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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
July 28, 2022
9:00 AM – 1:45 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING AGENDA

JULY 28, 2022

NOTICE IS HEREBY GIVEN that the Commission will conduct a teleconference meeting on **July 28, 2022, at 9:00 a.m.** This meeting will be conducted pursuant to the Bagley-Keene Open Meeting Act according to Govt. Code Section 11123. The remote locations from which Commissioners will participate are listed below and are open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

Date July 28, 2022

Time 9:00 AM – 1:45 PM

Location Mental Health Services Oversight & Accountability Commission
1812 9th Street, Sacramento, California 95811

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
John Boyd, Psy.D.
Bill Brown
Keyondria D Bunch, Ph.D.
Steve Carnevale
Wendy Carillo
Rayshell Chambers
Shuonan Chen
Dave Cortese
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
Alfred Rowlett
Khatera Tamplen

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: mhsoac-ca-gov.zoom.us/j/86936650259
Meeting ID: 977 9585 2516

FOR PHONE DIAL IN
Dial-in Number: (408)638-0968
Meeting ID: 869 3665 0259

Public participation is critical to the success of our work and deeply valued by the Commission. Please visit pages 4 and 5 for a detailed explanation of how to participate in public comment and for additional meeting locations.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

- Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.
- Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.
- Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

MHSOAC
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Oversight & Accountability Commission

Commission Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

9:00 AM

1. Call to Order

Chair Mara Madrigal-Weiss will convene the Commission meeting, make announcements, and hear committee updates.

9:15 AM

2. Roll Call

Roll call of Commissioners will be taken.

9:20 AM

3. General Public Comment

General Public Comment is reserved for items not listed on the agenda. No discussion or action by the Commission will take place.

9:40 AM

4. May 26, 2022 Meeting Minutes *Action*

The Commission will consider approval of the minutes from the May 26, 2022 teleconference meeting.

- Public Comment
- Vote

9:45 AM

5. CARE Court Update *Information*

The Commission will hear an update on SB 1338, CARE Court legislation presented by Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency and Keris Myrick, MS, MBS, Co-Director of S2i, The Mental Health Strategic Impact Initiative.

- Public Comment

11:45 AM

6. Break

The Commission may take a short break at the discretion of the Chair.

12:00 PM

7. Multi-County Full Service Partnership (FSP) Innovation Project Update *Information*

The Commission will hear an update on the progress made towards the implementation of a multi-county collaborative FSP Innovation Project, presented by Nicole Kristy, Director, Third Sector Capital Partners, Inc.

- Public Comment

12:30 PM

8. Commission 2022-2023 Spending Plan *Action*

The Commission will consider approval of the 2022-2023 Fiscal Year Spending Plan and associated contracts, presented by Norma Pate, Deputy Director.

- Public Comment
- Vote

1:15 PM

9. Mental Health Crisis Triage Legislative Update *Action*

The Commission will hear an update on recent adjustments made to the Mental Health Wellness Act (Senate Bill 82), consider approving funding for the EmPATH emergency psychiatry program, and provide guidance on the priorities for future funding opportunities, presented by Toby Ewing, Executive Director.

- Public Comment

Vote

1:45 PM

10. Adjournment

Mental Health Services
Oversight & Accountability Commission

Our Commitment to Transparency	Our Commitment to Those with Disabilities
Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov	Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fails, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.
- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if

you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **Under newly signed AB 1261,** by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

Additional Public Locations

Los Angeles
811 Wilshire Boulevard
Suite 1000
Los Angeles, CA 90017

Rancho Cordova
10850 Gold Center Drive,
Suite 325
Rancho Cordova, CA 95670

Berkley
1923 Gridiron Way
CMS 122, MC# 1768
Berkeley, CA 94720-1768

Cedars-Sinai Medical Center
Thalians Health Center
8730 Alden Drive
Los Angeles, CA 90048

AGENDA ITEM 4

Action

July 28, 2022 Commission Meeting

Approve May 26, 2022 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the May 26, 2022 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None

Enclosure: May 26, 2022 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the May 26, 2022 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

Mara Madrigal-Weiss
Chair
Mayra E. Alvarez
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Hybrid Meeting
May 26, 2022

MHSOAC
1812 9th Street
Sacramento, CA 95811

Additional public locations included 1923 Gridiron Way, CMS 122, MC# 1768, Berkeley, CA 94720-1768; 8730 Alden Drive, Los Angeles, CA 90048; 10850 Gold Center Drive, Suite 325, Rancho Cordova, CA 95670; 4436 Calle Real, Santa Barbara, CA 93110

Members Participating:

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair
Mark Bontrager
Sheriff Bill Brown*
Keyondria Bunch, Ph.D.
Steve Carnevale**
Rayshell Chambers
Shuonan Chen*
Itai Danovitch, M.D.*
David Gordon
Al Rowlett*
Khatera Tamplen

*Participation via Zoom

**Present via Zoom as an observer. The Commissioner's presence did not count toward the meeting quorum nor could he participate in discussion or action, because his remote location was not noticed per Bagley-Keene Opening Meeting Act requirements.

Members Absent:

John Boyd, Psy.D.
Assembly Member Wendy Carrillo
Senator Dave Cortese
Gladys Mitchell

Staff Present:

Toby Ewing, Ph.D., Executive Director
Maureen Reilly, Acting Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Lauren Quintero, Chief, Administrative Services
Sharmil Shah, Psy.D., Chief of Program Operations

CALL TO ORDER

Chair Mara Madrigal-Weiss called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at approximately 9:00 a.m. and welcomed everyone.

Chair Madrigal-Weiss reviewed a slide about how today's agenda supports the Commission's Strategic Plan goals and objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Chair Madrigal-Weiss congratulated Commissioners Bunch and Gordon on their reappointments and welcomed new Commissioner Rayshell Chambers, representing clients and consumers. She invited Commissioner Chambers to introduce herself.

Chair Madrigal-Weiss asked to pause for a moment of silence to honor and acknowledge the lives lost at the Uvalde school shooting in Texas.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

Chair Madrigal-Weiss gave the announcements as follows:

Announcements

- There will be no Commission meeting in June. The next MHSOAC meeting is scheduled for Thursday, July 28th. The location has yet to be determined.
- The April 2022 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- All Commissioners, partners, and members of the public are invited to the first Children's Committee meeting, which will take place today from 2:00-4:00 p.m.
- The Commission has moved to a new location in Sacramento. The new address is 1812 9th Street, Sacramento, CA 95811. The new phone number is 916-500-0577.
- Send comments or questions to staff regarding the Commission's Racial Equity Plan, which is anticipated to be presented to the Commission for adoption at the July meeting.

New Staff

Chair Madrigal-Weiss invited Lauren Quintero, Chief, Administrative Services, to share recent staff changes.

In response, she stated two new staff have joined the Commission since the last meeting. She introduced Kate Dvoretskikh, Budget Analyst; and Nai Saechao, Engagement and Grants Division Mental Health Student Services Act (MHSSA) Implementation.

Executive Director Ewing introduced Geoff Margolis, the new Chief Counsel for the MHSOAC.

On behalf of the Commission, Chair Madrigal-Weiss welcomed the new staff members to the Commission.

Immigrant Refugee Awards

- The Commission awarded contracts to four local-level organizations and one state-level advocacy organization on May 20th to support the advocacy, training and education, and outreach and engagement needs for immigrant and refugee populations in California.
- The four local-level organizations awarded to work directly with immigrant and refugee populations in their areas where the highest mental health needs exist are: 1)the Cambodian Family in Orange County, 2) the Center for Empowering Refugees and Immigrants in Alameda County, 3) Level Up NorCal in Shasta County, and 4) BPSOS Center for Community Advancement in Orange County.
- The state-level advocacy organization awarded to work closely with the four local-level organizations was the California Pan-Ethnic Health Network (CPEHN) in Alameda County.

Chair Madrigal-Weiss stated information on these organizations and their programs was provided in the meeting materials.

Committee Updates

Chair Madrigal-Weiss invited the Committee Chairs to provide updates on their activities.

Client and Family Leadership Committee Update

Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC), provided a brief update of the work of the Committee since the last Commission meeting:

- The Committee met on May 24th and discussed the Peer Specialist Certification Resource Guide and the proposed CARE Court legislation. She thanked the presenters who provided updates on the Resource Guide and Committee Members and members of the public who added to the conversation and shared their perspectives.
- The Draft Peer Specialist Certification Resource Guide is anticipated to be completed at the end of July.
- The Committee is continuing the conversation on the CARE Court legislation and creating a forum where both sides can be heard and solutions can be explored. She expressed that it takes the community to come together to find those solutions.

Cultural and Linguistic Competency Committee Update

Vice Chair Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CLCC met on May 12th. The Committee heard an update by Dr. Anna Naify, MHSOAC Consulting Psychologist, on the Commission's Racial Equity Plan and the

Committee discussed next steps regarding strategies to involve the Committee in the collaboration efforts with the Commission's advocacy contractors.

- The CLCC members discussed what they looked forward to contributing, including the scope of work and opportunities to influence the important work of the Commission to advance racial equity.
- The Committee heard a presentation from Dr. Lawford Goddard from the Association of Black Psychologists. His presentation touched on an array of subjects focused on Black communities, particularly the link between mental health and wellbeing and Black culture. He noted the lack of much-needed funding for mental health services for Black communities, cultural barriers between clinicians and Black communities, and the need for Black mental health professionals as well as therapeutic approaches that would better value Black culture.
- Part of the conversation focused on the challenges that many smaller organizations have in accessing funding, a recurring theme that has come up in the Committee's discussion.
- Dr. Goddard was one of the Committee's first Equity in Action presenters. Moving forward, the Committee would like the standing agenda item to focus on Equity in Action as it relates to mental health services and care delivery. The goal is for each of these meetings to feature these organization representatives to not only educate Committee Members and raise awareness, but to define opportunities for the Commission to support these efforts moving forward.
- Vice Chair Alvarez stated there is no need to look any further than many of the local leadership that is already happening in this work to operationalize the Commission's Racial Equity Plan.
- The next CLCC meeting is scheduled for Thursday, July 14th.

Research and Evaluation Committee Update

Chair Madrigal-Weiss stated the update for the Research and Evaluation Committee will be posted online.

Recognition

Executive Director Ewing thanked former Chief Counsel Filomena Yeroshek for everything she has done for this Commission, the state of California, and the people in the state who are working to better understand and address what mental health and wellbeing means. On behalf of the Commission, he presented Ms. Yeroshek with a resolution in appreciation for her dedication and years of service to the Commission and wished her all the best in her new role.

Roll Call

Maureen Reilly, Acting Chief Counsel, called the roll and confirmed the presence of a quorum.

GENERAL PUBLIC COMMENT

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), expressed her thanks, appreciation, and gratitude for Ms. Yeroshek and her work over the years and welcomed new Commissioner Chambers to the Commission. She thanked the Commission for listening to the community and having a statewide advocacy contractor for the Immigrant and Refugee contractors.

Stacie Hiramoto stated the hope that the Commission will take a position on the CARE Court bill. REMHDCO has an oppose position, which has become much stronger since the new amendments will allow Mental Health Services Act (MHSA) dollars to go to CARE Court programming. The speaker also stated that MHSA was meant for upstream prevention and not for programs that are coercive or institutional; although everyone deserves help, this is not where the funding should go.

Ruqayya Ahmad, Policy Fellow, CPEHN, welcomed Commissioner Chambers to the Commission. She thanked the Commission for the intent to award CPEHN the Immigrant and Refugee Advocacy Contract.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, thanked Ms. Yeroshek for her work and wished her well in the future. She thanked the CLCC Chair and staff for the high-quality presentation at the last CLCC meeting on community organizations and African and African immigrant issues.

Dr. Benhamida agreed that the CARE Court bill is a difficult subject and is divisive. She stated she finds the term "CARE Court" to be an oxymoron. The word "court" inspires dread not confidence to many who have lived experience with courts. Especially among immigrants and refugees, the use of psychiatry to punish dissidence has been one cause of pain, torture, and post-traumatic stress disorder (PTSD). The speaker expressed that psychiatry and the courts are not a good combination.

ACTION

1: April 28, 2022, MHSOAC Meeting Minutes

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the April 28, 2022, teleconference meeting. She stated meeting minutes and recordings are posted on the Commission's website.

Chair Madrigal-Weiss asked for a motion to approve the minutes.

Commissioner Tamplen made a motion to approve the April 28, 2022, teleconference meeting minutes.

Commissioner Gordon seconded.

Action: Commissioner Tamplen made a motion, seconded by Commissioner Gordon, that:

- *The Commission approves the April 28, 2022, Teleconference Meeting Minutes as presented.*

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Gordon, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioners Chambers and Danovitch.

ACTION

2: <u>Consent Calendar</u>

1. Kern County Innovation Project: Approval of $1,632,257 in Innovation funding over four years to support joining the Early Psychosis Learning Health Care Network Multi-County Innovation Project previously approved by the Commission on December 17, 2018.
2. Tri-City County Innovation Project: Approval of $789,360 in Innovation funding over three years to support joining the Psychiatric Advance Directives (PADs) Multi-County Innovation Project previously approved by the Commission on June 24, 2021.
3. Contra Costa County Innovation Project: Approval of $1,500,058 in Innovation funding over three years to support joining the Psychiatric Advance Directives (PADs) Multi-County Innovation Project previously approved by the Commission on June 24, 2021.

Chair Madrigal-Weiss stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

Commissioner Chambers recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Madrigal-Weiss asked for a motion to approve the Consent Calendar.

Commissioner Brown made a motion to approve the Consent Calendar.

Commissioner Rowlett seconded.

Action: Commissioner Brown made a motion, seconded by Commissioner Rowlett, that:

- *The Commission approves the Consent Calendar as presented.*

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Danovitch, Gordon, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Commissioner Chambers rejoined the meeting.

ACTION

3: <u>Orange County Innovation Project Approval</u>

Presenter:

- Sharon Ishikawa, Ph.D., Research Manager, Mental Health and Recovery Services, Orange County Health Care Agency

Chair Madrigal-Weiss stated the Commission will consider approval of $12,000,000 in Innovation funding for Orange County's Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice-Involved Young Adult Men: A Randomized Controlled Trial Innovation Project. She asked the county representative to present this agenda item.

Sharon Ishikawa, Ph.D., Research Manager, Mental Health and Recovery Services, Orange County Health Care Agency, provided an overview, with a slide presentation, of the need, current and proposed expansion, community contribution, learning objectives, and budget of the proposed Innovation Project. She stated, in direct response to pilot participant requests and feedback, this project will add and expand a range of behavioral health and supportive services, including peer mentoring.

Dr. Ishikawa noted that this project is voluntary. Consenting to participate in the Randomized Controlled Trial (RCT) research study is separate from consenting to participate in the Young Adult Court (YAC) interventions. An important element of the YAC is the dismissal or reduction of all prior felony charges after successful completion of the YAC programming. The increased data from additional participants and a longer follow-up period will play a critical role in influencing whether the Superior Court and the District Attorney's Office will continue to support charge dismissals and reductions.

Commissioner Questions

Commissioner Bunch asked if the $12 million request is for the research study only.

Dr. Ishikawa referred to the Budget presentation slide and stated the proposed funding is for both: $3.7 million is for the research study and $5.2 million is for mental health and supportive services.

Commissioner Bunch asked for additional details about keeping the existing two-year diversion program, which has a developmental focus.

Dr. Ishikawa referred to the Current and Proposed Expansion presentation slide and stated the left side of the slide describes what is currently being implemented through the YAC in Orange County, which is related to justice and court proceedings that ensure that participants in the YAC program attend all of their court hearings and appointments with probation officers and case managers who connect them to community-based resources. The activities listed on the left side of the slide will continue through non-Innovation funding.

Dr. Ishikawa stated the right side of the slide describes the proposed expanded services and supports, including mental health and co-occurring services, peer mentoring, apprenticeship programs, scholarships, housing and transportation vouchers, and other services.

Commissioner Tamplen asked about community involvement in the development of the pilot program and proposed projects.

Dr. Ishikawa stated the proposed expansion of services was borne out of the implementation of the original pilot program with UC Irvine and the Justice Collaborative, including feedback gathered from the young men who participated in the original pilot program. The recommended expansion of services was then presented to the community for support.

Commissioner Tamplen asked how the court will address young men of color with mental health issues who do not have access to the county's Full-Service Partnerships (FSPs).

Dr. Ishikawa observed that Full Service Partnerships (FSPs) serve those who are living with a serious mental health condition. Individuals who are involved in young adult work are either at risk due to trauma exposure or they are reporting mild to moderate symptoms of anxiety and depression. They would not qualify for FSPs, given their current level of mental health needs. This is one of the gaps the proposed project would address.

Commissioner Tamplen spoke in support of more prevention and early intervention and less court intervention. She stated the proposed project does not align with Innovation.

Commissioner Danovitch thanked Commissioner Tamplen for raising the question about the innovativeness of the proposed project. The speaker also observed that Innovation projects have two elements: they represent a solution to a problem, and they include a mechanism to evaluate whether that solution has had an impact.

Commissioner Danovitch stated the proposed project involves individuals who are in the criminal justice system and makes an effort to add an Innovation that takes care of them in a more effective way while they are in that system. This is feasible because there has already been some Innovation in its development and it includes a formal evaluation mechanism.

Commissioner Danovitch stated the evaluation proposal is one of the most compelling evaluation proposals the Commission has ever received in terms of the ability to practically ask and answer the questions at hand, which makes it possible at the end of the project to learn whether this investment of resources produces benefits to determine whether it should be sustained, shuttered, or adapted. The capacity to do these kinds of evaluations is almost as important as the substance of the Innovation.

