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Statement

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Disability Rights California Response to Governor Newsom's Framework for CARE Courts

"I need a community that allows me to be myself and accepts me for where I'm at. I need support, encouragement, and resources so I can thrive. I have been through so many experiences that no one but me knows what is best for my recovery and care."
– Lunyea Willis, Disability Rights California client/member of Mental Health Association of Orange County/homeless advocate.

Coerced treatment is not care, and a treatment plan issued under court order typically is not voluntary for the individual receiving treatment. The people who are most at risk in the Governor's proposed framework are individuals from low-resource communities, and these individuals are often not consulted when decisionmakers develop policies that affect them. We

urge Governor Newsom to ensure that this and other proposals to address homelessness undergo an equity analysis that centers individuals who are at greatest risk of experiencing discrimination, incarceration and coercion before it is finalized.

Governor Newsom's just-announced CARE Court framework seeks to mandate the provision of critical behavioral health services that play an important role in addressing homelessness. The CARE acronym stands for community assistance, recovery, and empowerment, and Disability Rights California supports all of those goals for Californians with mental health disabilities. However, these services held under a court's jurisdiction are likely to take on a form of coercion that deprives people with disabilities of their fundamental right to self-determination. We agree with Governor Newsom that California must do better for its unhoused people with mental health disabilities and substance use disorders. California must lead in civil rights, dignity, *and* provision of services that will truly address the homelessness crisis. Unhoused people with mental health disabilities and substance use disorders need and benefit from voluntary, community-based housing, services and supports. The right to make one's own decisions about care and treatment is fundamental for all people, regardless of housing status or disability status.

On Thursday, Governor Newsom launched a stakeholder engagement process to discuss his framework for CARE Court, and Disability Rights California will engage in this process with the goal of steering the plan away from forced treatment and toward more robust and reliable voluntary services and supports, including housing.

"On behalf of our clients, DRC looks forward to working with Governor Newsom, Secretary Ghaly and their colleagues in the upcoming stakeholder engagement process. We agree with Governor Newsom's and Secretary Ghaly's goals of helping people avoid bad outcomes like incarceration, conservatorship, and long-term homelessness, but we believe that the best way to get better outcomes is to provide people with person-centered services that they choose, not to require them to participate in court-ordered care. As we begin the process of refining the Governor's proposal, we believe it is critical that people with lived experience with mental health disabilities, substance use disorders, and homelessness be included in the process of vetting and developing solutions, as we believe the people closest to the problem will have insights

into how to improve their experiences," said Andrew Imparato, Executive Director of Disability Rights California.

Coerced treatment through a court process is *not* a "new framework" that the state is unlocking with CARE Court. It has long been the cause of unhoused people cycling in and out of the criminal legal system and mental health institutions, which has, in turn, contributed to the homelessness crisis by causing housing instability. Solving California's homelessness crisis requires production of affordable housing that does not displace low-income communities. This housing must be provided according to Housing First principles with voluntary, trauma-informed, client-directed supportive services tailored to individual needs.

Lili Graham, Disability Rights California's Litigation Counsel and a leading advocate for unhoused individuals, stated, "We need consistency of effort in our homeless programs, not an untested program that forces people into the latest homelessness solution. We need permanent affordable housing units and accessible supports offered voluntarily. Without increased investment into these two long-term resources that will ultimately solve homelessness, any intervention is destined to fail."

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Disability Rights California (DRC) – Is the agency designated under federal law to protect and advocate for the rights of Californians with disabilities. The mission of DRC is to defend, advance, and strengthen the rights and opportunities of people with disabilities. For more information visit: https://www.disabilityrightsca.org.

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California Association of Mental Health Peer Run Organizations (CAMHPRO)
Response to CARE Court Proposal

Governor Newsom's CARE Court proposal would create a new avenue for individuals living with serious mental health or behavioral health challenges to be referred for court-mandated treatment and services. The Governor describes the CARE Court as a new approach and a paradigm shift." CARE stands for "Community Assistance, Recovery, and Empowerment."

This plan is not a new approach and a paradigm shift. In fact, it resorts to the same old default of the behavioral health system – forced treatment. **A court order is forced treatment.** Also, force is force, whether in a hospital setting or located in the community, in a home.

"Coercion is the power to force compliance with authority using the threat of sanctions, including physical punishment, deprivation of liberty, financial penalty or some other undesirable consequence." (Geller et al., 2006)

Terms like recovery and empowerment are appropriated in the very name of CARE Court. Eduardo Vega, one of the founders of CAMHPRO and former board chair for several years, wrote, "Nothing is more disturbing than hearing the peer movement's words of recovery and empowerment being used in the context of forced treatment." Indeed, coercive treatment flies in the very face of the concepts of recovery and empowerment.

The Governor contends that the plan protects individual rights. To the contrary, the CARE Court subverts the rights protected in the Lanterman-Petris-Short Act (LPS), including its behavioral criteria for enforcing coercive treatment.

The CARE Court concept is based on the myth that the solution to treating mental health issues and to reduce homelessness is to expand forced treatment.

The facts are different from the myth:

- Voluntary, intensive services are the answer to mental and emotional distress. The expansion of forced treatment is not. The problem isn't that there are too few forced treatment options; the problem is that there are not enough person-centered, recovery based, culturally appropriate services. (Myrick & del Vecchio, 2016)
- The unsheltered and homeless population is NOT the result of mental illness. People with mental health issues are being scapegoated for economic and social problems that permeate our society. The problem is lack of affordable housing — and political will — not people diagnosed with mental illness (*Homelessness Task Force Report*, 2018).

