused populations, with the goal of improving the quality of CARE referrals and petitions.

Deputy Secretary Welch explained that CARE was originally designed as a civil court process, with the intent of distinguishing it from the criminal justice system. She said this rationale influenced the decision to include legal aid in the original framework, but acknowledged that what appeared appropriate in legislation did not always work as intended in practice. Deputy Secretary Welch emphasized that the purpose of the Working Group was to examine whether the original design remained the best approach and identify opportunities for improvement.

Closing Thoughts

Deputy Secretary Welch noted that the Working Group sunsets at the end of 2026, so the state was beginning to think about the final meeting and what would follow. She emphasized that the work and the state's commitment to the CARE population would continue through other advisory bodies and stakeholder processes.

Deputy Secretary Welch discussed continued training and technical assistance opportunities, including two upcoming regional convenings for county teams. She said new communication resources would be shared so counties could use existing tools rather than recreate them. Deputy Secretary Welch also highlighted NAMI California's work to operationalize recommendations from peer and family leaders.

She said the Data group will reconvene to develop suggestions for future annual reports. She also noted that the Working Group would engage with the independent evaluator in November regarding the early implementation evaluation and the next stage of the RAND evaluation.

Deputy Secretary Welch confirmed that the next Working Group meeting would be November 4 and would be held at a different location with free and ample parking closer to the airport.

Linkins encouraged members to attend the November meeting in-person to celebrate the work they had done over the last three years. She thanked the members for their participation and transitioned to public comment.

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.

- Pinky, a person with lived experience, an advocate, and case manager within the HMIS and CAAS system, stated that CARE could not be called successful simply because someone entered the system, received a CARE plan, or graduated. Rather, it matters what happens to the person afterward. She emphasized the need to listen to people receiving services and raised concern about what happens when people graduated from CARE and the housing and supportive services tied to their participation end. She stated that funds and services are often too difficult to access, creating a revolving door through the system. She emphasized that people should not lose housing and that graduation should mean greater stability, not greater vulnerability. She called for clear responsibility for services after CARE participation ends, no sudden cliffs in services, and greater attention to how many people remained housed. She urged the Working Group to look beyond compliance and completion rates.
- Katie Myata, with Myata Consulting, spoke to common challenges faced by contracted providers. Myata stated that many people working in the field have lived experience but are not being supported or compensated enough to become experts at what they do. Organizations are experiencing massive turnover and lack the capacity to support clients and staff because of the burden of billing, referrals, paperwork, administration, and training. She described the network she had developed as a TA Marketplace vendor, working to support organizations implementing CalAIM, ECM, and community supports. Myata stated that CARE is wonderful but had some contradictions because providers could not always prioritize CARE participants when there are other populations they are also required to prioritize.
- Lynn Rivas, CAMHPRO, stated that CAMHPRO supported efforts to include peers as part of CARE and additional training for other system participants. She said that

housing is critical but that she opposes CARE because it is undergirded by coercion. Rivas stated that there was no doubt CARE could be effective but referenced a recent study that demonstrated voluntary care was just as effective without the associated downsides and showed that most individuals in systems like CARE never refused treatment; they simply were not offered a comparable level of services.

- Elizabeth Kaino Hopper stated that it was important to have experts working to make the highest level of community care available in California and expressed appreciation for efforts to increase community care and include peers. She noted that she would provide comments on the HMA report, including questions about what qualified a person as not benefiting from CARE and why the incarceration rate was still increasing. Hopper also raised concern about people being criminalized rather than being hospitalized. She also raised concerns about CARE Court records being sealed, stating that while sealing records might protect a person and their HIPAA rights, those records could be important if the person later needed a higher level of care, such as LPS or a 30- or 60-day inpatient stay, to help providers understand why the person was again in need of higher-level care. Hopper said this could be particularly problematic for families, who are the default village when services were not available. She thanked Dr. Belford Saldana for addressing the challenges faced by families and stated that families do everything possible to support their loved ones. Hopper thanked the Working Group for its work and said she would submit her comments in writing.
- Jay Calcagno, on behalf of the California Behavioral Health Association, highlighted five suggestions: first, urging the state to prioritize sustainable provider capacity to support additional service delivery expectations for CARE clients referred to them; second, strengthening coordination between the courts, counties, and providers and providing additional resources to support system accountability, especially at the referral end; third, incorporating provider experience into CARE Act data evaluation and reporting; fourth, providing additional specialized training for all professionals who participated in the CARE process, including judges, lawyers, law enforcement, and clinicians; and finally, tracking warm handoffs from the CARE process to the community and supporting more integrated care approaches among communities, providers, and CARE teams. Calcagno thanked the Working Group and expressed appreciation for the opportunity to provide feedback.
- Gladys Lopez from Napa County stated that she was present because of her brother and served as his advocate. She said that, unfortunately, it was through the criminal justice system that he was petitioned to CARE. She suggested a fast track to treatment for people with severe mental illnesses, with judges able to review a person's criminal record and determine the severity of their illness. She stated that

her brother was currently in rehabilitation and that she would soon need to advocate for a transition program to help him return to the community.

- Matthew McCulley, who resides in Contra Costa County and is trained as a Crisis and Family Peer Support Specialist, stated that he was a correctional and recovery chaplain volunteer. He spoke about peer support and forced medication, emphasizing that meaning and purpose were very important to the population and that existential spiritual pain was common. McCulley stated that the importance of peer participation in all aspects of CARE implementation could not be ignored and that peers and chaplains could provide critical support to help people navigate support systems and survive mental health and substance use symptoms. He raised concern that the San Francisco Fire Department had recently canceled its contract for peer support specialists to ride along with crisis support teams, urging the group to be aware of any trends toward dropping proactive peer support services in other counties. McCulley also noted that legislation had been introduced that would require forced medication to access treatment for mental health and substance use disorders. He emphasized that CARE needed to ensure treatment options did not violate individual rights and that people should not be denied housing support or mental health resources because they refused medication. He urged the system to help people make their own health decisions rather than force them. He also asked whether the data report would be available to the general public.
- John Underwood with Housing as a Human Right OC in Orange County, noted that Orange County did not have a representative at the table. He spoke about the housing intervention legislative funding requirements and the BHSA pie charts presented earlier. In Orange County, he understood that the funding was being used and diverted by law enforcement, not necessarily to ameliorate camp environments and increase services, but to increase enforcement and removal of campsites. Underwood also questioned whether the 30% housing intervention funding was intended to be utilized for behavioral health services by the Orange County Sheriff's Department.

Linkins thanked all Working Group members and members of the public for staying and participating. Linkins also encouraged members to reach out with input on agenda items they wanted to cover in November.

Linkins adjourned the meeting.