Commissioner Brown asked about eligible offenses that this program would be used for.

Tamika Williams, Deputy District Attorney, who oversees the YAC, stated all felony charges are eligible except the most severe charges that involve guns, gang involvement, murder, or sexual assault.

Commissioner Brown asked if there is a restorative approach where the victims are involved in the decision-making process for someone to go through this alternative to the traditional justice system.

Ms. Williams stated the victims must be informed at every stage of the process. Victim witness advocates are available to help victims participate in the process, if they so choose.

Commissioner Brown asked how participants will be held accountable for their crimes and if this program will be seen as allowing criminal offenders to escape accountability for serious crimes. He asked if offenders who are in this two-year diversion program are supervised by probation and if they will be sanctioned if they commit new offenses while under supervision.

Ms. Williams stated a dedicated probation officer to the court will provide supervision. If a new offense is committed or they do not engage and follow through with the four phases of the program, they will not graduate and the sentence will be imposed.

Commissioner Brown stated the staff report mentions that the interagency collaborative group included the police department, which was conspicuously absent from the presentation. He asked if the police department is no longer supportive of the proposed project.

Dr. Ishikawa stated it was a typo. The public defenders' office was a member of the interagency collaborative, not the Irvine Police Department.

Commissioner Brown asked if there has been an attempt to invite the police agencies or the Orange County Sheriff's Office to be a part of the collaborative.

Frank Davis, Director, Orange County Alternate Defenders' Office, who oversees the YAC, stated one of the interested parties is the Orange County Sheriff's Department, as they are involved in the court system~~,~~ in transporting clients to and from the court, and also are in the court at all times. Police departments are also involved indirectly through Assembly Bill (AB) 109.

Mr. Davis stated, regarding the question on accountability, the county has step-up sanctions, which is common for community courts, such as: writing an essay; community service; GPS

ankles (ankle-worn monitoring devices); and flash incarceration, where clients can be taken in for up to 10 days. The speaker added that every YAC client is supervised by the Orange County Probation Department and case workers.

Vice Chair Alvarez- said it is important to state that the proposed project puts a partnership in place to make a warm handoff real, and is a whole-person approach to taking care of this community to reduce recidivism and promote wellbeing for these young people to put them on the path to success. The speaker said this same conversation about "wrapping around" people to meet all of their needs as a whole being, is occurring across systems. Vice Chair Alvarez recommended a cross-sector application of the data that will come out of this rigorous evaluation and thinking holistically about impacts. This would be valuable data for the county, state, and nation.

Commissioner Bunch asked if there is a specific qualifying diagnosis for participation and if there is a medication component.

Dr. Ishikawa stated there is no requirement for a mental health diagnosis to be part of the YAC. Medication, if clinically indicated, will be supported through the funding for mental health and behavioral health services.

Commissioner Tamplen asked about consequences of not completing the four phases of the program.

Elizabeth Cauffman, Ph.D., Professor of Psychological Science, Education, and Law, UC Irvine, stated if participants do not complete the four phases – engagement, goal planning, managing the goal, and ability to do without the service – they are terminated from the program.

Commissioner Gordon stated this Innovation will teach about what is possible and what works; it is not about making policy. The proposed project will provide information about what can be done better with substantial documentation from the research study.

Public Comment

Stacie Hiramoto stated REMHDCO has concerns about the proposed project since it is a tremendous amount of funding for an Innovation project. She thanked Commissioner Tamplen for asking why Community Services and Supports (CSS) funding could not be used for this program; or even prevention and early intervention funding. Oftentimes, youth from communities of color do not get a correct diagnosis. The speaker said that this program, no matter how good it is, does nothing to prevent or impact the school-to-prison pipeline; it comes far too late.

Stacie Hiramoto stated REMHDCO believes that Innovation funding should be more for prevention or upstream programs, since there are so few other sources for community-defined evidence programs. It would make more sense, be less expensive in the long run, and would prevent the crimes from taking place in the first place for these young men to be offered these wonderful services prior to their interaction with the criminal justice system.

Stacie Hiramoto stated the importance of having programs that would prevent individuals from falling into the criminal justice system. This can be accomplished by investing in community-defined evidence programs provided by community-based organizations. She asked the county about efforts to reach these young men as children or before they reach this stage.

Stacie Hiramoto stated REMHDCO is concerned that the Commission has the power to add to the priorities of prevention and early intervention for transition-age youth (TAY) from underserved communities who are not in college. Senate Bill (SB) 1004 includes PEI services for TAY in college, but not TAY who are not in college.

Richard Gallo, consumer and advocate and Volunteer State ACCESS Ambassador with Cal Voices, spoke in opposition to the proposed project. This funding should not be used for this purpose. The intent of the MHSA is about prevention. Funding needs to be used for prevention.

Laurel Benhamida echoed Stacie Hiramoto's comments and stated serious concerns about this proposal. She asked if the research study categories have been broken down by different ethnicities or language backgrounds so at least a little progress can be made to learn evidence-based practices for different groups.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion to approve Orange County's Innovation project.

Vice Chair Alvarez moved the staff recommendation.

Commissioner Gordon seconded.

Commissioner Rowlett stated he was uniquely moved by the proposed project because he has had the privilege to mentor young men who have had involvement with the criminal justice system. It is frustrating that the legal system does not recognize that current practices are completely ineffective and that the legal system does not make a door available to young men to ameliorate the implications for the rest of their lives of being charged with a felony. Although he believes that this randomized controlled trial should happen, he is concerned whether this is the right source of funding for it.

Action: Vice Chair Alvarez made a motion, seconded by Commissioner Gordon, that:

The Commission approves Orange County's Innovation Project, as follows:

> *Name: Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice Involved Young Adult Men: A Randomized Controlled Trial*
>
> *Amount: Up to $12,000,000 in MHSA Innovation funds*
>
> *Project Length: Five (5) Years*

Motion carried 9 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Chambers, Chen, Danovitch, Gordon, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner voted "No": Commissioner Tamplen.

ACTION

4: <u>Governor's Budget Revisions for 2022</u>

Presenter:

- Norma Pate, Deputy Director

Chair Madrigal-Weiss stated the Commission will be presented with the Governor's budget revisions for 2022. She asked staff to present this agenda item.

Norma Pate, Deputy Director, provided an overview, with a slide presentation, of the Governor's May Revise for 2022-23, children, youth, and families, Community Assistance, Recovery, and Empowerment (CARE) Court, equity and practice, homelessness, and Commission proposals for 2022-23. She noted that there is no action for Commissioners to take today.

Public Comment

Steve Leoni, consumer and advocate, stated the Commission needs to keep up-to-date on the CARE Court issue, which is divisive and does not advance racial equity. The Village Model, which is what the MHSA is based on, included patient, persistent, respectful outreach and trust building over time, not just offering individuals voluntary services. Trust building very carefully can help these individuals without the use of force, the speaker said.

Stacie Hiramoto stated REMHDCO has no objection to the Commission taking positions on legislation but strongly recommended creating a legislative committee to discuss legislation thoroughly prior to bringing it before the Commission. She also suggested including all perspectives when presenting bills at Commission meetings.

Steve McNally, Member, Orange County Behavioral Health Advisory Board, spoke on their own behalf. The speaker stated it is difficult for individuals at the local level to understand the nuances of the Governor's legislative information. The speaker asked the Commission to organize and align with the California Behavioral Health Planning Council, and the 59 local boards to inform the public, share information, and collect information for each other rather than acting in siloes.

Steve McNally asked the Commission to locate a legislative analyst who can help explain how MHSA funding can or cannot be used for matches for housing and how to leverage everything together to avoid duplication or delay implementation of programs due to miscommunication.

Richard Gallo spoke in opposition to the CARE Court bill. The speaker expressed that it is set up for failure, and there is no housing for participants. There are other innovative ways to do this successfully without CARE Courts, like a program in Long Beach. The Long Beach Model needs to be utilized to help the community, especially for those with severe mental illness. The speaker said, it is all about seeking the appropriate help, connecting with appropriate agencies and organizations to be housed, and then maintaining their independence living in a home.

Richard Gallo stated disappointment in the Commission's vote for the Orange County Innovation Project. The project was not transformative.

Tara Gamboa-Eastman, Legislative Advocate, Steinberg Institute, stated the Steinberg Institute is supportive of the Commission's proposed modifications to SB 82. She suggested the following changes to the proposed modifications: include additional clarity that it refers to crisis prevention and early intervention when talking about prevention and early intervention for SB 82 dollars; and, that leveraging every dollar possible to address the workforce shortage be a priority in grant-making, not a requirement for grant applications.

Vanessa Ramos, resident of Ventura County, asked the Commission to allow time for a CARE Court discussion. The CARE Court bill is based on stigma and stereotypes of individuals living with mental health disabilities and experiencing homelessness. It will disproportionately impact Black Californians who make up 40 percent of the unhoused population. The speaker emphasized that CARE Court only furthers institutional racism.

Vanessa Ramos stated the court system does not have appropriate care for individuals with mental health disabilities, especially for Black and brown individuals. She agreed with Richard Gallo that there are other successful methods rather than CARE Court. The speaker stated that CARE Court is a coerced court-ordered treatment system that will strip people with mental health disabilities of their rights to make their own decisions and will do more harm.

ADJOURN

Chair Madrigal-Weiss stated there will be no Commission meeting in June. The next Commission meeting is scheduled for July 28th. There being no further business, the meeting was adjourned at 11:49 a.m.

AGENDA ITEM 5

Information

July 28, 2022 Commission Meeting

CARE Court Update

Summary

The Commission will hear an update on SB 1338, CARE Court legislation presented by Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency and Keris Myrick, MS, MBS, Co-Director of S2i, The Mental Health Strategic Impact Initiative.

Background

California Governor Gavin Newsom has proposed the creation of the Community Assistance, Recovery and Empowerment (CARE) Court. According to the California Health and Human Services Agency (CalHHS), "CARE Court is a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need."

Governor Gavin Newsom. According to the Governor's Office:

- CARE Court is aimed at helping the thousands of Californians who are suffering from untreated mental health and substance use disorders leading to homelessness, incarceration or worse.

- California is taking a new approach to act early and get people the support they need and address underlying needs - and we're going to do it without taking away people's rights.

- CARE Court includes accountability for everyone– on the individual and on local governments with court orders for services.

Senate Bill 1338. The Governor's proposal is embodied in Senate Bill 1338, which is authored by Senators Umberg and Eggman, and coauthored by Senators Allen, Archuleta, Caballero, Cortese, Dodd, Hertzberg, Newman, Portantino, Stern, and Wiener; and, Assembly Members Aguiar-Curry, Berman, Bloom, Chen, Cooper, Cunningham, Gipson, Haney, Irwin, O'Donnell, Petrie-Norris, Rodriguez, Santiago, and Villapudua.

Legislative Intent. Through SB 1338, the Legislature has declared:

(a) Thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

(b) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. But too often this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

(c) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(d) California has made unprecedented investments in behavioral health, housing, and combating homelessness, and CARE Court helps those with the greatest needs access these resources and services. CARE Court provides a framework to ensure counties and other local governments focus their efforts to provide comprehensive treatment, housing, and supportive services to Californians with complex behavioral health care needs so they can stabilize and find a path to wellness and recovery.

(e) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated severe mental illnesses with the establishment of a new CARE Supporter role, in addition to legal counsel, provision of legal counsel for CARE proceedings. proceedings, agreements, and plans, as well as the promotion of supported decision-making.

(f) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution to ensure access to comprehensive services and supports for some of the most ill and most vulnerable Californians.

Bill Enactments. In addition to the making these policy declarations, the Bill specifically does the following:

1. Enacts the Community Assistance, Recovery, and Empowerment (CARE) Act, which authorizes specified persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services to adults who are

suffering from currently experiencing a severe mental illness and have a diagnosis of schizophrenia spectrum and psychotic disorders and who meet other specified criteria.

2. Specifies the process by which the petition is filed and reviewed, including requiring the petition to be signed under penalty of perjury, and to contain specified information, including the facts that support the petitioner's assertion that the respondent meets the CARE criteria. The bill would also specify the schedule of review hearings required if the respondent is ordered to comply with an up to one-year CARE plan by the court.

3. Makes the hearings in a CARE proceeding confidential and not open to the public, thereby limiting public access to a meeting of a public body.

4. Authorizes the CARE plan to be extended once, for up to one year, and would prescribe the requirements for the graduation plan that is required upon leaving the CARE program. plan.

5. By expanding the crime of perjury and imposing additional duties on the county behavioral health agencies, this bill imposes a state-mandated local program.

6. Requires the court to appoint counsel and a CARE supporter for the respondent, unless the respondent has retained their own counsel or CARE supporter, or chooses not to have a CARE supporter. counsel.

7. Authorizes the respondent to have a supporter.

8. Requires the California Department of Aging to administer the CARE Supporter program, which would make available a trained CARE supporter to each respondent, who can accept, decline, or choose their own voluntary, unpaid CARE supporter, and requires optional training to be made available for volunteer CARE supporters.

9. Requires the State Department of Health Care Services to provide optional training and technical resources for volunteer supporters on CARE Act proceedings, community services and supports, supported decision-making, and other topics.

10. Requires the California Health and Human Services Agency, or a designated department within that agency, to engage an independent, research-based entity to advise on the development of data-driven process and outcome measures for the CARE Act and to provide coordination and support among relevant state and local partners and other stakeholders throughout the phases of county implementation of the CARE Act.

11. Requires the State Department of Health Care Services to provide training and technical assistance to county behavioral health agencies to implement the act and requires the Judicial Council and the State Department of Health Care Services to provide training to judges and counsel regarding the CARE Act.

12. Authorizes the court, at any time during the proceedings if it finds the county or other local government entity not complying with court orders, to fine the county or other local government entity up to $1,000 per day and, if the court finds persistent noncompliance, to appoint a receiver to secure court-ordered care for the respondent at the county's cost.

13. Establishes the CARE Act Accountability Fund in the State Treasury to receive the fines collected under the Act, which would be used, upon appropriation, by the State Department of Health Care Services, to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders who experience or are at risk of homelessness, criminal justice involvement, hospitalization, or conservatorship.

14. Requires the independent, research-based entity retained by the State Department of Health Care Services, in consultation with various other entities, to develop an annual CARE Act report and an independent evaluation of the effectiveness of the CARE Act, and requires county behavioral health agencies and other local governmental entities to provide the department with specified information for that report.

15. Clarifies that MHSA funds may be used to provide services to individuals under a CARE agreement or a CARE plan. The Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund (MHSF), a continuously appropriated fund, to fund various county mental health programs, including children's mental health care, adult and older adult mental health care, prevention and early intervention programs, and innovative programs.

16. Requires health care service plans and insurers to cover the cost of developing an evaluation for CARE services and the provision of all health care services for an enrollee or insured when required or recommended for the person pursuant to a CARE plan, without cost sharing, except for prescription drugs. drugs, and regardless of whether the services are provided by an in-network or out-of-network provider.

17. Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning the defendant to competency. Existing law suspends a criminal action pending restoration to competency.

18. For a misdemeanor defendant who has been determined to be incompetent to stand trial, authorizes the court to refer the defendant to the CARE program.

There is significant interest in the bill, including organizations and individuals that either support, oppose, or have expressed concerns over the legislation.

Support. According to the Assembly Health Committee, the Bill's support includes more than "45 cities, including the Big City Mayor Coalition write in support of the bill. Specifically, local governments from San Diego, including the City and County of San Diego County (SD), state in support:

- That the creation of CARE Courts represents a thoughtful approach to addressing the behavioral health crisis we are witnessing on our streets and getting people connected with the care they need earlier.
- It appropriately recognizes the continuum of care that this small but highly visible segment of the population with significant mental health disorders deserve.
- As with local agencies throughout the State, SD's communities are facing a daunting homelessness crisis. However, the unsheltered population is as diverse as the general population, all who come to their housing situation with different backgrounds, upbringings, and traumas.
- It is imperative that we provide multi-faceted solutions to help the myriad situations our fellow Californians face. Some unsheltered individuals recently lost a job and need quick and focused assistance; some have SMI and SUD issues that have developed over many years resulting in an inability to care for themselves.
- SD states that CARE Court will provide a new and focused civil justice alternative to those struggling with schizophrenia spectrum or psychotic disorders and who lack medical decision-making capacity.
- The CARE plan envisioned by this bill provides numerous safeguards to ensure personal civil liberties are respected and protected.

The California Chamber of Commerce (Chamber), along with 27 local chambers of commerce and business associations, also in support state:

- the CARE Court is a thoughtful, measured response to the tragedy of homeless mentally ill or substance abuse disordered individuals. It attempts to thread the needle of providing necessary care and treatment in an environment appropriate to deliver those services; that is, a supportive setting that is neither outdoors or incarcerated.
- Importantly, the individuals to be served by this approach lack the capacity to make medical decisions for themselves; the only alternatives are the status quo, which is continued desperate deterioration living outdoors, or in a far more restrictive conservatorship or incarceration.
- The Chamber states in conclusion that California employers have a clear stake in improving the treatment and outcomes for severely mentally disabled individuals without a fixed residence.
    - First, they are our fellow Californians, in severe need, for whom we have an obligation of care.
    - Second, many employers share neighborhoods with mentally disabled or substance abuse disordered individuals, so have first-hand experience with the failure of our institutions to adequately serve them and address their misery.
    - Finally, as taxpayers and business leaders, employers want to see their private investment return healthy, thriving communities."