- Scapegoating people with mental health issues is a political answer to public pressure to get rid of the homeless.
- The options should not be between homelessness and forced treatment, locked facilities, or jails. There is an array of alternative voluntary services that are currently available, beginning to be available, and must be imagined.[1]
- The behavioral health system must think outside the conventional framework they have always used that has led to the current problems, to solve the problems.

CAMHPRO looks forward to participating in the community engagement and input on the CARE Court framework. We urgently request that mental health clients, peers who have been and are directly affected by the behavioral health system, be major participants in these discussions.

CAMHPRO is a nonprofit, statewide organization consisting of mental health consumer-run organizations, programs, and individual consumer members. CAMHPRO's mission is to transform communities and the mental health system throughout California to empower, support, and ensure the rights of consumers, eliminate stigma, and advance self-determination for all those affected by mental health issues, by championing the work of consumer-run organizations.

[1] Examples of voluntary methods research: *Whole Health Model* - Bouchery et al., 2018; *Crisis Respite* - Lyons et al., 2009; *Reduction in Coercion Model in Scandinavia* - Gooding et al., 2020; *Self-Managed Homelessness Shelters* - Huber et al., 2020; *Supportive Housing* - Cunningham et al., 2021; *Alternatives to Traditional Crisis Response Experiment* - Greenfield, 2008

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cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

CARE Courts Considerations

March 2022

CARE Court: The Problem

- Everyday Californians, including state leaders, are concerned about the degree of human suffering we witness on our streets.
- To be clear, the state's homelessness crisis is driven by a lack of affordable, accessible housing, not by individuals experiencing mental illness or substance use disorders.
- Homelessness will not be solved through a new court process that lacks additional resources for county behavioral health services and does not guarantee housing options.

CARE Court is designed with the idea that counties need court oversight in order to better prioritize individuals with schizophrenia and schizoaffective disorders within the broader population of clients we serve as a way to address our state's homeless crisis.

In reality, county behavioral health is proactive *and successful* in outreaching and engaging individuals into treatment services, however, housing discrimination and our clients' limited ability to compete in today's market for scarce and expensive housing options increase their vulnerability for becoming and staying homeless, even with housing navigation supports. Every county has clients who are valiantly engaged in treatment services, but who remain unhoused because the housing either does not exist, or they are not able to access it, often due to their behavioral health condition, criminal backgrounds, or poverty.

Three out of ten Californians experiencing homelessness has a significant mental health need, and two out of ten have a substance use disorder. The main predictor of homelessness today is older age, but many populations who have faced systemic discrimination and lack a broader safety net to connect to or remain housed are overrepresented in the homeless population, including Black Californians, LGBTQ youth, domestic violence survivors, and veterans.

Solutions

- Invest in housing dedicated to individuals with significant behavioral health needs. Support and expand on $1.5 billion Bridge Housing Solutions.
- Increase funding for county behavioral health safety net to address Californians with serious mental illness and substance use disorder needs experiencing homelessness. In particular, expanded funding for substance use disorder treatment services is overdue.

California needs to do more to create dedicated housing options for county behavioral health clients and invest in expanded funding for services to county behavioral health clients experiencing homelessness as the trauma of homelessness can both worsen existing conditions and trigger new substance use or mental health disorders, such as depression and anxiety. Funding for expanded services is crucial, particularly in light of the ongoing workforce crisis, to expand pay to outreach workers and expand service options. California's optional Medi-Cal benefits should also be reconsidered as fully funded statewide benefits, particularly peer support specialists and Drug Medi-Cal Organized Delivery System benefits, which fund expanded SUD services such as case management and residential treatment.

CARE Court Equity Concerns

It is well documented that the largely white profession of psychiatry tends to inappropriately misdiagnose Black and Latinx individuals with schizophrenia and other psychotic disorder diagnoses. A 2019 study[1] found that Black individuals are more likely to be diagnosed with a psychotic disorder than white individuals, despite no scientific evidence that Black or Latinx individuals are more likely to have schizophrenia. Researchers found that this misdiagnosis was due to racial bias and clinicians not appropriately screening for and diagnosing depression and mood disorders.

CARE Court focuses on individuals with schizophrenia and schizoaffective disorders, rather than the individual's competency, functioning, and ability to live safely in community. This focus will only increase stigma towards individuals with schizophrenia and schizoaffective disorders and expand court and justice involvement for Black clients of county behavioral health who are likely to be misdiagnosed based on these recent studies.

Client Outreach & Engagement is Successful

Overcoming an individual's mistrust of the justice and medical systems after a lifetime of systemic discrimination based on race, income, sexual orientation, gender identity, mental health condition or substance use disorder and disability status is the key to successful outreach and engagement. Eligibility that is tied solely to diagnosis will make engagement into services more challenging and add to the stigma and fears associated with schizophrenia, while failing to address the structural bias and housing and service support needs of those who could benefit from intensive pre-conservatorship interventions.