Opposition. Also according to the Assembly Health Committee, the Bill's opposition includes a "coalition of over 40 advocacy groups, including Disability Rights California, American Civil Liberties Union, and the Depression and Bipolar Support Alliance (Coalition), write in opposition to this bill. The Coalition states that the CARE Court framework this bill seeks to establish is unacceptable for a number of reasons:

a) It perpetuates institutional racism through a system of coerced treatment and worsens health disparities, directly harming Black, Indigenous and People of Color;
b) It denies a person's right to choose and have autonomy over personal healthcare decisions;
c) It does not guarantee housing provided with fidelity to principles that prioritize voluntary services, an approach that is backed by evidence;
d) Community evidence-based practices and scientific studies show that adequately resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment; and,
e) It will not matter that the terms used are called "Supportive Decision-Making" and "Supporter" because the Supporter's role is to implement an involuntary medical plan ordered by a civil court, and disregards the importance of voluntary decisions in mental health treatment.

The Coalition continues that:

- CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction.
- The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing homelessness.
- While the Coalition agrees that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with SMI, CARE Court is the wrong framework.
- The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services. In concluding, the Coalition states that because CARE Court will harm Californians with disabilities, they strongly oppose this bill and instead, would welcome a proposal developed with input from the people CARE Court seeks to help.
- The Coalition believes a community-based approach would be far more likely to succeed. Such an approach would expand resources for permanent affordable housing with voluntary supports and increase early access to voluntary, community-based treatment based on principles of trauma-informed care and the complete removal of law enforcement and the courts from the process."

Concerns. In addition to those that support or oppose the Bill, according to the Assembly Health Committee, "Numerous organizations write in with significant concerns regarding this bill, including 13 individual counties. One County Coalition (CC) representing the California State Association of Counties, the Rural County Representatives of California, the Urban Counties of

California, the County Behavioral Health Director's Association, the County Welfare Directors Association and the California State Association of Public Administrators, Public Guardians and Public Conservators. CC states that as currently drafted, this bill requires all 58 counties to establish a CARE Court. Counties would play a key and substantial role in implementation as the state's partners in providing critical behavioral health and social services. For these reasons, CC strongly advocates the adoption of the following policy recommendations and local investments to help ensure CARE Courts can be implemented in a practical and achievable manner in all 58 counties:

a) Phased-In Implementation: The path to success for counties – more importantly, for those who stand to benefit from CARE Court – must be grounded in an incremental phase-in model, in which counties most prepared to implement are the first adopters. This includes, but is not limited to, the resources and ability of courts to establish the new processes and procedures without contributing to further court backlogs; the staffing and funding capacity for behavioral health and social services to provide the necessary services to existing and new populations; and local solutions for ongoing housing shortages, which presents one of the biggest challenges and most critical elements for program success;
b) Resources: The CARE Court program includes new responsibilities and obligations imposed on counties that require additional resources and ongoing funding, likely in the hundreds of millions of dollars. Adequate and sustainable funding, as well as start-up funding is required across multiple departments, including county behavioral health, public defender, county counsel, public guardians and conservators, and county social services. This is in addition to funding required for court administration, operation, and staffing;
c) Fiscal Protections: The CARE Court proposal must provide protections to counties for any new responsibilities and costs. To ensure our counties have the appropriate long-term resources, we recommend fiscal provisions that preserve current funding and services, while also providing a mechanism for determining and allocating supplementary annual funding for new activities and duties required by this bill;
d) Sanctions: Sanctions should be reserved for deliberate and chronic deficiencies, imposed only after meaningful engagement within the existing regulatory framework along with the appropriate procedural safeguards. In addition, sanctions should not begin until after the program has been fully funded and implemented; and,
e) Housing: Housing is imperative for the successful treatment of those with SMI and foundational to addressing the larger problem of homelessness across California. To ensure that the state's recent housing investments are available to serve the CARE population, counties support recent amendments authorizing the Superior Court to order housing providers that have received specified state funds to accept placement of CARE participants at any available housing option or program as appropriate to meet the respondent's needs."

<u>Bill Support</u>

- Alameda County Families Advocating for The Seriously Mentally Ill
- Bay Area Council
- Big City Mayors
- Building Owners and Managers Association

- California Association of Code Enforcement Officers
- California Chamber of Commerce
- California Downtown Association
- California Hospital Association
- California Professional Firefighters
- California Travel Association (CALTRAVEL)
- Central City Association of Los Angeles
- City of Alhambra
- City of Bakersfield
- City of Berkeley
- City of Beverly Hills
- City of Buena Park
- City of Carlsbad
- City of Chino Hills
- City of Chula Vista
- City of Concord
- City of Corona
- City of Coronado
- City of Del Mar
- City of El Cajon
- City of Encinitas
- City of Escondido
- City of Fontana
- City of Fullerton
- City of Garden Grove
- City of Half Moon Bay
- City of Huntington Beach
- City of Imperial Beach
- City of Irvine
- City of La Mesa
- City of Lemon Grove
- City of Mission Viejo
- City of Montclair
- City of National City
- City of Oceanside
- City of Ontario
- City of Paramount
- City of Poway
- City of Rancho Palos Verdes
- City of Redwood City
- City of Riverside
- City of San Diego
- City of San Marcos
- City of Santa Monica
- City of Santa Rosa
- City of Santee
- City of Solana Beach
- City of Upland
- City of Vista
- County of Contra Costa
- County of Marin
- County of San Diego
- Family and Consumer Advocates for The Severely Mentally Ill
- Family Services Association
- Fontana Chamber of Commerce
- Fremont Chamber of Commerce
- Garden Grove Chamber of Commerce
- Golden Gate Restaurant Association (GGRA)
- Govern for California
- Harbor Association of Industry & Commerce
- Hotel Council of San Francisco
- Inland Empire Economic Partnership (IEEP)
- Laguna Niguel Chamber of Commerce
- Lake Elsinore Valley Chamber of Commerce
- Los Angeles Area Chamber of Commerce
- Los Angeles Business Council
- Los Angeles County Business Federation (BIZFED)
- National Alliance on Mental Illness (NAMI-CA)
- Neighborhood Partnership Housing Services, INC.
- Oceanside Chamber of Commerce
- Orange County Business Council
- Orange County Hispanic Chamber of Commerce
- Palos Verdes Peninsula Chamber of Commerce

- Psychiatric Physicians Alliance of California (PPAC)
- Redondo Beach Chamber of Commerce
- Sage Leadership Academy
- San Diego County District Attorney's Office
- San Diego Regional Chamber of Commerce
- San Francisco Chamber of Commerce
- San Francisco Travel Association
- San Pedro Chamber of Commerce
- Santa Clarita Valley Chamber of Commerce
- Santa Rosa Metro Chamber of Commerce
- Santee Chamber of Commerce
- South Bay Association of Chambers of Commerce
- Tulare Chamber of Commerce
- Valley Industry and Commerce Association
- West Ventura County Business Alliance

Bill Opposition

- A & L Association
- Abolition Study Group of Psychologists for Social Responsibility
- American Civil Liberties Union (ACLU), Center for Advocacy & Policy CA
- American Civil Liberties Union California Action
- American Civil Liberties Union of California
- Anti Police-terror Project
- Bay Area Legal Aid
- California Behavioral Health Planning Council
- Cal Voices
- California Advocates for Nursing Home Reform
- California Assoc. of Mental Health Peer Run Organizations (CAMHPRO)
- California Democratic Party Black Caucus Legislative Committee
- California Pan-ethnic Health Network
- Caravan 4 Justice
- Care First California
- Corporation for Supportive Housing (CSH)
- County of Humboldt
- Depression and Bipolar Support Alliance
- Dignity and Power Now

- Disability Rights Advocates
- Disability Rights California
- Disability Rights Education & Defense Fund (DREDF)
- Disability Rights Legal Center
- Drug Policy Alliance
- Ella Baker Center for Human Rights
- Funders Together to End Homelessness San Diego
- Housing California
- Housing Is a Human Right - Orange County
- Human Rights Watch
- Inland Equity Partnership
- Justice in Aging
- Justice LA
- Justice Teams Network
- Justice2jobs Coalition
- Kelechi Ubozoh Consulting
- LA Defensa
- Law Foundation of Silicon Valley
- Los Angeles Community Action Network
- Lotus Collective
- Love and Justice in The Streets
- Loyola Law School
- Mental Health Advocacy Services
- Mental Health America of California
- NAACP San Mateo Branch #1068 Housing Committee
- National Association of Social Workers, California Chapter
- National Health Law Program
- National Homelessness Law Center
- Nextgen California
- No CARE Court California Coalition
- Norcal Resist
- Peers Envisioning and Engaging in Recovery Services (PEERS)
- People's Budget Orange County
- People's Homeless Task Force Orange County
- Project Amiga
- Public Interest Law Project
- Racial and Ethnic Mental Health Disparities Coalition
- Rosen Bien Galvan & Grunfeld, LLP
- Sacramento Homeless Organizing Committee
- Sacramento LGBT Community Center
- Sacramento Regional Coalition to End Homelessness
- San Bernardino Free Them All
- San Francisco Pretrial Diversion Project
- San Francisco Public Defender's Office
- Senior & Disability Action
- Senior and Disability Action
- Starting Over INC.
- Stop the Musick Coalition
- Street Watch LA
- Stronger Women United
- The Bar Association of San Francisco
- The Coelho Center for Disability Law Policy and Innovation
- Western Center on Law & Poverty
- Western Regional Advocacy Project
- Women's Wisdom Art
- 10 individuals

Response Letters. The Mental Health Oversight & Accountability Commission has received several letters regarding SB 1338. These letters are included in the Enclosures listed below.

Presenter(s): Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
Keris Myrick, MS, MBS, Co-Director of S2i, The Mental Health Strategic Impact Initiative

Enclosures (7):

1. Presenter Bios
2. SB 1338 (Umberg)
3. CalHHS CARE Court FAQ
4. CalHHS CARE Court Framework
5. Governor Newsom's New Plan to Get Californians in Crisis Off the Streets and Into Housing, Treatment, and Care
6. CBHDA CARE Courts Considerations March 2022
7. CARE Court Response Letters

Handouts: None

Mental Health Services
Oversight & Accountability Commission

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

Stephanie N. Welch was appointed Deputy Secretary of Behavioral Health at the California Health & Human Services Agency in 2020.

Welch previously served as Executive Officer for the Council on Criminal Justice and Behavioral Health since 2015. Welch was the Senior Program Manager for the California Mental Health Services Authority from 2011 to 2015, an Associate Policy Director at the County Behavioral Health Directors Association from 2007 to 2011, and the Associate Director of Public Policy at the Council of Community Behavioral Health Agencies from 2000 to 2005. Welch earned a BA in Social Work from University of California at Davis and a Master's Degree in Social Work from the University of Southern California.

AMENDED IN ASSEMBLY JUNE 30, 2022

AMENDED IN ASSEMBLY JUNE 16, 2022

AMENDED IN SENATE MAY 19, 2022

AMENDED IN SENATE APRIL 7, 2022

AMENDED IN SENATE MARCH 16, 2022

SENATE BILL No. 1338

Introduced by Senators Umberg and Eggman
(Coauthors: Senators Allen, Archuleta, Caballero, Cortese, Dodd, Hertzberg, Newman, Portantino, Stern, and Wiener)
(Coauthors: Assembly Members Aguiar-Curry, Berman, *Bloom,* Chen, Cooper, Cunningham, Gipson, Haney, Irwin, O'Donnell, Petrie-Norris, Rodriguez, Santiago, and Villapudua)

February 18, 2022

An act to add Section 1374.723 to the Health and Safety Code, to add Section 10144.54 to the Insurance Code, to amend Section 1370.01 of the Penal Code, and to amend Sections 5801 and 5813.5 of, and to add Part 8 (commencing with Section 5970) to Division 5 of, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1338, as amended, Umberg. Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(1) Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, requires each county to offer specified mental health programs, unless a county or group of counties opts out by a resolution passed by the governing body, as specified. Existing law, the Lanterman-Petris-Short Act, provides for

short-term and longer-term involuntary treatment and conservatorships for people who are determined to be gravely disabled.

This bill would enact the Community Assistance, Recovery, and Empowerment (CARE) Act, which would authorize specified persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services to adults who are ~~suffering from~~ *currently experiencing a severe mental illness and have a diagnosis of* schizophrenia spectrum and psychotic disorders and who meet other specified criteria. The bill would specify the process by which the petition is filed and reviewed, including requiring the petition to be signed under penalty of perjury, and to contain specified information, including the facts that support the petitioner's assertion that the respondent meets the CARE criteria. The bill would also specify the schedule of review hearings required if the respondent is ordered to comply with an up to one-year CARE plan by the court. The bill would make the hearings in a CARE proceeding confidential and not open to the public, thereby limiting public access to a meeting of a public body. The bill would authorize the CARE plan to be extended once, for up to one year, and would prescribe the requirements for the graduation ~~plan that is required upon leaving the CARE program.~~ *plan.* By expanding the crime of perjury and imposing additional duties on the county behavioral health agencies, this bill would impose a state-mandated local program.

This bill would require the court to appoint counsel ~~and a CARE supporter~~ for the respondent, unless the respondent has *retained* their own ~~counsel or CARE supporter, or chooses not to have a CARE supporter.~~ *counsel. The bill would authorize the respondent to have a supporter, as defined.* The bill would require the ~~California Department of Aging, subject to appropriation, to administer the CARE Supporter program, which would make available a trained CARE supporter to each respondent, who can accept, decline, or choose their own voluntary, unpaid CARE supporter. The bill would require optional training to be made available for volunteer CARE supporters.~~ *State Department of Health Care Services to provide optional training and technical resources for volunteer supporters on CARE Act proceedings, community services and supports, supported decisionmaking, and other topics, as prescribed.*

This bill, subject to appropriation, would require the *California Health and Human Services Agency, or a designated department within that agency, to engage an independent, research-based entity to advise on the development of data-driven process and outcome measures for the CARE Act and to provide coordination and support among relevant state and local partners and other stakeholders throughout the phases of county implementation of the CARE Act. The bill, also subject to appropriation, would require the* State Department of Health Care Services to provide *training and* technical assistance to county behavioral health agencies to implement the act and would require the Judicial Council and the State Department of Health Care Services to provide training to judges and counsel regarding the CARE Act, as specified.

This bill would authorize the court, at any time during the proceedings if it finds the county or other local government entity not complying with court orders, to fine the county or other local government entity up to $1,000 per day and, if the court finds persistent noncompliance, to appoint a receiver to secure court-ordered care for the respondent at the county's cost. *The bill would establish the CARE Act Accountability Fund in the State Treasury to receive the fines collected under the Act, which would be used, upon appropriation, by the State Department of Health Care Services, to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders who experience or are at risk of homelessness, criminal justice involvement, hospitalization, or conservatorship.*

This bill would require the *independent, research-based entity retained by the* State Department of Health Care Services, in consultation with various other entities, to develop an annual CARE Act report and an independent evaluation of the effectiveness of the CARE Act, and would require county behavioral health agencies and other local governmental entities to provide the department with specified information for that report. By increasing the duties of a local agency, this bill would impose a state-mandated local program.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund (MHSF), a continuously appropriated fund, to fund various county mental health programs, including children's mental health care, adult and older adult mental health care, prevention and early intervention programs, and innovative programs.

This bill would clarify that MHSA funds may be used to provide services to individuals under a CARE agreement or a CARE plan.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and insurers to provide coverage for medically necessary treatment of mental health and substance use disorders. Violation of the Knox-Keene Act by a health care service plan is a crime.

This bill would require health care service plans and insurers to cover the cost of developing an evaluation for CARE services and the provision of all health care services for an enrollee or insured when required or recommended for the person pursuant to a CARE plan, as specified, without cost sharing, except for prescription ~~drugs.~~ *drugs, and regardless of whether the services are provided by an in-network or out-of-network provider.* Because a violation of this requirement by a health care service plan would be a crime, this bill would impose a state-mandated local program.

(3) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning the defendant to competency. Existing law suspends a criminal action pending restoration to competency.

This bill, for a misdemeanor defendant who has been determined to be incompetent to stand trial, would authorize the court to refer the defendant to the CARE program.

(4) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(5) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

(b) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. But too often this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

(c) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(d) California has made unprecedented investments in behavioral health, housing, and combating homelessness, and CARE Court helps those with the greatest needs access these resources and services. CARE Court provides a framework to ensure counties and other local governments focus their efforts to provide comprehensive treatment, housing, and supportive services to Californians with complex behavioral health care needs so they can stabilize and find a path to wellness and recovery.

~~(d)~~

(e) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated severe mental illnesses with the ~~establishment of a new CARE Supporter role, in addition to legal counsel,~~ *provision of legal counsel* for CARE ~~proceedings.~~ *proceedings, agreements, and plans, as well as the promotion of supported decisionmaking.*

~~(e)~~

(f) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution *to ensure access to comprehensive services and supports* for some of the most ill and most vulnerable Californians.

SEC. 2. Section 1374.723 is added to the Health and Safety Code, to read:

1374.723. (a) A health care service plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses shall cover the cost of developing an evaluation pursuant to Section 5977 of the Welfare and Institutions Code and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under Sections 5977 and 5982 of the Welfare and Institutions ~~Code.~~ *Code, regardless of whether the service is provided by an in-network or out-of-network provider.*

(b) (1) A health care service plan shall not require prior authorization for ~~services~~ *services, other than prescription drugs,* provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) A health care service plan may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health care service plan may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The health plan's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) A health care service plan shall provide for reimbursement of prescription drugs provided to an enrollee pursuant to this section at the health care service plan's contracted rate.

(3) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE ~~plan.~~ *plan, regardless of whether the service is delivered by an in-network or out-of-network provider.*

(e) No later than July 1, 2023, the department may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse a health care service plan from complying with Section 1374.72.

~~(f)~~

(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter

8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

~~(g)~~

(h) This section shall become operative on July 1, 2023.

SEC. 3. Section 10144.54 is added to the Insurance Code, to read:

10144.54. (a) An insurance policy issued, amended, renewed, or delivered on or after July 1, 2023, shall cover the cost of developing an evaluation pursuant to Section 5977 of the Welfare and Institutions Code and the provision of all health care services for an insured when required or recommended for the insured pursuant to a CARE agreement or CARE plan approved by a court in accordance with the court's authority under Sections 5977 and 5982 of the Welfare and Institutions ~~Code.~~ *Code, regardless of whether the service is delivered by an in-network or out-of-network provider.*

(b) (1) An insurer shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) An insurer may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the insurer reasonably determines the insured was not insured at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), an insurer may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) An insurer shall provide for reimbursement of services provided to an insured pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The insurer's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) An insurer shall provide for reimbursement of prescription drugs provided to an insured pursuant to this section at the insurer's contracted rate.

(3) An insurer shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an insured pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the insured, nor seek reimbursement from the insured, for services provided pursuant to a CARE agreement or CARE ~~plan.~~ *plan, regardless of whether the service is delivered by an in-network or out-of-network provider.*

(e) No later than July 1, 2023, the department may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse an insurer from complying with Section 10144.5.

SEC. 4. Section 1370.01 of the Penal Code is amended to read:

1370.01. (a) If the defendant is found mentally competent, the criminal process shall resume, and the trial on the offense charged or hearing on the alleged violation shall proceed.

(b) If the defendant is found mentally incompetent, the trial, judgment, or hearing on the alleged violation shall be suspended and the court may do either of the following:

(1) (A) Conduct a hearing, pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, and, if the court deems the defendant eligible, grant diversion pursuant to Section 1001.36 for a period not to exceed one year from the date the individual is accepted into diversion or the maximum term of imprisonment provided by law for the most serious offense charged in the misdemeanor complaint, whichever is shorter.

(B) If the court opts to conduct a hearing pursuant to this paragraph, the hearing shall be held no later than 30 days after the

finding of incompetence. If the hearing is delayed beyond 30 days, the court shall order the defendant to be released on their own recognizance pending the hearing.

(C) If the defendant performs satisfactorily on diversion pursuant to this section, at the end of the period of diversion, the court shall dismiss the criminal charges that were the subject of the criminal proceedings at the time of the initial diversion.

(D) If the court finds the defendant ineligible for diversion based on the circumstances set forth in subdivision (b) or (d) of Section 1001.36, the court may, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether to do any of the following:

(i) Order modification of the treatment plan in accordance with a recommendation from the treatment provider.

(ii) Refer the defendant to assisted outpatient treatment pursuant to Section 5346 of the Welfare and Institutions Code. A referral to assisted outpatient treatment may only occur in a county where services are available pursuant to Section 5348 of the Welfare and Institutions Code, and the agency agrees to accept responsibility for treatment of the defendant. A hearing to determine eligibility for assisted outpatient treatment shall be held within 45 days after the date of the referral. If the hearing is delayed beyond 45 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into assisted outpatient treatment, the charges shall be dismissed pursuant to Section 1385.

(iii) Refer the defendant to the county conservatorship investigator in the county of commitment for possible conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. A defendant shall only be referred to the conservatorship investigator if, based on the opinion of a qualified mental health expert, the defendant appears to be gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institution Code. Any hearings required in the conservatorship proceedings shall be held in the superior court in the county of commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the county mental health director or the director’s designee and shall notify the county mental health

director or their designee of the outcome of the proceedings. Before establishing a conservatorship, the public guardian shall investigate all available alternatives to conservatorship pursuant to Section 5354 of the Welfare and Institutions Code. If a petition is not filed within 60 days of the referral, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending conservatorship proceedings. If the outcome of the conservatorship proceedings results in the establishment of conservatorship, the charges shall be dismissed pursuant to Section 1385.

(iv) Refer the defendant to the CARE program pursuant to Section 5978 of the Welfare and Institutions Code. A hearing to determine eligibility for CARE shall be held within 14 days after the date of the referral. If the hearing is delayed beyond 14 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into CARE, the charges shall be dismissed pursuant to Section 1385.

(2) Dismiss the charges pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the county behavioral health director or the director's designee.

(c) If the defendant is found mentally incompetent and is on a grant of probation for a misdemeanor offense, the court shall dismiss the pending revocation matter and may return the defendant to supervision. If the revocation matter is dismissed pursuant to this subdivision, the court may modify the terms and conditions of supervision to include appropriate mental health treatment.

(d) It is the intent of the Legislature that a defendant subject to the terms of this section receive mental health treatment in a treatment facility and not a jail. A term of four days will be deemed to have been served for every two days spent in actual custody against the maximum term of diversion. A defendant not in actual custody shall otherwise receive day for day credit against the term of diversion from the date the defendant is accepted into diversion. "Actual custody" has the same meaning as in Section 4019.

(e) This section shall apply only as provided in subdivision (b) of Section 1367.

SEC. 5. Section 5801 of the Welfare and Institutions Code is amended to read:

5801. (a) A system of care for adults and older adults with severe mental illness results in the highest benefit to the client, family, and community while ensuring that the public sector meets its legal responsibility and fiscal liability at the lowest possible cost.

(b) The underlying philosophy for these systems of care includes the following:

(1) Mental health care is a basic human service.

(2) Seriously mentally disordered adults and older adults are citizens of a community with all the rights, privileges, opportunities, and responsibilities accorded other citizens.

(3) Seriously mentally disordered adults and older adults usually have multiple disorders and disabling conditions and should have the highest priority among adults for mental health services.

(4) Seriously mentally disordered adults and older adults should have an interagency network of services with multiple points of access and be assigned a single person or team to be responsible for all treatment, case management, and community support services.

(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment, or the client is under a court order for assisted outpatient treatment pursuant to Section 5346 and, prior to the filing of the petition for assisted outpatient treatment pursuant to Section 5346, the client has been offered an opportunity to participate in treatment on a voluntary basis and has failed to engage in that treatment, or the client is under a court order for CARE pursuant to Part 8 (commencing with Section 5970) and, prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so.

(6) Clients and families should directly participate in making decisions about services and resource allocations that affect their lives.

(7) People in local communities are the most knowledgeable regarding their particular environments, issues, service gaps and strengths, and opportunities.

(8) Mental health services should be responsive to the unique characteristics of people with mental disorders including age,

gender, minority and ethnic status, and the effect of multiple disorders.

(9) For the majority of seriously mentally disordered adults and older adults, treatment is best provided in the client's natural setting in the community. Treatment, case management, and community support services should be designed to prevent inappropriate removal from the natural environment to more restrictive and costly placements.

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(11) State and county government agencies each have responsibilities and fiscal liabilities for seriously mentally disordered adults and seniors.

SEC. 6. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison. Funds may be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1), and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5, shall refer to those contracts.

SEC. 7. Part 8 (commencing with Section 5970) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 8. THE COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT ACT

CHAPTER 1. GENERAL PROVISIONS

5970. This part shall be known, and may be cited, as Community Assistance, Recovery, and Empowerment (CARE) Act.

5970.5. ~~It is the intent of the Legislature that this part be implemented in a manner that ensures it is effective.~~ *This part shall be implemented as follows, with technical assistance and continuous quality improvement, pursuant to Section 5983:*

(a) A first cohort of counties, representing at least one-half of the population of the state, shall begin no later than July 1, 2023, with additional funding provided to support the earlier implementation date.

(b) A second cohort of counties, representing the remaining population of the state, shall begin no later than July 1, 2024.

5971. Unless the context otherwise requires, the following definitions shall govern the construction of this part.

(a) "CARE agreement" means a voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing *community-based* services and supports.

(b) "CARE plan" means an individualized, appropriate range of *community-based* services and ~~supports consisting of~~ *supports, as set forth in this part, which include clinically appropriate* behavioral health ~~care,~~ *care and* stabilization medications, housing, and ~~enumerated services,~~ *other supportive services, as appropriate,* pursuant to Section 5982.

~~(c) "CARE supporter" means an adult, designated pursuant to Chapter 4 (commencing with Section 5980), who assists the person who is the subject of the petition, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE Act court process, including a CARE agreement, a CARE plan, and a graduation plan. A CARE supporter shall not act independently.~~

(c) "Counsel" means the attorney representing the respondent, provided pursuant to Section 5980, or chosen by the respondent,

in CARE proceedings and matters related to CARE agreements and CARE plans.

(d) "County behavioral health agency" means the local director of mental health services described in Section 5607, the local behavioral health director, or both as applicable, or their designee.

(e) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Section 5977.

(f) "Graduation plan" means a voluntary agreement entered into by the parties at the end of the CARE program that includes a strategy to support a successful transition out of court jurisdiction and that may include a psychiatric advance directive. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports. The graduation plan shall not place additional requirements on the ~~counties~~ *local government entities* and is not enforceable by the court.

(g) "Indian health care provider" means a health care program operated by the Indian Health Service, an Indian tribe, a tribal organization, or urban Indian organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. Sec. 1603).

(h) "Licensed behavioral health professional" means either of the following:

(1) A licensed mental health professional, as defined in subdivision (j) of Section 4096.

(2) A person who has been granted a waiver of licensure requirements by the State Department of Health Care Services pursuant to Section 5751.2.

(i) "Parties" means the respondent, the county behavioral health agency in the county where proceedings under this part are pending, and other parties added by the court pursuant to clause (ii) of subparagraph (B) of paragraph (3) of subdivision (d) of Section 5977.

(j) "Psychiatric advance directive" means a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions, that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis.

(k) "Respondent" means the person who is subject to the petition for CARE Act court proceedings.

(l) "Stabilization medications" means medications included in the CARE plan that primarily consist of antipsychotic medications, to reduce symptoms of hallucinations, delusions, and disorganized thinking. Stabilization medications may be administered as long-acting injections if clinically indicated. Stabilization medications shall not be forcibly administered.

(m) "Supporter" means an adult, designated pursuant to Chapter 4 (commencing with Section 5980), who assists the person who is the subject of the petition, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE Act court process, including a CARE agreement, a CARE plan, and developing a graduation plan. A supporter shall not act independently.

(n) "Trauma-informed care" means practices that recognize and respond to the signs, symptoms, and risks of trauma to better support the health needs of patients who have experienced Adverse Childhood Experiences (ACEs) and toxic stress.

Chapter 2. Process

5972. An individual shall qualify for CARE proceedings only if all of the following criteria are met:

(a) The person is 18 years of age or older.

(b) The person is currently ~~suffering from~~ *experiencing* a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. *This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.* A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for CARE proceedings.

(c) The person is not clinically stabilized in on-going voluntary treatment.

(d) At least one of the following is true:

(1) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

(2) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

(e) Participation in *the* CARE Act ~~services~~ would be the least restrictive alternative necessary to ensure the person's recovery and stability.

(f) It is likely that the person will benefit from ~~CARE Act services.~~ *the CARE Act.*

5973. *(a)* Proceedings under this part may be commenced in any of the following:

~~(a)~~

(1) The county in which the respondent resides.

~~(b)~~

(2) The county where the respondent is found.

~~(c)~~

(3) The county where the respondent is facing criminal or civil proceedings.

(b) If the respondent does not reside in the county in which proceedings are initiated under this subdivision, as determined in accordance with Section 244 of the Government Code, except as provided in subdivision (e) of Section 5982, and this part is operative in the respondent's county of residence, the proceeding shall, with the respondent's consent, be transferred to the county of residence as soon as reasonably feasible. Should the respondent not consent to the transfer, the proceedings shall continue in the county where the respondent was found.

5974. The following persons may file a petition to initiate CARE proceedings:

(a) A person 18 years of age or older with whom the respondent resides.

(b) A spouse, parent, adult sibling, adult child, or grandparent or other adult who stands in loco parentis to the respondent.

(c) The director of a hospital, or their designee, in which the respondent is hospitalized, including hospitalization pursuant to Section 5150 or 5250.

(d) The director of a public or charitable organization, agency, or home, or their designee, who has, within the previous 30 days, provided or who is currently providing behavioral health services to the respondent or in whose institution the respondent resides.

(e) A licensed behavioral health professional, or their designee, who is, or has been within the previous 30 days, either supervising the treatment of, or treating the respondent for a mental illness.

(f) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker, who has had repeated interactions with the respondent in the form of multiple arrests, multiple detentions and transportation pursuant to Section 5150, multiple attempts to engage the respondent in voluntary treatment, or other repeated efforts to aid the respondent in obtaining professional assistance.

(g) The public guardian or public conservator, or their designee, of the county in which the respondent is present or reasonably believed to be present.

(h) The director of a county behavioral health agency, or their designee, of the county in which the respondent ~~is present or reasonably believed to be present.~~ *resides or is found.*

(i) The director of county adult protective services, or their designee, of the county in which the respondent ~~is present or is reasonably believed to be present.~~ *resides or is found.*

(j) The director of a California Indian health services program, California tribal behavioral health department, or their designee.

(k) The judge of a tribal court that is located in California, or their designee.

(*l*) A prosecuting attorney, pursuant to subdivision (b) of Section 5978.

(m) The respondent.

5975. The petition shall be signed under the penalty of perjury and contain all of the following:

(a) The name of the respondent and, if known, the respondent's address.

(b) The petitioner's relationship to the respondent.

(c) Facts that support the petitioner's assertion that the respondent meets the CARE criteria in Section 5972.

(d) Either of the following:

(1) An affidavit of a licensed behavioral health professional, stating that the licensed behavioral health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent to submit to an examination, within 60 days of the petition, and that the licensed behavioral health professional had determined that the respondent meets, or has reason to believe, explained with specificity in the affidavit, that the respondent meets the diagnostic criteria for CARE proceedings.

(2) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to Article 4 (commencing with Section 5250) of Chapter 2 of Part 1, the most recent one within the previous 60 days.

5975.1. Notwithstanding Section 391 of the Code of Civil Procedure, if a person other than the respondent files a petition for CARE Act proceedings that is without merit or is intended to harass or annoy the respondent, and the person has previously filed ~~pleadings~~ *a pleading* in CARE Act proceedings that ~~were~~ *was* without merit or ~~were~~ *was* intended to harass or annoy the respondent, the petition shall be grounds for the court to determine that the person is a vexatious litigant for the purposes of Title 3A (commencing with Section 391) of Part 2 of the Code of Civil Procedure.

5976. The respondent shall:

(a) Receive notice of the hearings.

(b) Receive a copy of the court-ordered evaluation.

(c) Be represented by counsel at all stages of a proceeding commenced under this chapter, regardless of the ability to pay.

(d) Be ~~offered a CARE~~ *allowed to have a* supporter, as described in Section 5982.

(e) Be present at the hearing unless the respondent waives the right to be present.

(f) Have the right to present evidence.

(g) Have the right to call witnesses.

(h) Have the right to cross-examine witnesses.

(i) Have the right to appeal decisions, and to be informed of the right to appeal.

5976.5. (a) Notwithstanding any other law, and except as otherwise provided in this section, a hearing held under this part is presumptively closed to the public.

(b) The respondent may demand that the hearing be public and be held in a place suitable for attendance by the public.

(c) The respondent may request the presence of any family member or friend without waiving the right to keep the hearing closed to the rest of the public.

(d) A request by any other party to the proceeding to make the hearing public may be granted if the ~~judge, hearing officer, or other person~~ *judge* conducting the hearing finds that the public interest in an open hearing clearly outweighs the respondent's interest in privacy.

(e) Before commencing a hearing, the judge shall inform the respondent of their rights under this section.

5977. (a) (1) The court shall promptly review the petition to determine if the petition may contain the information required by Section 5975.

(2) If the court finds that the petition does not contain the information required by Section 5975, the court shall dismiss the case without prejudice subject to consideration of Section 5975.1.

(3) If, based upon the information in the petition, the court finds that the petition may contain the information required by Section 5975, the court shall order a county agency, or their designee, as determined by the presiding judge, to investigate, as necessary, and file a written report with the court within 21 days that includes a determination as to whether the respondent meets, or is likely to meet, the criteria for CARE proceedings and the outcome of efforts made to voluntarily engage the respondent during the 21-day report period. The court shall provide notice to the respondent and petitioner that a report has been ordered.

(4) The county agency shall submit a written report to the court with the findings and conclusions of the investigation, along with any recommendations. If the county agency is making progress to engage the respondent, it may request up to an additional 30 days to continue to engage and enroll the individual in treatment and services.

(5) The court shall, within five days of receipt of the report, review the report and take one of the following actions:

(A) If the court determines that the respondent meets, or likely meets the criteria, and engagement is not effective, the court shall do all of the following:

(i) Set an initial hearing within 14 days.

(ii) *(I)* Appoint counsel, unless the respondent has *retained* their own counsel.

(II) If the respondent has not retained legal counsel and does not plan to retain legal counsel, whether or not the respondent lacks or appears to lack legal capacity, the court shall, before the time of the initial hearing, appoint a qualified legal services project, as defined in Sections 6213 to 6214.5, inclusive, of the Business and Professions Code or, if no legal services project has agreed to accept these appointments, a public defender to represent the respondent for all purposes related to this part, including appeals.

(III) Counsel appointed in this case shall have the authority to represent the individual in any proceeding under this part, and shall have the authority to represent the individual, as needed, in matters related to CARE agreements and CARE plans.

(iii) ~~Appoint a CARE~~ *Allow the respondent to select a* supporter, unless the respondent chooses ~~their own CARE supporter or chooses~~ not to have a ~~CARE~~ supporter.