[1] Michael A. Gara, Shula Minsky, Steven M Silverstein, Theresa Miskimen, Stephen M. Strakowski. A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic. Psychiatric Services, 2019; 70 (2): 130 DOI: 10.1176/appi.ps.201800223

Additional CARE Court Concerns & Considerations

Sanctions

CARE Court proposes to sanction and even appoint a court agent to direct county behavioral health resources for failing to provide court-ordered services. Although county behavioral health plans are required to offer and provide Medi-Cal specialty mental health and substance use disorder services, the services that are funded and available beyond Medi-Cal may not be available in every county. Even within Medi-Cal, the state has several significant optional benefits, which means that services differ throughout the state – often based on a county's inability to support a new program without new funding. Finally, CARE Court would require counties to provide services to individuals regardless of payer. Therefore, a court could order the county to provide publicly funded services to individuals with commercial insurance or face penalties.

Under CARE Court, a county without the resources needed to comply with the court ordered plan would be further financially penalized, taking funding away from the county's core Medi-Cal entitlement responsibilities and subjecting them to further fiscal sanctions from other regulators, such as DHCS.

New Legal Presumption

CBHDA is concerned that this proposal would bypass the professional judgement of Public Guardians and county behavioral health clinicians by creating a new presumption for LPS Conservatorship for anyone who is found by the court to have failed to comply with the Care Plan developed in this new court process. Trained professionals should have the ability to advise the court on the individual's progress and whether conservatorship is appropriate or necessary as the experience of involuntary treatment can further traumatize and harm individuals, particularly when it is not necessary or helpful in their recovery and engagement into services.

Housing Diversion

Any client of county behavioral health should be considered a priority for housing, given the vulnerability of the population overall. As such, this proposal should be carefully constructed so that access to housing does not become contingent upon participation in CARE Court.

Implementation Timeline

Implementation should be delayed to ensure county behavioral health and courts have the time to build up services and staffing to support CARE Courts, including the additional infrastructure under the Behavioral Health Continuum Infrastructure Program and Community Care Expansion program which launched this year.

CARE Court Outcomes & Evaluation

CARE Courts should be evaluated to understand outcomes, any unintended consequences, and to center the voice of the individuals who move through this new court process.

Legislation

CBHDA currently has no position on SB 1338 (Umberg and Eggman) as amended on March 16th, but looks forward to engaging with the Legislature and the Administration to ensure that all Californians with significant behavioral health needs receive timely access to treatment services and explore this new framework.

MHAC Responds to Governor Newsom's new CARE Court Proposal

The mission of Mental Health America of California is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion or socioeconomic status,
Mental Health America of California (MHAC) appreciates Governor Newsom's dedication to improving the lives of people living with mental health challenges but we urge the Governor to ensure that all programs aimed at increasing access to mental health services are not only voluntary, but also treat individuals living with mental health challenges with compassion and dignity.

Governor Newsom's new CARE Court proposal would create a new avenue for individuals living with serious mental health or behavioral health challenges to be referred for court-mandated treatment and services. Research demonstrates, however, that very few people who are offered voluntary housing or services will decline the offer, and for those people California has the Assisted Outpatient Treatment (AOT) program which enables counties to provide services for individuals with serious mental illnesses when a court determines that a person is unlikely to survive safely in the community without supervision.

MHAC agrees that California must improve access to services for our residents, both housed and unhoused, who live with behavioral health challenges. Because involuntary services are traumatizing to the individual, and do not take into consideration a person's autonomy or self-determination, we believe that the best way to get more people into treatment and services, is to ensure that there are adequate voluntary, community-based culturally competent mental health services and permanent, safe, affordable supportive housing programs so that every person in California has access to appropriate mental health services at the time those services are needed. If accessible and appropriate services are available, and if individuals have information about how to access those services, people will voluntarily seek housing, services and treatment.

We look forward to working collaboratively with the Administration as this proposal is developed. We agree with the Governor's goal of providing services to unhoused people with behavioral health challenges, and we believe strongly that this goal can be reached with a program that is both compassionate and voluntary. services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, who require mental health rights, or opportunities based on their need for mental health services.

CAL VOICES

ADVOCACY • RECOVERY • PEER SUPPORT

Cal Voices' Statement on Governor Newsom's Flawed "Care Court" Proposal

Governor Newsom's proposal to end homelessness is one of the greatest threats to civil liberties in the 21st century. Forcing unhoused individuals into mandated treatment for the "crime" of being homeless is reminiscent of California's shameful history of institutionalization, sterilization, and forced treatment of those with psychiatric disabilities. The solution to homelessness is permanent, affordable, and supportive housing, not criminalizing the most vulnerable among us based on their unhoused status.

We must fix our broken and fragmented public behavioral health care system. We need fiscal transparency, accountability, and greater access to community-based services. Coercing the unhoused into court-supervised treatment programs will only exacerbate the causes of homelessness while violating their civil rights, and is a surprising reversal of the Governor's prior positions on forced treatment.

The Governor's draconian proposal lacks empathy and understanding of California's behavioral health needs. Cal Voices has advocated for the rights of Californians affected by mental illness for more than 75 years. We have consistently promoted access to voluntary community-based services and supports since before the passage of the Mental Health Services Act. Nothing about California's current homeless situation is compelling enough to deviate from this policy priority.

Blaming California's current homelessness crisis on mental illness and substance use disorders is a transparent ploy to raid public behavioral health funding to forcibly remove the unhoused from public view instead of addressing the root causes of these intersecting issues and holding social service agencies accountable.

Cal Voices urges the Governor to abandon his deeply troubling Care Court proposal and collaborate with civil rights organizations, behavioral health advocates, housing policy groups, and other stakeholders, including Black, Indigenous, and people of color, and members of the LGBTQ+ community, to develop a comprehensive strategy to target the underlying causes of homelessness and solve the state's affordable housing crisis.

March 23, 2022

Governor Gavin Newsom
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Secretary Mark Ghaly, MD, MPH
California Health & Human Services Agency
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RE: Comments and Recommendations Regarding Community Assistance Recovery and Empowerment CARE Court

Dear Governor Newsom and Secretary Ghaly,

The undersigned organizations represent state and national leaders in behavioral health, criminal justice, substance use disorder services, and homelessness policy and advocacy. Mental Health America of California (MHAC), the lead organization of this letter, is a peer-run organization that has been leading the state in behavioral health public policy and advocacy since 1957.

We support the Administration's goal of providing behavioral health services to some of our state's most vulnerable residents through the recently announced Community Assistance Recovery and Empowerment (CARE) Court Program and we appreciate the opportunity to provide input.

Our comments and recommendations are intended to strengthen the plan by ensuring that every individual participating in the program has the greatest opportunity to succeed. While we agree strongly that California must improve access to services for our residents, both housed and unhoused, who live

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with behavioral health challenges, we believe that the best way to get more people into treatment and services is to ensure that there are adequate voluntary, community-based culturally competent behavioral health services and permanent, safe, affordable supportive housing programs that are provided with dignity and compassion.

Below, we offer our suggestions to strengthen the CARE Court program.

Recommendation #1: Services Should be Voluntary

The mission of MHAC is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. In accordance with our mission, we believe that every person deserves access to appropriate, voluntary services within the community that are delivered with compassion and respect for each individual's dignity and autonomy.

While the CARE Court framework includes elements of self-directed care, the overall foundation of the plan puts accountability on both local governments *and* the individual to comply with court-mandated medication and services. The fact that services are court-mandated causes these services to be involuntary, and therefore coercive.

Coercion in behavioral health care can be formal, such as the use of restraints, seclusion, or involuntary hospitalization; or informal, which includes influence or pressure placed on an individual to influence their decisions or choices.[1] Coercion in behavioral health care is often described as a hierarchy of pressures including, at the lower end of the hierarchy: persuasion, interpersonal leverage, inducements; and higher up the hierarchy are threats and compulsory treatment.[2] Coercion can also take the form of perceived coercion[3]--fear by the individual that noncompliance will result in compulsion or forced treatment[4], often referred to as "shadow compulsion" or "the black robe effect".

From the perspective of an individual experiencing a behavioral health challenge, any level of coercion, including perceived coercion reduces the voluntary nature of services by varying degrees, and consequently decreases an individual's trust in the system and in their care providers. Involuntary services are traumatizing and do not take into consideration a person's autonomy or self-determination.

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[1] Hotzy, F., & Jaeger, M. (2016). Clinical Relevance of Informal Coercion in Psychiatric Treatment-A Systematic Review. Frontiers in psychiatry, 7, 197. https://doi.org/10.3389/fpsyt.2016.00197

[2] Szmukler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. J Ment Health (2008) 17(3):233–44.10.1080/09638230802156731

[3] Lee, M.H.; Seo, M.K. Perceived Coercion of Persons with Mental Illness Living in a Community. Int. J. Environ. Res. Public Health 2021, 18, 2290. https://doi.org/10.3390/ijerph18052290

[4] Szmukler G (2015) Compulsion and "coercion" in mental health care. World Psychiatry 14, 259.

Two main elements of the CARE Court plan include formal or informal coercive measures. First, the CARE Court process begins with an evaluation followed by immediate involvement of the court system and court-mandated treatment. Attending court is stressful for most people, but for the unhoused or individuals with mental health conditions, being ordered to court, especially for no reason other than the existence of a mental health condition not only causes trauma and stigma, it also impacts the therapeutic relationship[5].

Second, the CARE Court Proposal creates a new presumption under the Lanterman-Petris-Short (LPS) Act that "failure to participate in any component of the Care Plan may result in additional actions…including possible referral for conservatorship with a new presumption that no suitable alternatives exist"[6]: The threat of conservatorship in and of itself causes treatment to no longer be perceived as voluntary.

We firmly believe that, with appropriate outreach and engagement, and active involvement of certified peers, individuals will accept voluntary housing and treatment. A recent study conducted in Santa Clara found that of 400 people offered a permanent home, only one person refused the offer.[7] Data from the Assisted Outpatient Treatment Program (AOT) shows that 75% of individuals who received AOT services accepted those services voluntarily[8]. We believe this number could be further increased with focused and extensive outreach and engagement efforts prior to an individual's mandatory participation in CARE Court.