(iv) Provide notice of the hearing to the petitioner, the respondent, the appointed ~~counsel and CARE~~ *counsel, the* supporter, ~~and~~ the county behavioral health agency in the county where the respondent ~~resides.~~ *resides, and, if different, the county where the CARE court proceedings have commenced.*

(B) If the court determines that the respondent meets, or likely meets, the criteria, voluntary engagement is effective, and that the individual has enrolled in behavioral health treatment, the court shall dismiss the matter.

(C) If the court determines that the individual does not meet, or is likely not to meet, the criteria, the court shall dismiss the matter. This section shall not prevent county behavioral health from voluntarily engaging with individuals who do not meet CARE criteria but who are in need of services and supports.

(6) If the court dismisses the matter pursuant to subparagraph (B) or (C) of paragraph (5), the court shall notify the petitioner

and the respondent of the dismissal and the reason for dismissal. The petitioner shall have the ability to request reconsideration of the dismissal within 10 days. Should the court grant reconsideration, the court may set an initial hearing as outlined in subparagraph (A) of paragraph (5).

(b) At the initial hearing, the court shall permit the respondent to substitute their own counsel for appointed ~~counsel and substitute their own CARE supporter for the appointed CARE supporter or elect to proceed without a CARE supporter.~~ *counsel.*

(c) All of the following apply for the initial hearing:

(1) The petitioner shall be present. If the petitioner is not present, the matter may be dismissed.

(2) The respondent may waive their appearance and appear through their counsel. If the respondent does not waive their appearance and does not appear at the hearing, and appropriate attempts to elicit the attendance of the respondent have failed, the court may conduct the hearing in the respondent's absence. If the hearing is conducted without the respondent present, the court shall set forth the factual basis for doing so and the reasons the proceedings will be successful without the respondent's presence.

(3) A representative from the county behavioral health agency shall be present.

(4) The ~~CARE supporter shall~~ *supporter may* be present, subject to the consent of the respondent.

(5) If the respondent is enrolled in a federally recognized Indian tribe or is otherwise receiving services from an Indian health care provider, a tribal court, or a tribal organization, a representative from the program, the tribe, or the tribal court shall be allowed to be present, subject to the consent of the respondent.

(d) (1) At the initial hearing, the court shall determine if the petitioner has presented prima facie evidence that the respondent meets the CARE criteria. In making this determination, the court shall consider all evidence properly before it, including the report from the county required pursuant to paragraph (3) of subdivision (a) and any additional evidence presented by the parties.

(2) If the court finds there is no reason to believe that the facts stated in the petition are true, the court shall dismiss the case without prejudice, unless the court makes a finding, on the record, that the petitioner's filing was not in good faith. Any new petition

shall be based on changed circumstances that warrant a new petition.

(3) If the court finds that there is reason to believe that the facts stated in the petition appear to be true, the court shall order the county behavioral health agency to work with the respondent, the respondent's counsel, and the ~~CARE~~ supporter to engage in behavioral health treatment. The court shall set a case management hearing within 14 days.

(4) If the respondent is enrolled in a federally recognized Indian tribe, the court shall provide notice of the case management hearing to the tribe, subject to the consent of the respondent.

5977.1. (a) (1) At the case management hearing, the court shall determine whether the parties may enter into a CARE agreement.

(2) The court's findings that the parties may enter into a CARE agreement shall require a recitation of all terms and conditions on the record.

(3) If the court finds that the parties have agreed to a CARE agreement, and the court agrees with the terms of the CARE agreement, the court shall stay the matter and set a progress hearing for 60 days.

(b) (1) If the court finds that the parties have not reached, and are not likely to reach, a CARE agreement, the court shall order a clinical evaluation of the respondent. The evaluation shall address the clinical diagnosis and shall address the issue of whether the defendant has capacity to give informed consent regarding psychotropic medication.

(2) The court shall order the county behavioral health agency, through a licensed behavioral health professional, to conduct the evaluation unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation.

(c) (1) The court shall set a clinical evaluation hearing to review the evaluation within 14 days.

(2) At the clinical evaluation review hearing, the court shall review the evaluation and any other evidence from the petitioner, the county behavioral health agency, the respondent, ~~and, if requested by the respondent, the CARE~~ *and the* supporter. The petitioner and the respondent may present evidence and call witnesses, including the person who conducted the evaluation.

Only relevant and admissible evidence that fully complies with the rules of evidence may be considered by the court.

(3) The clinical evaluation hearing may be continued for a maximum of 14 days upon stipulation of the respondent and the county behavioral health agency, unless there is good cause for a longer extension.

(4) (A) If the court finds by clear and convincing evidence, after review of the evaluation and other evidence, that the respondent meets the CARE criteria, the court shall order the county behavioral health agency, the respondent, and the respondent's counsel and ~~CARE~~ supporter to jointly develop a CARE plan.

(B) The respondent and the county behavioral health agency may request appellate review of the order to develop a CARE plan.

(5) If the court finds, in reviewing the evaluation, that clear and convincing evidence does not support that the respondent meets the CARE criteria, the court shall dismiss the petition.

(6) The evaluation and all reports, documents, and filings submitted to the court shall be confidential.

(d) (1) The CARE plan shall be developed by the respondent, in consultation with their ~~CARE~~ supporter and counsel, and the county behavioral health agency.

(2) If the proposed CARE plan includes services and supports, such as housing, provided directly or indirectly through another local governmental entity, that local entity may agree to provide the service or support or the court may consider a motion by either of the parties to add the local entity as a party to the CARE proceeding.

(3) If the respondent is an American Indian or Alaska Native individual, as defined in Sections 1603(13), 1603(28), and 1679(a) of Title 25 of the United States Code, has been determined eligible as an Indian under Section 136.12 of Title 42 of the Code of Federal Regulations, or is otherwise receiving services from an Indian health care provider or tribal court, the county behavioral health agency shall use best efforts to meaningfully consult with and incorporate the Indian health care provider or tribal court available to the respondent to develop the CARE plan.

(4) The date for the hearing to review and consider approval of the proposed CARE plan shall be set not more than 14 days from

the date of the order to develop a CARE plan, unless there is good cause for an extension.

(e) (1) The county behavioral health agency or the respondent, or both, may present a proposed CARE plan.

(2) After reviewing the proposed CARE plan and hearing from the parties, the court may issue any orders necessary to support the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding pursuant to Section 5982.

(3) A court may only order medication if it finds, upon review of the court-ordered evaluation and hearing from the parties that, by clear and convincing evidence, the respondent lacks the capacity to give informed consent to the administration of medically necessary medication, including antipsychotic medication. To the extent the court orders medically necessary stabilization medication, the medication shall not be forcibly administered and the respondent's failure to comply with a medication order shall not result in a penalty, including, but not limited to, contempt or Section 5979.

(4) If the court determines that additional information is needed, including from a licensed behavioral health professional, the court shall order a supplemental report to be filed and the court may grant a continuance for no more than 14 days, unless there is good cause for an extension.

(5) If there is no CARE plan because the parties have not had sufficient time to complete it, the court may grant a continuance for no more than 14 days, unless there is good cause for an extension.

(f) The issuance of the order approving the CARE plan begins the up-to-one-year CARE program timeline.

5977.2. (a) (1) At intervals of not less than 60 days during the CARE plan implementation, the court shall have a status review hearing. The county behavioral health ~~worker~~ *agency* assigned to the respondent's case shall file with the court and serve on the respondent, and the respondent's counsel and ~~CARE~~ supporter, a report not less than seven days prior to the review hearing with the following information:

(A) Progress the respondent has made on the CARE plan.

(B) What services and supports in the CARE plan were provided, and what services and supports were not provided.

(C) Any issues the respondent expressed or exhibited in adhering to the CARE plan.

(D) Recommendations for changes to the services and supports to make the CARE plan more successful.

(2) Subject to applicable law, intermittent lapses or setbacks described in this section of the report shall not impact access to services, treatment, or housing.

(3) A status review hearing shall occur unless waived by all parties and approved by the court.

(b) The county behavioral health agency or the respondent may request, or the court upon its own motion may set, a hearing to occur at any time during the CARE Act proceedings to address a change of circumstances.

5977.3. (a) (1) In the 11th month of the program timeline, the court shall hold a one-year status hearing. At that hearing, the court shall determine whether to graduate the respondent from the program with a graduation plan or reappoint the respondent to the program for another term, not to exceed one year.

(2) The one-year status hearing shall be an evidentiary hearing. At least seven days prior to the one-year status hearing, the county behavioral health agency shall submit to the court and to the respondent, the respondent's counsel, and the respondent's ~~CARE~~ supporter, a report on the progress the respondent has made on the CARE plan, what services and supports in the CARE plan were provided, what services and supports were not provided, any issues the respondent had in adhering to the plan, and any recommendations for completion and graduation or continuation in CARE Act programming. The respondent shall have the right at the hearing to call witnesses and present evidence ~~information~~ as to whether or not the respondent agrees with the report.

(b) (1) If the respondent has successfully completed participation in the one-year CARE program, the respondent shall not be reappointed to the program. The court shall review with the parties the voluntary agreement for a graduation plan to support a successful transition out of court jurisdiction and may include a psychiatric advance directive. The graduation plan shall not place additional requirements on the ~~counties~~ *local government entities* and is not enforceable by the court.

(2) At the one-year status hearing, the respondent may request reappointment to the CARE ~~program.~~ *Act.* If the respondent elects

to accept voluntary ~~reappointment to the program,~~ *reappointment*, the respondent may request any amount of time, up to and including one additional year, to be reappointed to the CARE ~~program.~~ *Act.* A respondent may only be reappointed ~~to the CARE program~~ once, for up to one additional year. The respondent may be voluntarily reappointed ~~to the program~~ if the court finds by clear and convincing evidence that ~~all~~ *both* of the following conditions apply:

(A) The respondent did not successfully complete the ~~program.~~ *CARE Act.*

(B) The respondent would benefit from continuation ~~of the CARE program.~~ *in the CARE Act.*

~~(C) The court finds, by clear and convincing evidence, that the respondent currently meets the requirements in Section 5972.~~

~~(3) If the courts finds that the respondent has not successfully completed the program and that the respondent would benefit from continuation of the program, and the court cannot find, by clear and convincing evidence, that the respondent currently meets the requirements in Section 5972, but the respondent voluntarily requests to continue the program, the court may require that the county continue to provide the services and supports required in the CARE plan for another year.~~

(c) The respondent may be involuntarily reappointed to the program only if the court finds, by clear and convincing evidence, that all of the following conditions apply:

(1) The respondent did not successfully complete the ~~program.~~ *CARE Act.*

(2) All services and supports required ~~by~~ *through* the CARE ~~plan~~ *Act proceedings* were provided to the respondent.

(3) The respondent would benefit from continuation in the CARE ~~program.~~ *Act.*

(4) The respondent currently meets the requirements in Section 5972.

(d) A respondent may only be reappointed to the CARE ~~program~~ *Act* once, for up to one additional year.

5977.4. (a) The judge shall control all proceedings during the hearings with a view to the expeditious and effective ascertainment of the jurisdictional facts and the ascertainment of all information relative to the present condition and future welfare of the respondent. Except when there is a contested issue of fact or law, the proceedings shall be conducted in an informal nonadversarial

atmosphere with a view to obtaining the maximum cooperation of the respondent, all persons interested in the respondent's welfare, and all other parties, with any provisions that the court may make for the disposition and care of the respondent. All evaluations and reports, documents, and filings submitted to the court pursuant to CARE Act proceedings shall be confidential.

(b) The hearings described in this chapter shall occur in person unless the court, in its discretion, allows a party or witness to appear remotely through the use of remote technology. The respondent shall have the right to be in person for all hearings.

(c) Consistent with its constitutional rulemaking authority, the Judicial Council shall adopt rules to implement the policies and provisions in this section and in Sections 5977, 5977.1, 5977.2, and 5977.3 to promote statewide consistency, including, but not limited to, what is included in the petition form packet, the clerk's review of the petition, and the process by which counsel ~~and CARE supporter~~ will be appointed.

5978. (a) A court may refer an individual from assisted outpatient treatment and conservatorship proceedings to CARE proceedings. If the individual is being referred from assisted outpatient treatment, the county behavioral health director or their designee may be the petitioner. If the individual is being referred from conservatorship proceedings, the conservator may be the petitioner.

(b) A court may refer an individual from misdemeanor proceedings pursuant to Section 1370.01 of the Penal Code, in which case the prosecuting attorney may be the petitioner.

Chapter 3. Accountability

5979. (a) (1) If, at any time during the proceedings, the court determines by clear and convincing evidence that the respondent is not participating in CARE proceedings, after the respondent receives notice, or is not adhering to their CARE plan, after the respondent receives notice, the court may terminate the respondent's participation in the CARE program.

(2) To ensure the respondent's safety, the court may utilize existing legal authority pursuant to Article 2 (commencing with Section 5200) of Chapter 2 of Part 1. The court shall provide notice

to the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority.

(3) If the respondent was timely provided with all of the services and supports required by the CARE plan, the fact that the respondent failed to successfully complete their CARE plan, including reasons for that failure, shall be a fact considered by the court in a subsequent hearing under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)), provided that the hearing occurs withing six months of the termination of the CARE plan and shall create a presumption at that hearing that the respondent needs additional intervention beyond the supports and services provided by the CARE plan.

(b) If, at any time during the proceedings, the court finds that the county or other local government entity is not complying with court orders, the court may fine the county or other local government entity up to one thousand dollars ($1,000) per day for noncompliance. If a county or other local government entity is found to be persistently noncompliant, the court may appoint a receiver to secure court-ordered care for the respondent at the county's cost. In determining the application of the remedies available, the court shall consider whether there are any mitigating circumstances impairing the ability of the county or other local government entity to fully comply with the requirements of this part. Funds collected pursuant to this subdivision shall be deposited in ~~a special fund and used to support county activities serving individuals with serious mental illness.~~ *the CARE Act Accountability Fund, which is hereby created in the State Treasury. All moneys in the fund shall be used, upon appropriation, by the State Department of Health Care Services to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders and who experience, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship.*

(c) Either the respondent or the county behavioral health agency may appeal an adverse court determination.

CHAPTER 4. ~~THE CARE~~ SUPPORTER *AND COUNSEL*

5980. (a) Subject to appropriation, ~~the California Department of Aging shall administer the CARE Supporter program, which~~

~~shall make available a trained CARE supporter to the respondent, who may accept, decline, or choose their own CARE supporter. The department shall train CARE supporters on supported decisionmaking with individuals who have behavioral health conditions, with support and input from peers, family members, disability groups, providers, the County Behavioral Health Directors Association, and other relevant stakeholders, and on the use of psychiatric advance directives. The department may enter into a technical assistance and training agreement to provide training directly to either CARE supporters or to the contracted entities who will be responsible for hiring and matching CARE supporters to respondents. The CARE Supporter program contracts shall include labor standards under state and federal law.~~ *the State Department of Health Care Services, with support and input from relevant stakeholders, shall provide optional training and technical resources for volunteer supporters on CARE Act proceedings, community services and supports, supported decisionmaking, and people with behavioral health conditions, trauma-informed care, and psychiatric advance directives. The department may enter into a technical assistance and training agreement for this purpose, pursuant to Section 5984.*

(b) The ~~CARE Supporter program shall be designed to~~ *supporter shall* do all of the following:

(1) Offer the respondent a flexible and culturally responsive way to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating, and implementing their own informed choices.

(2) Strengthen the respondent's capacity to engage in and exercise autonomous decisionmaking and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship.

(3) Assist the respondent with understanding, making, and communicating decisions and expressing preferences throughout the CARE court process.

~~(c) If the respondent chooses to have a CARE supporter outside of the CARE Supporter program, that person may serve as a volunteer CARE supporter without compensation. Optional training shall be made available and strongly encouraged for volunteer CARE supporters.~~

5981. (a) Notwithstanding any other provision of this part, the respondent may have ~~their CARE~~ *a* supporter present in any meeting, judicial proceeding, status hearing, or communication related to any of the following:

(1) An evaluation.

(2) Development of a CARE agreement or CARE plan.

(3) Establishing a psychiatric advance directive.

(4) Development of a graduation plan.

(b) A ~~CARE supporter shall~~ *supporter is intended to* do all the following:

(1) Support the will and preferences of the respondent to the best of their ability and to the extent reasonably possible.

(2) Respect the values, beliefs, and preferences of the respondent.

(3) Act honestly, diligently, and in good faith.

(4) Avoid, to the greatest extent possible, and disclose to the court, the respondent, and the respondent's counsel, minimize, and manage, conflicts of interest. A court may remove a ~~CARE~~ supporter because of any conflict of interest with the respondent, and shall remove the ~~CARE~~ supporter if the conflict cannot be managed in such a way to avoid any possible harm to the respondent.

(c) Unless explicitly authorized by the respondent with capacity to make that authorization, a ~~CARE~~ supporter shall not do either of the following:

(1) Make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury.

(2) Sign documents on behalf of the respondent.

(d) In addition to the obligations in this section, a ~~CARE~~ supporter shall be bound by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. This section does not limit a ~~CARE~~ supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion, or mistreatment, including liability under the Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600) of Part 3 of Division 9), including, but not limited to, Sections 15656 and 15657.

(e) The ~~CARE~~ supporter shall not be subpoenaed or called to testify against the respondent in any proceeding relating to this part, and the supporter's presence at any meeting, proceeding, or communication shall not waive confidentiality or any privilege.