Unhoused, and particularly unsheltered individuals have been subject to extreme levels of trauma that most of us cannot conceive. Not only does early trauma play a role in many individuals becoming unhoused[9], but the process of becoming unhoused, and the situations leading up to homelessness are traumatic. Furthermore, unhoused individuals are exposed to a multitude of traumatic events, including being victims of personal violence[10], witnessing serious violence[11], and frequent encounters with police which are often unrelated to criminal activity [12]. In addition, court and law enforcement strategies are

[5] See Lee, M.H; Seo, M.K. (2021)
[6] Care Court Frequently Asked Questions, p.3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[7] Maria C. Raven MD, MPH, MSc,Matthew J. Niedzwiecki PhD,Margot Kushel MD, Human Health Research, A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services, September 25, 2020. Available at https://doi.org/10.1111/1475-6773.13553
[8] Laura's Law: Assisted Outpatient Treatment Project Demonstration Project Act of 2002 Report to the Legislature, Department of Health Care Services, May 2021 accessed at: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf
[9] Alison B. Hamilton, Ines Poza, Donna L. Washington,"Homelessness and Trauma Go Hand-in-Hand": Pathways to Homelessness among Women Veterans, Women's Health Issues, Volume 21, Issue 4, Supplement, 2011,Pages S203-S209, ISSN 1049-3867, https://doi.org/10.1016/j.whi.2011.04.005.
[10] Kagawa, R.M.C., Riley, E.D. Gun violence against unhoused and unstably housed women: A cross-sectional study that highlights links to childhood violence. Inj. Epidemiol. 8, 52 (2021). https://doi.org/10.1186/s40621-021-00348-4
[11] Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime Prevalence of Trauma among Homeless People in Sydney. Australian & New Zealand Journal of Psychiatry, 34(6), 963–966. https://doi.org/10.1080/000486700270
[12]Rountree, J., Hess, N., Lyke A. Health Conditions Among Unsheltered Adults in the U.S.. California Policy Lab. Policy Brief. (10/2019) p.7 Accessed at: https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf

more likely to be targeted to people of color, and are more likely to be traumatic to people of color--especially Black men, who are likely to be disproportionately involved with the court system. For this reason, it is essential that a trusting relationship be developed between an unhoused individual and the peer outreach worker, to enable the individual to seek voluntary treatment.

We believe that every person can achieve improvements in their mental wellness but, for our most vulnerable citizens who have been unhoused for longer periods of time, extensive outreach and engagement by a trained peer is necessary to build a trusting relationship. Because peers have "been there," there is less fear of stigma and judgment from those who they are helping. Peer support builds relationships that are based upon mutuality, shared power, and respect[13]. When a trusting relationship which is built on shared power and respect is created between a peer and a person with a behavioral health challenge, that individual will receive services voluntarily, which leads to self-empowerment for the individual. Self-empowerment, in turn, has been shown to improve quality of life, self-esteem, and reduce mental health symptoms[14], and is therefore a key variable of success.

Recommendation #2: Mandate that Certified Peer Support Specialists are Meaningfully Involved at Every Stage of the Process in Every County

In addition to the peer outreach worker, we ask that certified peer specialists be incorporated throughout the entire CARE Court process. The CARE Court framework describes a "Case Worker" and "Supporter" who assists the individual in various aspects of the CARE Court process, however the required qualifications of this supporter are not made clear in the current CARE Court framework. We believe that this Case Worker and Supporter must be a mandated certified peer support specialist in every county and in all circumstances.

Peer support is an evidence-based practice that has been shown to reduce re-hospitalization[15], reduce the number of homeless days[16], and improve quality of life, among many proven benefits. Trained and certified peers with lived experience of homelessness and/or behavioral health conditions are uniquely positioned to provide support and build a trusting relationship with people who are currently unhoused and/or people living with behavioral health conditions.

For the CARE Court program to meet its goal of improving the lives of people with behavioral health conditions, peer support specialists must be actively and meaningfully involved at every stage of the program, beginning with robust initial outreach and engagement efforts designed to encourage voluntary participation, and continuing until the individual completes the program.

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[13] Mead S. Intentional Peer Support; 2001. [2020-02-28]. Peer Support as a Socio-Political Response to Trauma and Abuse https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9_DbPm5kSST9_Q/edit

[14] Patrick W Corrigan, Dale Faber, Fadwa Rashid, Matthew Leary, The construct validity of empowerment among consumers of mental health services, Schizophrenia Research,Volume 38, Issue 1,1999

[15] Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers. Accessed at:https://www.nyaprs.org/e-news-bulletins/2013/bergeson-cost-effectiveness-of-using-peers-as-providers

[16] van Vugt, M. D., Kroon, H., Delespaul, P. A., & Mulder, C. L. (2012). Consumer-providers in assertive community treatment programs: associations with client outcomes. Psychiatric Services, 63(5), 477–481. doi:10.1176/appi.ps.201000549.

Recommendation #3: Provide Permanent Supportive Housing Before Services are Mandated

California has adopted the "Housing First" approach, which recognizes that an unhoused person must first be able to access safe, affordable, permanent housing ***before*** stabilizing, improving health, or reducing harmful behaviors[17].According to state statute, "any California state agency or department that funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of homelessness, must incorporate the core components of housing first"[18].

Permanent supportive housing, which follows the Housing First approach, is targeted to individuals with mental health, substance use, or other disabilities who have experienced long-term homelessness. It provides long-term rental assistance in combination with supportive services. Research has shown that individuals, even those with chronic homelessness, remain housed long-term in permanent supportive housing[19]. In a New York program, individuals with prior jail and shelter stays were offered permanent supportive housing through a state program. At 12 months 91% of these people were housed in permanent housing compared to 28% in the control group who were not offered housing through the program[20]. In a Denver supportive housing program, 86% of participants remained housed after one year, and experienced notable reductions in jail stays[21].

To give every individual the best chance of succeeding, it is imperative that individuals who have been found to qualify for the CARE Court program be offered permanent supportive housing and a chance to stabilize and accept voluntary services before any services are court mandated.

Recommendation #4: Analyze and Publicly Report Plans for Addressing the Permanent Housing Needs of CARE Court Participants

Permanent, stable housing is essential to the successful participation in treatment, services and supports of people with behavioral health care needs; the State should analyze and publicly document the projected permanent housing needs for people who may participate in the CARE Court program. That analysis and public documentation should include clear information regarding:

- The projected permanent housing needs of potential CARE Court participants;
- The permanent housing options that are expected to be made available to meet those needs;
- The number of those housing options currently available;
- How additional housing options will be funded, and when they will be available to CARE Court participants; and
- The expectations regarding choice among permanent housing options to be provided to CARE Court participants.

[17] Welfare and Institutions Code § 8255
[18] Welfare and Institutions Code § 8255 (e) and § 8256 (a)
[19] Davidson, C., et al. (2014) "Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use." Psychiatric Services. 65(11), 65(11): 1318-24
[20] Aidala, A.; McAllister, W; Yomogida, M; and Shubert, V. (2013) Frequent User Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report. Columbia University Mailman School of Public Health.
[21] Urban Institute (2021) "Breaking the Homelessness-Jail Cycle with Housing First, accessed at https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first_1.pdf

This information is essential for assessing the viability and potential success of the CARE Court proposal, and the lack of such information currently makes a full assessment of the proposal impossible.

Recommendation #5: Ensure Integrated Care of Behavioral Health – Mental Health and Substance Use Disorder Services

Due to the unique behavioral health care funding streams in California, individuals receiving specialty mental health services who also have a substance use challenge must navigate two separate systems (county mental health plans for mental health and county drug Medi-Cal for substance use disorder) to access services. This system fragmentation often results in lack of care coordination and disruptions in care[22], which ultimately results in inadequate services.

To ensure that every individual who is eligible for CARE Court has the greatest opportunity to succeed, it is imperative that every person participating in the program, and those who are pre-enrollment, but receiving outreach and engagement services, be provided with integrated mental health and substance use care.

Recommendation #6: Address System Gaps and Require an Independent Ombudsperson

We believe strongly in the right of all individuals to have access to voluntary, high-quality health and behavioral health services. Services and supports must be available and accessible, and be representative of the diverse needs of Californians. Before California creates another new program, we must first ensure that appropriate services are available for all who need them.

It is well recognized that California has not fully developed system capacity for the full continuum of behavioral health services [23]. California's lack of system capacity includes workforce shortages[24], lack of diversity in mental health professionals[25], and network inadequacy of County Mental Health Plans[26]. Furthermore, the recent report by the State Auditor found that the continuum of services, from intensive treatment to step-down community-based options, are not readily available for people in need[27]. The same report also found that in San Francisco, only about 5% of individuals with five or more holds over 3 years were connected to intensive aftercare services. In Los Angeles, this number was around 10%.

In addition to lack of available services, individuals who receive Specialty Mental Health Services through a County Plan do not always have a source of independent, unbiased assistance or support to help them access needed services. While individuals with HMO insurance can access assistance from the Department of Managed Health Care (DMHC), and individuals with Medi-Cal Managed Care can

[22] California Health Care Foundation, Behavioral Health Integration in Medi-Cal: A Blueprint for California, dated February, 2019. Accessed at: https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf
[23] California Health Care Foundation, Mental Health in California: For Too Many Care Not There, dated March 15, 2018.
[24] UCSF, Healthforce Center, California's Current and Future Behavioral Health Workforce, February 12, 2018.
[25] Ibid.
[26] Department of Health Care Services, Report to CMS: Annual Network Certification on Specialty Mental Health Services. 2020
[27] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.

receive assistance from the DMHC or the Medi-Cal Ombudsman, individuals receiving Specialty Mental Health Services are limited to the county Patients' Rights Advocate (PRA) or the county appeal and grievance process.

Although PRAs are authorized by statute to assist individuals to "secure or upgrade treatment or other services to which they are entitled"[28], there are no minimum PRA staffing ratios defined in the guidelines which results in inadequate staffing of county Patients' Rights Offices so PRAs spend much of their time representing people at certification review hearings and capacity hearings.[29] Another challenge with PRAs is the inherent conflict of interest which arises from the fact that they are either employees or contractors of the county, so their efforts to assert the rights of an individual requires the PRA to essentially dispute their employer which has resulted in multiple instances of retaliation.[30] Lastly, the California Office of Patients' Rights (COPR) is a contract dually executed by the Department of State Hospitals (DSH) and the Department of Health Care Services, however funding for the COPR contract is provided solely by DSH, which results in a majority of COPR's efforts being geared towards supporting PRAs in state hospitals. Support for the county PRAs is very limited, which results in their limited capacity to assist individuals with access to appropriate specialty mental health services and supports.

Without a PRA or an ombudsperson, the county appeal and grievance process can be intimidating, confusing, and lengthy. Individuals rarely know this assistance is available, much less know how to access the process. In addition, lower income individuals often do not have access to computers or internet access, which makes the grievance and appeal process nearly impossible.

Independent Ombuds serve as a liaison between an individual and their health care payor without fear of retaliation. Research has shown that Ombuds increase accountability[31], increase access to health care[32], monitor the functioning of policies, and much more. We believe that access to an independent and unbiased Ombudsperson or entity, either at the state or county level, would have the dual effect of assisting individuals with accessing appropriate services, and identify local gaps in necessary services prior to crisis.