5981.5. Subject to appropriation for this purpose, the Judicial Council shall provide funding to qualified legal services projects, as defined in Sections 6213 to 6214.5, inclusive, of the Business and Professions Code, to be used to provide legal counsel appointed pursuant to subdivision (c) of Section 5976, for representation in CARE proceedings, matters related to CARE agreements and CARE plans, and to qualified support centers, as defined in subdivision (b) of Section 6213 of, and Section 6215 of, the Business and Professions Code, for training, support, and coordination.

Chapter 5. CARE Plan

5982. (a) The CARE plan may only include the following:

(1) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, ~~non-Medi-Cal behavioral health, commercial plans,~~ *health care plans and insurers, services provided pursuant to Part 5 (commencing with Section 17000) of Division 9,* and services supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800).

(2) Medically necessary stabilization medications, to the extent not described in paragraph (1).

(3) Housing resources funded through the No Place Like Home Program (Part 3.9 (commencing with Section 5849.1) of Division 5 of the Welfare and Institutions Code); California Housing Accelerator (Chapter 6.6 (commencing with Section 50672) of Part 2 of Division 31 of the Health and Safety Code); the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2 of Division 31 of the Health and Safety Code); the Homeless Housing, Assistance, and Prevention Program (Chapter 6 (commencing with Section 50216) of Part 1 of Division 31 of the Health and Safety Code); the Encampment Resolution Funding Program (Chapter 7 (commencing with Section 50250) of Part 1 of Division 31 of the Health and Safety Code); the Project Roomkey and Rehousing Program pursuant to Provision 22 of

Item 5180-151-0001 of the Budget Act of 2021 (Ch. 21, Stats. 2021); the Community Care Expansion Program (Chapter 20 (commencing with Section 18999.97) of Part 6 of Division 9 of the Welfare and Institutions Code); the CalWORKs Housing Support Program (Article 3.3 (commencing with Section 11330) of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code); the CalWORKs Homeless Assistance pursuant to clause (i) of subparagraph (A) of paragraph (2) of subdivision (f) of Section 11450 of Article 6 of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code; the Housing and Disability Advocacy Program (Chapter 17 (commencing with Section 18999) of Part 6 of Division 9 of the Welfare and Institutions Code); the Home Safe Program (Chapter 14 (commencing with Section 15770) of Part 3 of Division 9 of the Welfare and Institutions Code); the Bringing Families Home Program (Article 6 (commencing with Section 16523) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code); the Transitional Housing Placement program for nonminor dependents (Article 4 (commencing with Section 16522) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code); the Transitional Housing Program-Plus pursuant to subdivision (s) of Section 11400 and paragraph (2) of subdivision (a) of Section 11403.2 of Article 5 of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code and Article 4 (commencing with Section 16522) of Chapter 5 of Part 4 of Division 9 of the Welfare and Institutions Code; the Behavioral Health Continuum Infrastructure Program (Chapter 1 (commencing with Section 5960) of Part 7 of Division 5 of the Welfare and Institutions Code); the Behavioral Health Bridge Housing Program; HUD-Veterans Affairs Supportive Housing Program (Section 8(o)(19) of the United States Housing Act of 1937 [42 U.S.C. Section 1437f(o)(19)]); Supportive Services for Veteran Families (Section 604 of the Veterans' Mental Health and Other Care Improvements Act of 2008 [38 U.S.C. Sec. 2044]); HUD Continuum of Care program (Section 103 of the McKinney-Vento Homeless Assistance Act [42 U.S.C. Sec. 11302]); the Emergency Solutions Grant (Subtitle B of Title IV of the McKinney-Vento Homeless Assistance Act [42 U.S.C. Secs. 11371-11378]); HUD Housing Choice Voucher program (Section 8 of the United States Housing Act of 1937 [42 U.S.C. Sec. 1437f]); the Emergency Housing Vouchers (Section 3202 of the American Rescue Plan

Act of 2021 [Public Law 117-2]; Section 8(o) of the United States Housing Act of 1937 [42 U.S.C. Sec. 1437f(o)]); HOME Investment Partnerships Program (Title II of the Cranston-Gonzalez National Affordable Housing Act [42 U.S.C. Sec. 12721 et seq.]); the Community Development Block Grant Program (Title 1 of the Housing and Community Development Act of 1974 [42 U.S.C. Sec. 5301 et seq.]); housing supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800); community development block grants; and other state and federal housing resources.

(4) Social services funded through Supplemental Security Income/State Supplementary Payment (SSI/SSP), Cash Assistance Program for Immigrants (CAPI), CalWORKs, California Food Assistance Program, In-Home Supportive Services program, and CalFresh.

(5) Services provided pursuant to Part 5 (commencing with Section 17000) of Division 9.

(b) Individuals who are CARE program participants shall be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

(c) All CARE plan services and supports ordered by the court are subject to all applicable federal and state statutes and regulations, contractual provisions, and policy guidance governing program eligibility and available ~~funding, including, but not limited to, the following:~~ *funding. In addition to the resources funded through programs listed in subdivision (a), the State Department of Health Care Services may identify other adjacent covered Medi-Cal services, including, but not limited to, enhanced care management and available community supports, which may be provided, although not ordered, by the court, subject to all applicable federal and state statutes, regulations, contractual provisions, and policy guidance.*

~~(1) Medically necessary behavioral health treatment and stabilization medications covered under the Medi-Cal program, including, but not limited to, treatment authorized pursuant to Article 3.2 (commencing with Section 14124.20) of Chapter 7 of Part 3 of Division 9 of, Section 14184.400 of, or Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9 of, this code or Section 11758.20 of the Health and Safety Code.~~

~~(2) Housing resources funded through the programs listed in paragraph (3) of subdivision (a).~~

~~(3) SSI/SSP, CAPI, CalWORKs, and CalFresh.~~

~~(4) Other adjacent covered Medi-Cal services identified by the State Department of Health Care Services, including, but not limited to, enhanced care management and available community supports.~~

(d) This section does not prevent a county or other local government entity from recommending their own services that are their own responsibility not listed in subdivision (a) or (c). Any such recommendation is not required by this section and shall be made at the request of the county for the purposes of Section 6 of Article XIII B, and Sections 6 and 36 of Article XIII of the California Constitution.

(e) (1) For respondents who are Medi-Cal beneficiaries, the county in which the respondent resides is the county of responsibility as defined in Section 1810.228 of Title 9 of the California Code of Regulations.

(2) If a proceeding commences in a county where the respondent is found or is facing criminal or civil proceedings that is different than the county in which the respondent resides, the county in which the respondent is found or is facing criminal or civil proceedings shall not delay proceedings under this part and is the responsible county behavioral health agency for providing or coordinating all components of the CARE agreement or CARE plan.

(3) The county in which the respondent resides, as defined in paragraph (1), shall be responsible for the costs of providing all CARE agreement or CARE plan behavioral health services, as defined in paragraph (1) of subdivision (a).

(4) In the event of a dispute over responsibility for any costs of providing components of the CARE agreement or CARE plan, the impacted counties shall resolve the dispute in accordance with the arbitration process established in Section 1850.405 of Title 9 of the California Code of Regulations for county mental health plans, including for respondents who are not Medi-Cal beneficiaries, and pursuant to any related guidance issued pursuant to subdivision (b) of Section 5984.

CHAPTER 6. TECHNICAL ASSISTANCE AND ADMINISTRATION

5983. (a) *Subject to appropriation for this purpose, the California Health and Human Services Agency, or a designated department within the agency, shall do both of the following:*

(1) Engage an independent, research-based entity, as described in Section 5986, to advise on the development of data-driven process and outcome measures to guide the planning, collaboration, reporting, and evaluation of the CARE Act pursuant to this part.

(2) Provide coordination and on-going engagement with, and support collaboration among, relevant state and local partners and other stakeholders throughout the phases of county implementation to support the successful implementation of the CARE Act.

(b) Subject to ~~appropriation,~~ *appropriation for this purpose,* the State Department of Health Care Services shall provide *training and* technical assistance to county behavioral health agencies to support the implementation of this part, including training regarding the CARE statute, CARE plan services and supports, *supported decisionmaking, the supporter role, trauma-informed care, elimination of bias, psychiatric advance directives,* and data collection.

~~(b)~~

(c) Subject to appropriation, the Judicial Council, in consultation with the State Department of Health Care Services, other relevant state entities, and the County Behavioral Health Directors Association, shall provide training and technical assistance to judges to support the implementation of this part, including training regarding the CARE statutes, CARE plan services and supports, working with the ~~CARE~~ supporter, *supported decisionmaking, the supporter role, trauma-informed care, elimination of bias,* best practices, and evidence-based models of care for people with severe behavioral health conditions.

~~(c)~~

(d) Subject to appropriation, the State Department of Health Care Services, in consultation with other relevant state departments and the California Interagency Council on Homelessness, shall provide training to counsel regarding the CARE statute and CARE plan services and supports.

5984. (a) For purposes of implementing this part, the California Health and Human Services ~~Agency,~~ *Agency and* the State Department of Health Care ~~Services, and the California Department of Aging~~ *Services* may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this part shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the California Health and Human Services ~~Agency,~~ *Agency and* the State Department of Health Care ~~Services, and the California Department of Aging~~ *Services* may implement, interpret, or make specific this part, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

5985. (a) The State Department of Health Care Services shall develop, in consultation with county behavioral health agencies, ~~CARE supporters,~~ *other relevant state or local government entities,* disability rights groups, individuals with lived experience, *families, counsel,* and other appropriate stakeholders, an annual CARE Act report. The department shall post the annual report on its internet website.

(b) County behavioral health agencies and any other state or local governmental entity, as ~~determined~~ *identified* by the department, shall provide data related to the CARE Act participants, services, and supports to the department. The department shall determine the data measures and specifications, ~~and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this part, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.~~ *and shall publish them via guidance issues pursuant to subdivision (b) of Section 5984.*

(c) Each county behavioral health department and any other *state and* local governmental entity, as ~~determined~~ *identified* by the department, shall provide the required data to the department, in a format and frequency as directed by the department.

(d) The department shall provide information on the populations served and demographic data, stratified by age, sex, race, ethnicity, languages spoken, disability, *sexual orientation, gender identity,* and county, to the extent statistically relevant data is available.

(e) The report shall include, at a minimum, information on the effectiveness of the CARE Act model in improving outcomes and reducing homelessness, criminal justice involvement, conservatorships, and hospitalization of participants. *The annual report shall include process measures to examine the scope of impact and monitor the performance of CARE Act model implementation, such as the number and source of petitions filed for CARE Court; the number, rates, and trends of petitions resulting in dismissal and hearings; the number, rates, and trends of supporters; the number, rates, and trends of voluntary CARE agreements; the number, rates, and trends of ordered and completed CARE plans; the services and supports included in CARE plans, including court orders for stabilizing medications; the rates of adherence to medication; the number, rates, and trends of psychiatric advance directives; and the number, rates, and trends of developed graduation plans. The report shall include outcome measures to assess the effectiveness of the CARE Act model, such as improvement in housing status, including gaining and maintaining housing; reductions in emergency department visits and inpatient hospitalizations; reductions in law enforcement encounters and incarceration; reductions in involuntary treatment and conservatorship; and reductions in substance use. The annual report shall examine these data through the lens of health equity to identify racial, ethnic, and other demographic disparities and inform disparity reduction efforts.*

(f) The outcomes shall be presented to relevant state oversight bodies, including, but not limited to, the California Interagency Council on Homelessness.

5986. (a) ~~The~~ *An independent, research-based entity shall be retained by the* State Department of Health Care Services ~~shall~~ *to* develop, in consultation with county behavioral health agencies, county CARE courts, and other appropriate stakeholders, an

independent evaluation of the effectiveness of the CARE Act. *The independent evaluation shall employ statistical research methodology and include a logic model, hypotheses, comparative or quasi-experimental analyses, and conclusions regarding the extent to which the CARE Act model is associated, correlated, and causally related with the performance of the outcome measures included in the annual reports. The independent evaluation shall highlight racial, ethnic, and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts.*

(b) The department shall provide a preliminary report to the Legislature three years after the implementation date of the CARE Act and a final report to the Legislature five years after the implementation date of CARE Act. The department shall post the preliminary and final reports on its internet website.

(c) Each county behavioral health department, each county CARE court, and any other state or local governmental entity, as determined by the department, shall provide the required data to the department, in a format and frequency as directed by the department.

(d) A report to be submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 8. The Legislature finds and declares that Section 7 of this act, which adds Sections 5973.5, 5977.1 and 5977.4 to the Welfare and Institutions Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

This act protects the sensitive medical information of the respondent in a CARE court proceeding, including medical and psychological records.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime

or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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CalHHS
California Health & Human Services Agency

CARE Court FAQ

A New Framework for Community Assistance, Recovery, and Empowerment

1. What is CARE Court?

CARE Court is a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

It connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan.

2. How is self-determination supported in the CARE Court model?

Supporting a self-determined path to recovery and self-sufficiency is core to CARE Court, with a Public Defender and a newly established Supporter for each participant in addition to their full clinical team.

The role of the Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible.

The Care Plan ensures that supports and services are coordinated and focused on the individual needs of the person it is designed to serve.

The creation of a Mental Health Advance Directive further provides direction on how to address potential future episodes of impairing illness that are consistent with the expressed interest of the participant and protect against negatives outcomes such as involuntary hospitalization.

3. What are the criteria for participation in CARE Court?

The criteria are two part: individuals with a) a schizophrenia spectrum or other psychotic disorder diagnosis AND b) whose judgment is so impaired by symptoms of their mental illness (e.g., hallucinations, delusions, disorganization and/or cognitive impairment) that they lack the capacity to make informed or rational decisions about their medically necessary treatment.

CARE Court is NOT for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity to serve these Californians – before they enter the criminal justice system or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship.

4. What is the purpose of CARE Court?

CARE Court aims to deliver behavioral health services to the most severely ill and vulnerable individuals, while preserving self-determination and community living.

CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration; this is based on evidence which demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community.

CARE Court may be an appropriate next step after a short-term involuntary hospital hold (either 72 hours/5150 or 14 days/5250), an arrest, or for those who can be safely diverted from a criminal proceeding. Remote or virtual proceedings may be especially effective for CARE Court participants.

5. Is CARE Court a conservatorship?

No, it seeks to prevent the need for conservatorship by intervening prior to the need for such restrictive services and providing shorter-term court ordered, community-based care with Supportive Decision Making.

Current Lanterman-Petris-Short (LPS) Act Mental Health conservatorship is rarely timely, difficult to have granted, establishes a substitute decision maker for the person, and typically relies on locked placements as a first line intervention.

6. What does a participant in CARE Court receive?

The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. A housing plan is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.

Each participant will also be provided a new, designated Supporter to assist with Supported Decision Making for the CARE Court Care Plan, the creation of a Mental Health Directive, and a "graduation" plan for recovery and wellness post-CARE Court. The role of the Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible. Participants will also have a designated court appointed attorney, for court proceedings.

7. How does CARE Court work?

Referral: The first step is a petition to the Court, by a family member, behavioral health provider, first responder, or other approved party to provide care and prevent institutionalization.

Clinical Evaluation: The civil court orders a clinical evaluation after a reasonable likelihood of meeting the criteria is found. Court appoints a public defender and Supporter. The court reviews the clinical evaluation and, if the individual meets the criteria, the court orders the development of a Care Plan.

Care Plan: The Care Plan is developed by county behavioral health, participant and Supporter including behavioral health treatment, stabilization medication, and a housing plan. The court reviews and adopts the Care Plan with both the individual and county behavioral health as party to the court order for up to12 months.

Support: The county behavioral health care team, with the participant and Supporter, begin treatment and regularly review and update the Care Plan, as needed, as well as a Mental Health Advance Directive for any future crises. The court provides accountability with status hearings, for up to a second 12 months, as needed.

Success: Upon successful completion and graduation by the Court, the participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery. The Mental Health Advance Directive remains in place for any future crises.

8. What is meant by court-ordered stabilization medications?

Stabilization medications may be included in the court ordered Care Plan.

Court ordered stabilization medications are distinct from an involuntary medication order in that they cannot be forcibly administered. Seeking an involuntary medication order for a participant would be outside the proceedings and subject to existing law. Failure to participate in any component of the Care Plan may result in additional actions, consistent with existing law, including possible referral for conservatorship with a new presumption that no suitable alternatives exist.

Stabilization medications would be prescribed by the treating licensed behavioral healthcare provider/prescriber and medication management supports will be offered by the care team. As a participant in the development and on-going maintenance of the Care Plan, the participant will work with their behavioral healthcare provider and their Supporter to address medication concerns and make changes to the treatment plan.

Stabilizing medications will primarily consist of antipsychotic medications, which are evidence-based treatments to reduce the symptoms of hallucinations, delusions, and disorganization—these are the symptoms that cause impaired insight and judgment in individuals living with Schizophrenia spectrum and other psychotic disorders. Medications may be provided as long-acting injections which reduce the day-to-day –adherence challenges many people experience with daily medications.

9. What if an individual does not participate in the Court-ordered Care Plan?

An individual who does not participate in the court-ordered Care Plan may be subject to additional court hearing(s). If a participant cannot successfully complete a Care Plan, the individual may be referred by the Court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under a new presumption that no suitable alternatives to conservatorship are available. For individuals whose criminal cases were diverted, those proceedings will resume.

10. Will CARE Court be available statewide?

Yes—all counties will participate in Care Court. There is not an option to opt-out.

11. What if a local government does not provide the court-ordered Care Plan?

If local governments do not meet their specified responsibilities under the court-ordered Care Plans, the Court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

12. How is CARE Court different from current approaches in California - namely Mental Health (or LPS) Conservatorship and the more recent Laura's Law (Assisted Outpatient Treatment)?