Recommendation #7: Do Not Expand the Lanterman-Petris-Short (LPS) Act

The LPS Act includes protections intended to protect the civil rights of the individual, including referral, evaluation, multiple certification hearings, an investigation, and a court hearing to determine whether the individual, because of a mental health condition or alcohol use, is a danger to themself or others, or is gravely disabled. Gravely disabled is defined as an inability to provide for his or her basic personal needs for food, clothing, or shelter. If, ***after a hearing***, a person is found to meet one of these

[28] Welfare and Institutions Code § 5500(a)
[29] California Behavioral Health Planning Council, Title 9 County Patients' Rights Advocates, highlighting resource, training, and retaliation issues in county patients' rights programs in California. 10/2017 p. 5
[30] Id. Page 8
[31] Durojaye, E., & Agaba, D. K. (2018). Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. Health and human rights, 20(2), 161–168.
[32] Silva, R., Pedroso, M. C., & Zucchi, P. (2014). Ouvidorias públicas de saúde: estudo de caso em ouvidoria municipal de saúde [Ombudsmen in health care: case study of a municipal health ombudsman]. Revista de saude publica, 48(1), 134–141.

requirements, and if the court finds that they should be detained, they are first placed on 72-hour hold, and then may continue to be placed on successively longer holds, after a certification hearing at each stage, until and if a referral to conservatorship is eventually ordered. A referral to conservatorship requires a comprehensive investigation by an officer, and a determination by the court that a person is gravely disabled, they refuse to accept treatment voluntarily ***and*** that no reasonable alternatives to conservatorship exist.

The creation of a new presumption in the CARE Court program, that noncompliance with ***any*** aspect of the individual's court-mandated plan may result in referral for conservatorship with the new presumption that no alternatives exist[33], effectively bypasses the entire LPS process in a number of ways including, but not limited to:

- ***A presumption that no alternatives exist could be construed to include the implicit presumption that the person is gravely disabled.*** Nothing in the CARE Court framework indicates that grave disability is a requirement for referral to conservatorship from the program;
- An individual who complies with the majority of their court-mandated plan could still be referred for fast-track conservatorship for refusing to comply with a single element of their plan, even if they are receiving services voluntarily;
- This process eliminates the 72-hour, 14-day, and 30-day holds which are created in statute to give the individual a chance to stabilize;
- The presumption does not allow for investigation into other alternatives that may exist.

The new presumption represents a dangerous expansion of LPS law. A recent comprehensive State Audit of LPS protocols and procedures at the county-level was conducted last year[34]. The auditor states: "Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change"[35].

In closing, we strongly support the goal of reducing homelessness and providing mental health services to everyone who needs those services. We believe strongly that individuals can and will succeed when they have access to appropriate services that meet their individual needs.

Thank you for the opportunity to provide comments and recommendations on the CARE Court Framework. We look forward to continuing to collaborate with the Administration as this proposal continues to be developed.

[33] See CARE Court FAQ #8, page 3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[34] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.
[35] Ibid. page 1

In community,

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March 25, 2022

Mark Ghaly, MD, MPH

Secretary, California Health and Human Services Agency

1215 O Street

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RE: Preliminary Feedback on CARE Court Proposal

Dear Secretary Ghaly:

On behalf of the undersigned statewide provider advocacy associations, we would like to thank the Administration for reaching out to community-based organizations (CBOs) representing the backbone of the public behavioral health delivery system about the proposed CARE Court framework. We commend Governor Newsom and the Administration for thinking creatively about gaps in the continuum of care for individuals living with behavioral health challenges. We believe the attention to linking some of the most at-risk individuals with severe mental illness who are ready for treatment to important social supports including counseling, medication and housing, are critical interventions in promoting whole person care.

Due to the lack of detail in the proposal to date, our organizations do not have an official position on the CARE Court proposal, and we look forward to additional discussion via the stakeholder workgroups and other communication mechanisms before registering a position. In this vein, we offer the following questions and considerations that we believe should guide the

development of this new program. Our organizations and the members we represent stand ready to engage and lend our expertise as you develop the details of the CARE Court framework.

As we solicited input from our various members, it became clear that there are two overarching concerns that need to be addressed in order to move the framework forward. In particular, coercive treatment and the need to have a very thoughtful implementation process.

Individuals coerced into treatment experience these services as trauma, not "care." Though we understand that the Administration's goal is not to look to conservatorship, 5150's and other types of mandated treatment as a first option, the fact that these may ultimately be a part of some individuals' treatment plans during CARE Court is concerning. Research shows that coerced treatment is also ineffective treatment and there are numerous studies demonstrating this with respect to services for individuals experiencing mental health and substance use conditions. Accordingly, coerced treatment should be a last resort, and only used in those instances where there is an immediate threat to life or risk of serious harm. This is a value shared in common by all four state associations and our member organizations.

It is important to note that when it comes to the proposed target population for CARE Court, those individuals experiencing co-occurring mental health and substance use disorders might be the majority group as they are more likely to come to the attention of those who might make referrals into the CARE Court process. Additionally, we remain concerned about clients who never have had contact with the legal system but through this initiative would be experiencing it through this new program. This is why it is of utmost importance to ensure that the CARE Court referral and treatment process is comprehensive and attends to the various impacts of the social determinants of health on this population.

During our conversations with CalHHS staff, we understand that the Administration's commitment to focusing on the least restrictive treatment environments and allowing as much individual choice in the CARE Court process is valued. However, many of our members continue to react to the messaging around CARE Court which seems to feed into stigma-based beliefs around violence and incompetence on the part of those that CARE Court would look to

serve. This messaging can and will have an impact on those who might participate in CARE Court, and as you have rightly stated, “care” and “court” are two words that don’t make much sense when combined.

With respect to timeline, we believe the January 2023 start date for CARE Court is overly ambitious for an effort with this level of complexity. We are concerned that the ambitious timeline may leave many important details and questions unresolved, and ultimately fail the individuals the proposal aims to help. For example, if critical resources such as workforce for treatment settings and housing do not exist, an individual is bound to fail. As such, we request consideration of a more realistic implementation date.

Below, we outline additional feedback from our members:

How does the Administration envision substance use disorder conditions to be included in CARE Court? Is methamphetamine-induced psychosis, a transient condition, included under the eligibility criteria? Regardless, individuals with co-occurring conditions will be included under CARE Court and the services described do not match what is needed for an individual with a substance use disorder condition. Access to MAT, recovery residences, harm reduction services, contingency management, and individualized treatment are critical for individuals with substance use disorders. Additionally, what will prevent CARE Court from being used to further criminalize or coerce substance use disorders? How will additional treatment capacity be funded for substance use disorder care? Drug Medi-Cal alone cannot meet the full needs. Since a high percentage of the population in question are co-occurring there is a significant capacity shortage today to meet the need of this population.

There will need to be a new workforce of evaluators for CARE Court that is trained specifically on the eligible diagnoses and impairment criteria. From conversations regarding alienist evaluations for felony incompetent to stand trial (IST) evaluations, there is not sufficient training or an adequate amount of evaluators leading to delays before evaluation and inappropriate evaluations leading to individuals who are competent being placed on the IST waitlist. How will the state prevent something similar from happening with CARE Court? One potential solution could include adapting the Massachusetts model for IST evaluations which includes workshops

for evaluators, individual mentoring, review of reports, written examination and an ongoing quality improvement process overseen by the state mental health agency. Additionally, it is imperative that the CARE Court process include protections for underserved, underrepresented and under-resourced communities that have been historically targeted by law enforcement for crimes at a higher rate than other communities.

Given that there is an existing behavioral health staffing shortage, what will prevent CARE Court from draining staff from community-based programs into a costly and time-consuming court process where individuals are already receiving services? We hear from provider agencies that the critical barrier that prevents them from offering additional services is the lack of ability to hire and retain qualified workforce. One specific example is when San Francisco City and County declared a local state of emergency in December regarding the situation in the Tenderloin allowing them to waive the government hiring process and fill nearly all of the hundreds of vacant and funded positions within the behavioral health branch of the Department of Public Health. However, doing this gutted the vital workforce from local CBOs. While we appreciate that the Administration has proposed a Care Economy Workforce request in the Fiscal Year 2022-23 State Budget, workforce development will take time and the immediate need is far greater than what is proposed to meet the needs of Californians with mental health and substance use conditions.

While we understand that CARE Court is not intended to be a silver bullet solution to homelessness, likely a significant portion of the individuals in CARE Court will be experiencing homelessness or housing insecurity. How does CARE Court intend to operate when we are experiencing a general lack of housing services for individuals with behavioral health conditions? We have members that are currently doing a superb job of engaging predominantly individuals experiencing homelessness with both mental health and substance use conditions, but are having a difficult time linking individuals to housing and services particularly for individuals with co-occurring conditions because these options simply do not exist. Clients are able to take a shower, access harm reduction services, and get short-term services, but there remains a need for more housing options for individuals with behavioral health conditions.

It is also important to note that research from Dr. Margot Kushel of UC San Francisco indicates that half of all individuals experiencing homeless today are over the age of 50 with half of this population having their first experience of homelessness after they turned 50 years old. There is a significant percentage of this population who have geriatric conditions beyond their biological age including urinary incontinence, hearing impairment and mobility impairment. As such, access to services, including housing needs to be designed to address these needs. Does the CARE Plan designed within the CARE Court model include adequate access to primary care and physical health care services?

Our members raised several questions about the mechanics of CARE Court and how it will actually work on the ground. The pathway of Referral, Clinical Evaluation, Care Plan, Support, and Success is highly aspirational and does not reflect all of the possible situations that could occur including refusal of treatment. As well as the successful examples outlined in the materials we have seen, is it possible to see a diagram or decision tree that reflects a person refusing or failing out of CARE Court, at each point in the pathway, in order to better understand their treatment options?

Lastly, our members are also concerned about the role that different system representatives play in the CARE Court model. What will happen if a homeless outreach worker or a police officer refers an individual to be evaluated and placed into CARE Court, but the individual refuses? Will the person be arrested or detained by law enforcement? Further, how does the person actually get to the court? Are they transported? Where will the person be detained until they are evaluated? We believe that jails are not the appropriate place for individuals with behavioral health conditions and psychiatric hospitals are already at capacity. What protections will exist for situations where an inappropriate referral is made?

Our organizations combined represent the backbone of California's public behavioral health system. These CBOs will be the providers on the ground serving individuals ordered into CARE Court. We have provided commentary and questions reflecting fundamental details that need to be resolved prior to CARE Court passing the Legislature, being signed by the Governor, and implemented.

We are committed to continuing discussions with our respective members and with the CalHHS team and will engage in the stakeholder and legislative process. If you have any questions, please do not hesitate to outreach to any of our organizations.

Sincerely,

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