CARE Court applies only to a small and distinct group of adults with under or untreated Schizophrenia spectrum and other psychotic disorders who lack the capacity to make informed or rational decisions about their medically necessary treatment.

CARE Court differs fundamentally from Mental Health/LPS Conservatorship. It does not include custodial settings or long-term involuntary medications. CARE Court provides a new Supporter role, to empower the individual in directing their care as much as possible. Lastly, the court ordered Care Plan is no longer than 12 or, if extended, 24 months.

CARE Court is different from both Mental Health/LPS Conservatorship and Laura's Law approaches in that it may be initiated on a petition to the Court by family members, service providers, and other authorized parties, in addition to County Behavioral Health. Local government is also part of the court order, along with the participant, to ensure accountability to the provision of treatment and care.

CARE Court is also separate from Probate Conservatorship where a court may appoint a conservator for people determined to be incapacitated to manage their financial or personal care decisions.

13. How is CARE Court funded?

Existing funding sources for the Care Plan services and supports include nearly $10 billion annually for behavioral healthcare (including Mental Health Services Act, mental health realignment, federal funds) and the proposed $1.5 billion for behavioral health bridge housing, as well as various housing and clinical residential placements available to cities and counties under the Governor's $12 billion homelessness investments which began in 2021. County behavioral health is responsible for Medi-Cal Specialty Mental Health Services and Substance Use Disorder (SUD) treatment and community mental health services.

Costs for the Court, the Public Defender, the new Supporter program, and state oversight will require new funding. The state will provide technical assistance to the Counties and will be responsible for data collection, evaluation, and reporting.

14. What housing is available to an individual in CARE Court?

Housing is an important component of CARE Court—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle. Care Plans will include a housing plan. Individuals who are served by CARE Court will have diverse housing needs on a continuum ranging from clinically enhanced interim or bridge housing, licensed adult and senior care settings, supportive housing, to housing with family and friends.

In the 2021 Budget Act, the state made a historic $12 billion investment to prevent and end homelessness which included unprecedented new funding to create new community based residential settings and long-term stable housing for people with severe behavioral health conditions. Additionally, the Governor's proposed 2022-2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which will fund clinically enhanced bridge housing settings that are well suited to serving CARE Court participants.

CalHHS
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CARE Court

A New Framework for Community Assistance, Recovery & Empowerment

CARE Court is a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

THE CARE COURT IS A NEW APPROACH AND A PARADIGM SHIFT

It connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services, including housing. Housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.

CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration; this is based on evidence which demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community.

CARE Court is not for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capacity – before they get arrested and committed to a State Hospital or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. Although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions—this proposal aims connect these individuals to effective treatment and support, mapping a path to long-term recovery. CARE Court will help thousands of Californians on their journey to sustained wellness.

CARE Court engagement begins with a petition to the Court from a wider range of individuals, including care providers, family members, first responders, or counties, among others. CARE Court may be an appropriate next step after a short-term involuntary hospital hold (either 72 hours/5150 or 14 days/5250) or for those who can be safely diverted from a criminal proceeding.

Supporting a path to recovery and self-sufficiency is core to CARE Court, with a Public Defender and a newly established Supporter for each participant in addition to their full clinical team. The role of the Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible. The Care Plan ensures that supports and services are coordinated and focused on the individual needs of the person it is designed to serve. Often times, care for this vulnerable population fails to bring together the clinical treatment and a plan for housing. The creation of a Mental Health Advance Directive will further provide direction on how to address potential future episodes of impairing illness that are consistent with the expressed interest of the participant and protect against negatives outcomes.

ACCOUNTABILITY IN CARE COURT GOES BOTH WAYS

If a participant cannot successfully complete a Care Plan, the individual may be referred by the Court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under the presumption that no suitable alternatives to conservatorship are available. For individuals whose criminal cases were diverted, those proceedings will resume.

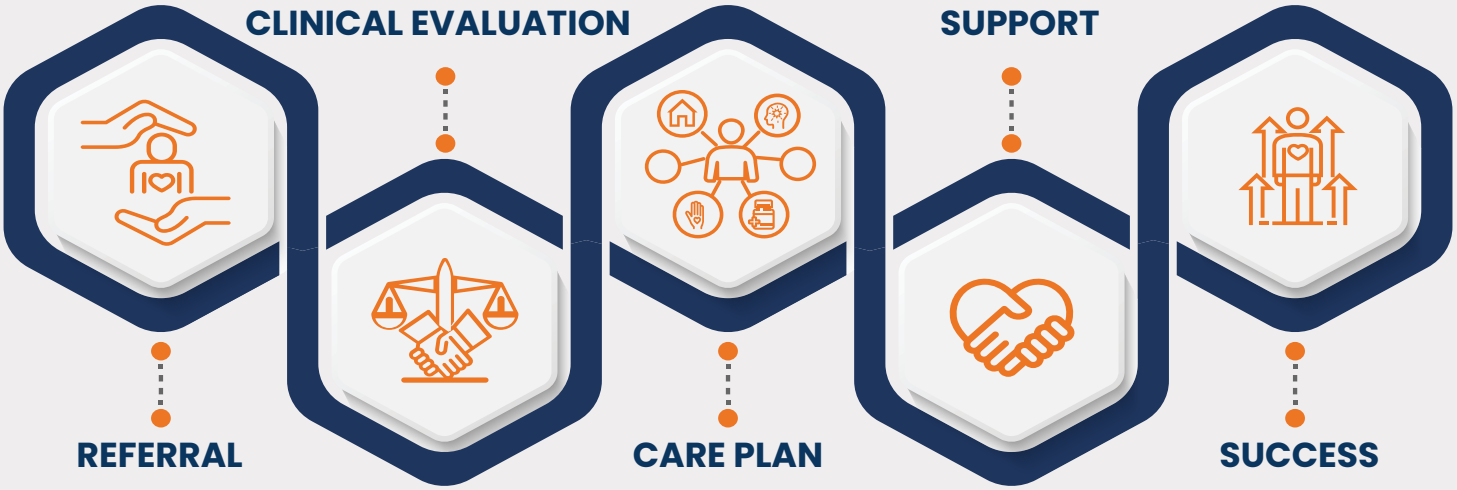
The CARE Court will also hold local governments accountable for providing care to the people who need it, using the variety of robust funding streams available to counties today. These funding sources include: Mental Health Services Act, mental health realignment, federal funds, and the proposed $1.5 billion for behavioral health bridge housing, as well as various housing and clinical residential placements available to cities and counties under the Governor's $12 billion homelessness plan. If local governments do not meet their specified responsibilities under the court-ordered Care Plans, the Court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

A FRAMEWORK THAT REQUIRES COMMUNITY ENGAGEMENT AND INPUT

This is a framework that requires deep engagement with the community to ensure that it is built with Californians and not for them. In the coming weeks, we intend to engage a broad set of stakeholders to further build this framework out and ensure that it can deliver meaningful results for some of our most vulnerable neighbors.

> We call on organizations and individuals alike to engage with us by providing written feedback that can be sent to us at **CARECourt@chhs.ca.gov.**

Pathway through the CARE Court



REFERRAL
Individual with untreated schizophrenia spectrum or other psychotic disorder who lacks medical decision-making capacity may be referred to the court by a family member, behavioral health provider, first responder, or other approved party to provide care and prevent institutionalization.

CLINICAL EVALUATION
The civil court orders a clinical evaluation and appoints public defender and Supporter. Court reviews the clinical evaluation and, if the individual meets the criteria, the court orders the development of a Care Plan.

CARE PLAN
Care Plan is developed by county behavioral health, participant and Supporter including behavioral health treatment, stabilization medication, and a housing plan. Court reviews and adopts the Care Plan with both the individual and county behavioral health as party to the court order for up to 12 months.

SUPPORT
County behavioral health care team, with participant, and Supporter, begin treatment and regularly review and update Care Plan, as needed, as well as a Mental Health Advance Directive for any future crises. Court provides accountability with status hearings, for up to a second 12 months, as needed.

SUCCESS
Successful completion and graduation by the Court. Participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery. Mental Health Advance Directive in place for any future crises.

GOVERNOR NEWSOM'S NEW PLAN TO GET CALIFORNIANS IN CRISIS OFF THE STREETS AND INTO HOUSING, TREATMENT, AND CARE

- Community Assistance, Recovery and Empowerment (CARE) Court is a new framework to get people with mental health and substance use disorders the support and care they need.
- CARE Court is aimed at helping the thousands of Californians who are suffering from untreated mental health and substance use disorders leading to homelessness, incarceration or worse.
- California is taking a new approach to act early and get people the support they need and address underlying needs - and we're going to do it without taking away people's rights.
- CARE Court includes accountability for everyone – on the individual and on local governments – with court orders for services.

HOW CARE COURT WORKS

CARE Court connects a person struggling with untreated mental illness – and often also substance use challenges – with a court-ordered Care Plan for up to 24 months. Each plan is managed by a care team in the community and can include clinically prescribed, individualized interventions with several supportive services, medication, and a housing plan. The client-centered approach also includes a public defender and supporter to help make self-directed care decisions in addition to their full clinical team

CARE Court is designed on the evidence that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. It's a long-term strategy to positively impact the individual in care and the community around them. The plan focuses on people with schizophrenia spectrum and other psychotic disorders, who may also have substance use challenges, and who lack medical decision-making capacity and advances an upstream diversion from more restrictive conservatorships or incarceration.

The court-ordered response can be initiated by family, county and community-based social services, behavioral health providers, or first responders. Individuals exiting a short-term involuntary hospital hold or an arrest may be especially good candidates for CARE Court. The Care Plan can be ordered for up to 12 months, with periodic review hearings and subsequent renewal for up to another 12 months. Participants who do not successfully complete Care Plans may, under current law, be hospitalized or referred to conservatorship - with a new presumption that no suitable alternatives to conservatorship are available.

All counties across the state will participate in CARE Court under the proposal. If local governments do not meet their specified duties under court-ordered Care Plans, the court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

CARE Court builds on Governor Newsom's $14 billion multi-year investment to provide 55,000 new housing units and treatment slots as well as a more than $10 billion annual investment in community behavioral health services. The Governor's comprehensive approach combines a focus on bridge housing to quickly rehouse unsheltered individuals with behavioral health issues, all while more new units come online, while also transforming Medi-Cal to provide more behavioral health services to people struggling the most.

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.

Disability Rights California
California's protection & advocacy system

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Intake Line: (800) 776-5746
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Statement

For Immediate Release
March 7, 2022
Media Contact:
Melody Pomraning, Communications Director, Disability Rights California
(916) 504-5938, Melody.Pomraning@disabilityrightsca.org

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."

###

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.

2000 Embarcadero Cove, Suite 400, Box 80, Oakland, CA 94606 ● www.camhpro.org

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
California State Capitol
1021 O Street, Suite 9000
Sacramento, CA 95814-5704

Secretary Mark Ghaly, MD, MPH
California Health & Human Services Agency
1600 9th St Ste 460
Sacramento, CA 95814-6439

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,

Heidi. L. Strunk
President & CEO
Mental Health America of California
California Youth Empowerment Network

Nan Roman
Chief Executive Officer
National Alliance to End Homelessness

Sam Lewis

Sam Lewis
Executive Director
Anti-Recidivism Coalition

Guyton Colantuono

Guyton Colantuono, NCPS
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Project Return Peer Support Network

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Mark Salazar, MHA
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Courtney Hanson
Development & Communications Coordinator
California Coalition for Women Prisoners

Angela Chan

Angela Chan
Chief of Policy
San Francisco Public Defender's Office

Christopher Martin

Christopher Martin
Policy Director
Housing California

Guyton Colantuono
Statewide Directors
California Association of Peer Supporters
Academy

March 25, 2022

Mark Ghaly, MD, MPH

Secretary, California Health and Human Services Agency

1215 O Street

Sacramento, CA 95814

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,

Le Ondra Clark Harvey, Ph.D.,
Chief Executive Officer,
California Council of Community Behavioral Health Agencies

Tyler Rinde, Executive Director, California Association of Alcohol and Drug Addiction Program Executives

Chad Costello, CPRP, Executive Director,
California Association of Social Rehabilitation Agencies

Christine Stoner-Mertz, LCSW, Chief Executive Officer, California Alliance of Child and Family Services

CC:

Marko Mijic, Undersecretary, CalHHS

Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS

Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, CalHHS

Michelle Baass, Director, Department of Health Care Services (DHCS)

Jacey Cooper, Chief Deputy Director and State Medicaid Director, DHCS

Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS

Agnes Lee, Policy Consultant, Office of Assembly Speaker Rendon

Marjorie Swartz, Policy Consultant, Office of Senate President pro Tempore Atkins

Judy Babcock, Senior Consultant, Assembly Health Committee

Scott Bain, Principal Consultant, Assembly Health Committee

Andrea Margolis, Consultant, Assembly Budget Committee

Reyes Diaz, Principal Consultant, Senate Health Committee

Scott Ogus, Consultant, Senate Budget Committee

Eusevio Padilla, Chief of Staff, Office of Assemblymember Joaquin Arambula

Liz Snow, Chief of Staff, Office of Assemblymember Jim Wood

David Stammerjohan, Chief of Staff, Office of Senator Susan Eggman

Darin Walsh, Chief of Staff, Office of Senator Richard Pan

Aria Ghafari, Chief of Staff, Office of Senator Tom Umberg

Guy Strahl, Chief of Staff, Office of Assemblymember Richard Bloom

NAMI California
National Alliance on Mental Illness

March 14, 2022

The Honorable Gavin Newsom, Governor
State of California
California Capitol
Sacramento, CA 95814

Re: CARE Court Framework – SUPPORT

Dear Governor Newsom:

NAMI-CA is in support of the Administration's CARE Court framework, which intends to deliver services to Californians with a serious mental illness or substance use disorder who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

NAMI-CA is the statewide affiliate of the country's largest mental health advocacy organization, the National Alliance on Mental Illness. Our over 110,000 active advocates and 58 affiliates include many people living with serious mental illnesses, their families, and supporters. NAMI-CA advocates on their behalf, providing education and support to its members and the broader community.

NAMI-CA believes that all people should have the right to make their own decisions about medical treatment. However, we are aware that there are individuals with serious mental illnesses who have very high complex needs, at times, due to their illness, lack insight or good judgment about their need for medical treatment. In cases like this, a higher level of care may be necessary, but must be the last resort. Our members have been calling for reform for their loved ones for years.

NAMI-CA believes that the availability of effective, comprehensive, community-based systems of care for persons suffering from serious mental illnesses will diminish the need for assisted outpatient treatment. Before we reach the stage of last resort, we must fully fund, build and staff our community-based system, so all who need care can access it long before they reach a crisis level.

NAMI-CA urges the state to ensure that any services that are made available through the CARE Court model are also available as voluntary services in the community care continuum. There is currently no statewide standard that specifies that specific services be available to all people in all counties. We can no longer accept a fail-first system composed of partially realized solutions.

NAMI-CA deplores the higher rates of involuntary commitment and incarceration in penal facilities that occurs among communities of color with serious mental illnesses. We are thankful to have an Administration that understands that equity must be a top tenet of policymaking. Recognizing that communities of color and other underrepresented communities often suffer the unintended consequence of the court system serving as their behavioral health delivery system, the Administration must work closely with underrepresented communities to ensure that CARE Courts serve as an example of health equity in action.

NAMI-CA is heartened to see that accountability is one of the pillars of the CARE Court framework. We must hold the system accountable at all delivery points. We cannot take anything for granted in the implementation of a framework, as its effectiveness lies in the words that end up in statute, how it is implemented through the regulatory process, and to how each of our 58 counties will interpret the framework.

Additionally, more can be done to ensure the public (family members and consumers, in particular) and policymakers have the information they need to be assured that public programs treating people with serious mental illness are doing so effectively. In particular, little information is currently collected or shared about one of the most profound roles government plays in the mental health field – involuntary evaluation, treatment, and conservatorship under the LPS Act.

Many questions remain to be answered. What will the court process look like? What does success look like? If an individual has been diverted from legal proceedings, will their record be expunged upon completion of the CARE Court process? Who will qualify as a Supporter? What new resources will be directed to the proposal other than the preexisting federal, homelessness and county funds that were underscored in the framework? NAMI-CA looks forward to working closely with the Administration to implement the promise of the CARE Court framework.

I may be reached at jessica@namica.org or (916) 567-0163.

Sincerely,

Jessica Cruz,
MPA/HS
Chief Executive Officer

Cc: Ana J. Matosantos, Cabinet Secretary, Office of Governor Gavin Newsom
Dr. Mark Ghaly, Secretary, California Health and Human Services Agency (CHHS)
Stephanie Welch, Deputy Secretary, CHHS
Michelle Baass, Director, DHCS
Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Stephanie Clendenin, Director, DSH
Mary Watanabe, Director, DMHC
Richard Figueroa, Office of the Governor
Tam Ma, Office of the Governor
Marjorie Swartz, Office of the Senate President Pro Tempore
Chris Woods, Office of the Senate President Pro Tempore
Agnes Lee, Office of the Speaker of the Assembly
Jason Sisney, Office of the Speaker of the Assembly
Joe Parra, Senate Republican Fiscal Office

Joe Shinstock, Assembly Republican Fiscal Office
Corey Hashida, Legislative Analyst's Office (LAO)
Ben Johnson, LAO

March 23, 2022

Governor Gavin Newsom
California State Capitol
1021 O Street, Suite 9000
Sacramento, CA 95814-5704

Secretary Mark Ghaly, MD, MPH
California Health & Human Services Agency
1600 9th St Ste 460
Sacramento, CA 95814-6439

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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California Youth Empowerment Network

Nan Roman
Chief Executive Officer
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California Association of Peer Supporters
Academy

March 25, 2022

Mark Ghaly, MD, MPH

Secretary, California Health and Human Services Agency

1215 O Street

Sacramento, CA 95814

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,

Le Ondra Clark Harvey, Ph.D.,
Chief Executive Officer,
California Council of Community Behavioral Health Agencies

Tyler Rinde, Executive Director, California Association of Alcohol and Drug Addiction Program Executives

Chad Costello, CPRP, Executive Director, California Association of Social Rehabilitation Agencies

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CC:

Marko Mijic, Undersecretary, CalHHS

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April 11, 2022

Assembly Member Mark Stone
Chair of the Judiciary Committee
Assembly Judiciary Committee
1020 N Street, Room 104
Sacramento, CA 95814

RE: AB 2830 The Community Assistance, Recovery, and Empowerment Act - OPPOSE

Dear Assembly Member Stone;

The California Association of Mental Health Peer Run Organizations (CAMHPRO) strongly opposes AB 2830. Assembly Bill 2830 (Bloom), in alignment with Governor Newsom's CARE Court framework, states the bill 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."

"A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new Community Assistance, Recovery, and Empowerment (CARE) Court Program." (AMENDMENTS TO ASSEMBLY BILL NO. 2830 AS AMENDED IN ASSEMBLY MARCH 24, 2022, Amendment 2, c.)

AB 2830 is not a new approach and a paradigm shift. In fact, it resorts to the default method of the behavioral health system – forced treatment. **A court order is forced treatment.**

"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 the California Association of Mental Health Peer Run Organizations (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.

AB 2833 also asserts that the bill protects self-determination and civil liberties, individual rights.
To the contrary, the CARE Court subverts the rights protected in the Lanterman-Petris-Short Act (LPS), most specifically, the behavioral criteria – clear measurements - for initiating coercive treatment. Before the landmark LPS, people could be forcibly treated on the word of a broad array of petitioners without any objective criteria of behavior. The Community Assistance, Recovery, and Empowerment Act takes us back to those days, obliterating the rights protections for people with mental disabilities of the last 50 years. With AB 2830, almost anyone can initiate a court proceeding. The only criteria, "lack of capacity for medical decision-making" is vague and without definition.

The CARE Court concept is based on myths:

Firstly, people with mental conditions are inherently incompetent and not able to make their own decisions. This is a paternalistic attitude toward people with mental conditions and leads to forced treatment as a solution.

The myth that people diagnosed with mental illness are not competent to make their own decisions and are incapable of insight into their illness is discredited by researchers.

Most people with mental disabilities are competent to make decisions about their treatment. According to the MacArthur Treatment Competence Study, "Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions. Taken by itself, mental illness does not invariably impair decision making capacities." [1]In the Surgeon General's words, "Typically, people retain their personality and, in most cases, their ability to take responsibility for themselves."

Finally, the bill contradicts itself. While naming that a person "lacks medical decisionmaking capacity" fits criteria for CARE Court, the same bill later states that a Supporter would "offer the respondent a flexible and culturally responsive way to maintain autonomy and decisionmaking authority over their own life." This reflects the inherent and absolute uncertainty and slippery slope that using lack of ability to decide for oneself creates as criteria.

Secondly, coercive treatment is effective and leads to treatment compliance

The expansion of forced treatment will not stop "treatment noncompliance," which is viewed as a problem that more forced treatment will solve. In fact, researchers have found that forced treatment may cause noncompliance. The Well Being Project, a research project supported by the California Department of Mental Health, found that 55 % of clients interviewed who had experienced forced treatment reported that fear of forced treatment caused them to avoid all treatment for psychological and emotional problems.[2]

Forced treatment is antithetical to recovery. Self-determination and choice are essential to recovery.

Third, 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

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[1]*U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. (Incompetency myth) MacArthur Treatment Competence Study. http.www.sys.virginia.edu.macarthur (Incompetency myth)*

[2] *Campbell, Jean, Schraiber, Ron. The Well-Being Project: Mental Health Clients Speak for Themselves. California Network of Mental Heath Clients, California Department of Mental Health, 1989.*

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 and peer-run services that are currently available, beginning to be available, and must be imagined.[3]
- 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 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.

Please oppose AB 2830.

Sincerely,

Andrea L Wagner

Andrea Wagner, *Interim Executive Director*
Avery Hulog-Vicente, *Advocacy Coordinator*
California Association of Mental Health Peer Run Organizations (CAMHPRO)
236 W East Avenue
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Chico, CA 95926
530.354.3024

CC: Assembly Member Richard Bloom

[3] 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

April 21, 2022

The Honorable Thomas Umberg
Chair, Senate Judiciary Committee
1021 O Street, Ste. 6730
Sacramento, CA 95814

RE: SB 1338 (Umberg) - OPPOSE

Dear Senator Umberg:

The organizations sending this letter advance and protect the civil rights of Californians living with disabilities, experiencing homelessness, and involved in the criminal legal system. Respectfully, we **oppose SB 1338**.

The CARE Court framework that it seeks to establish is unacceptable for a number of reasons:

- It does not guarantee housing as a solution to address homelessness;
- Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment;
- It will perpetuate institutional racism and worsen health disparities;
- There are flaws in SB 1338's reliance on a person's lack of capacity to make medical decisions;
- Use of the terms "Supportive Decision-Making" and "Supporter" reflects a misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court; and
- Critical terms and concepts are not defined by SB 1338 or elsewhere in California law.

We believe that a transformational proposal like CARE Court should be thoroughly vetted by stakeholders and informed by research and data before it is adopted. That has not happened here. Because CARE Court will harm Californians with disabilities, experiencing homelessness, and involved in the criminal legal system, we cannot support this proposal.

I. Background

The California Legislature has declared that, "[i]n the absence of a controversy, a court is normally not the proper forum in which to make health care decisions."[1] Yet, SB 1338 seeks to establish a new court system in which health care decisions will be made. Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court is a system of coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives.

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction.[2] The CARE Court proposal is based on

[1] Probate Code § 4650(c). "Return to Main Document"

[2] Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery* (https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf). "Return to Main Document"

stigma and stereotypes of people living with mental health disabilities and experiencing homelessness.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services.

II. Ending homelessness for all Californians living with mental health disabilities requires guaranteed housing provided with fidelity to principles that prioritize voluntary services.

Instead of allocating vast sums of money towards establishing an unproven system of court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to homelessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing is proven to reduce utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing homelessness.[3]

To effectuate guaranteed housing, California should use the funds targeted towards CARE Court to instead make large-scale investments in low-barrier, deeply affordable (15% of area median income or less), accessible, integrated housing for people experiencing homelessness. This housing should be made available with access to voluntary, trauma-informed, culturally-responsive, evidence-based services such as Assertive Community Treatment, Intensive Case Management, Peer Support, and substance use disorder services that follow the Harm Reduction approach.

Informed by Housing First Principles, California has recognized that it is crucial to use housing as a tool rather than a reward for recovery, and to provide or connect unhoused people to permanent housing as quickly as

[3] David A. Snow and Rachel E. Goldberg, *Homelessness in Orange County: The Costs to Our Community* (June 2017) at 43 (https://www.unitedwayoc.org/wp-content/uploads/2017/08/united-way-cost-study-homelessness-2017-report.pdf). "Return to Main Document"

possible. Housing First principles, as an evidence-based model, require offering services as needed and requested on a voluntary basis, and not making housing contingent on participation in services.[4] By statute, state programs that provide housing or housing-based services to people experiencing homelessness or at risk of homelessness must adopt guidelines and regulations to incorporate the core components of Housing First.[5]

Evidence shows that housing provided with fidelity to Housing First principles leads to the types of positive outcomes for unhoused people that the state is misguidedly proposing to attain via CARE Court. For example, a recent UCSF randomized controlled study of unhoused high utilizers of public systems in Santa Clara County found that permanent supportive housing (which incorporates Housing First principles) combined with intensive case management, significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.[6] In addition, Housing First programs that closely adhere to the evidence-based model result in positive housing and substance use outcomes for chronically homeless people with substance use disorders.[7]

CARE Court flies in the face of any evidence-based approach to ending homelessness. It requires a person to be court-ordered into a treatment plan that includes a "housing plan," without any guarantee that the plan will ever lead to permanent housing. As the Health and Human Services Agency recognizes, "finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle."[8] On this premise, a person should be offered housing

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[4] Welf. & Inst. Code § 8255(d)(1). "Return to Main Document"

[5] Welf. & Inst. Code § 8256(a). SB 1338's stated plan to give CARE Court participants priority for the "Behavioral Health Bridge Housing" proposed in the Governor's Budget violates the State's commitment to Housing First as codified here. CARE Court is *not* a Housing First program because it will likely require participants to comply with a program or services as a condition of tenancy. "Return to Main Document"

[6] Maria C. Raven, M.D., M.P.H., M.Sc., *et al*., *A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services*, Health Services Research 2020;55 (Suppl. 2): 797 at 803. "Return to Main Document"

[7] Clare Davidson, M.S.W., *et al*., *Association of Housing First Implementation and Key Outcomes Among Homeless Persons with Problematic Substance Use*, Psychiatric Services 2014; 65:1318 at 1323. "Return to Main Document"

[8] California Health and Human Services Agency, *CARE Court: A New Framework for Community Assistance, Recovery, and Empowerment* (https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf) (accessed April 10, 2022). "Return to Main Document"

before they can be reasonably expected to engage in mental health services. Because SB 1338 specifically precludes a court from ordering housing and does not require a county to provide housing, CARE Court will create a system of distrust and further hinder participants from obtaining appropriate treatment and services by employing a coercive model. With SB 1338's built-in presumption that "failure to comply" will lead to a "factual presumption that no suitable community alternatives are available" to treat the person, CARE Court is a fast track to conservatorship and re-institutionalization of people with mental health disabilities, exactly the outcomes that SB 1338 purports to avoid.

III. Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment.

Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court sets up a system of coerced, involuntary outpatient civil commitment that deprives people with mental health disabilities of the right to make self-determined decisions about their own lives. Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment provided in accordance with evidence-based practices.[9] Conversely, evidence shows that involuntary, coercive treatment is harmful.[10]

In 2000, the California Senate Committee on Rules commissioned the RAND Institute to develop a report on involuntary outpatient treatment, with a primary objective to identify and synthesize empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives.[11] The findings of the RAND report remain relevant today. Then and now, no studies exist to prove that a court order for outpatient treatment *in and of*

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[9] Joseph P. Morrissey, Ph.D., *et al*., *Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*, Psychiatric Services 2014:812 at 814 (2014). "Return to Main Document"

[10] S.P. Sashidharan, Ph.D., *et al.*, *Reducing Coercion in Mental Healthcare*, Epidemiology and Psychiatric Sciences 2019: 28, 605-612 (All forms of coercive practices are inconsistent with human rights-based mental healthcare); Daniel Werb, Ph.D., *et al.*, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, International Journal of Drug Policy 2016: 28, 1-9 (Because evidence, on the whole, does not suggest improved outcomes related to compulsory drug treatment approaches and some studies suggest potential harms, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms). "Return to Main Document"

[11] M. Susan Ridgely, *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND Health and RAND Institute for Civil Justice, 2001 (https://www.rand.org/pubs/monograph_reports/MR1340.html). "Return to Main Document'

itself has any independent effect on client outcomes.[12] Studies show that any positive effects that result from outpatient commitment are due to the provision of intensive services, and whether court orders have any effect at all in the absence of intensive treatment is an unanswered question.[13] In addition, a well-resourced treatment system with the appropriate infrastructure to deliver high-intensity services is critical for the success of any outpatient commitment program.[14]

On the other hand, the RAND study provided strong evidence of the effectiveness of Assertive Community Treatment (ACT), a multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management.[15] The report's authors concluded that there is clear evidence that, when implemented with fidelity to evidence-based models, community-based mental health interventions like ACT can produce good outcomes for people living with severe mental illness.[16] Furthermore, psychosocial rehabilitation programs are evidence-based recovery models and interventions considered best practices in addressing the recovery of unhoused individuals with mental health disabilities.[17] The State's resources would be better utilized to expand and strengthen the availability of ACT, psychosocial rehabilitation recovery models, and other intensive evidence-based treatment modalities throughout California.[18]

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[12] *Id*. at xvi. "Return to Main Document"

[13] *Id*. at 27. "Return to Main Document"

[14] *Id*. at 67. "Return to Main Document"

[15] *Id*. at 29. The primary difference between California's Full Service Partnerships (FSP) and ACT is that there is no evidence-based model that FSPs must follow. There is significant variation in FSP delivery across counties. Some counties have ACT programs as part of their FSP offerings. When offered as part of an FSP, ACT generally provides a more engaged level of service than the standard FSP. "Return to Main Document"

[16] *Id*. at 32. "Return to Main Document"

[17] Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System that Works for All People Living with SMI and SED and their Families and Caregivers* (December 13, 2017) at 25 (https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf). "Return to Main Document"

[18] The recent behavioral health needs assessment published by DHCS found that ACT is not yet available with fidelity on the scale necessary to support optimal care for people who could benefit from the level of engagement that it offers. State of California, Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022) at 60 (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf) "Return to Main Document"

IV. CARE Court will perpetuate institutional racism and worsen health disparities.

Due to a long and ongoing history of racial discrimination in housing, banking, employment, policing, land use and healthcare, Black people experience homelessness at a vastly disproportionate level compared to the overall population of the state. In Los Angeles County alone, Black people make up 8% of the population, but 34% of people experiencing homelessness.[19] Statewide statistics are even more dire: 6.5% of Californians identify as Black or African-American, but they account for nearly 40% of the state's unhoused population.[20]

In addition, research shows that Black, indigenous, and people of color (BIPOC) and immigrant racial minorities are more likely to be diagnosed with psychotic disorders than white Americans.[21] In California, rates of serious mental illness vary considerably by racial and ethnic groups, with. American Indian and Alaska Native and Black Californians experiencing the highest rates of serious mental illness.[22]

By targeting unhoused people with diagnoses of schizophrenia and other psychotic disorders, CARE Court will exacerbate health disparities under the directive of a court system. CARE Court will disproportionately impact BIPOC Californians, who are significantly more likely to be homeless and diagnosed with such conditions.

V. There are numerous flaws in SB 1338's reliance on a person's lack of capacity to make medical decisions as a condition of eligibility for CARE Court.

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[19] Steve Lopez, *Column: Black people make up 8% of L.A. population and 34% of its homeless. That's unacceptable.*, Los Angeles Times, June 13, 2020 (https://www.latimes.com/california/story/2020-06-13/column-african-americans-make-up-8-of-l-a-population-and-34-of-homeless-count-heres-why). "Return to Main Document"

[20] Kate Cimini, *Black people disproportionately homeless in California*, Cal Matters, October 5, 2019 (updated February 27, 2021) (https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/). "Return to Main Document"

[21] Robert C. Schwartz, Ph.D., *et al*., *Racial disparities in psychotic disorder diagnosis: A review of empirical literature*, World Journal of Psychiatry 2014: 4:4, 133-140. "Return to Main Document"

[22] California Health Care Foundation, *Health Disparities by Race and Ethnicity in California: Pattern of Inequity* (October 2021) at 33 (https://www.chcf.org/wp-content/uploads/2021/10/DisparitiesAlmanacRaceEthnicity2021.pdf). "Return to Main Document"

The CARE Court framework described by SB 1338 rests on the premise that certain people diagnosed with schizophrenia or other psychotic disorders may be court-ordered into treatment if they lack medical decision-making capacity. This premise has serious flaws. SB 1338 ignores California's legal requirements that must be met before a finding that a person lacks medical decision-making capacity is legally authorized. In addition, requiring a finding that a person lacks medical decision-making capacity as a prerequisite for ordering a person into CARE Court services undermines the entire CARE Court framework, which assumes a participant's ability to participate in the development of their treatment plan and ultimately consent to it without the appointment of a substitute decision-maker.

A. SB 1338 ignores specific procedures that California requires to determine whether a person lacks capacity to make medical decisions.

Californians are presumed competent to make health care decisions.[23] The law is clear that "the mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act" and that a finding of incapacity to make a certain decision or do a certain act must be based on evidence of a deficit in a mental function related to the decision or action in question.[24] Because the right to refuse medical treatment is a fundamental liberty interest regarding one's bodily autonomy, the right to due process attaches when it is questioned.

California law is very clear about the process, which includes the right to a court hearing, that must be followed to determine whether a person lacks medical decision-making capacity.[25] SB 1338 does not require any of these steps. Instead, it allows unacceptable shortcuts: submission of an affidavit of a behavioral health professional based on an evaluation that occurred up to three months prior or not at all, or evidence of an LPS hold within the past 90 days. Neither of these shortcuts is sufficient to prove that a person lacks capacity to make medical decisions or satisfy due process requirements for stripping a person of their right to control their bodily autonomy and make their own medical decisions.

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[23] Probate Code § 4657. "Return to Main Document"

[24] Probate Code § 811(a), (d). "Return to Main Document"

[25] Probate Code §§ 3200-3212. "Return to Main Document"

B. Finding that a person lacks capacity to make medical decisions requires offering a treatment plan on a voluntary basis first, with the opportunity to give informed consent.

Under California law, "capacity" means "a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives."[26]

According to this definition of capacity, a person must be provided with a description of the proposed treatment plan, information about risks, benefits, and alternatives to the plan, and an opportunity to voluntarily engage in the plan *before a finding of incapacity is made*. Under the language of SB 1338, the process is reversed: a person is first found incompetent to make decisions about medical treatment and, only after such finding, offered any information about the proposed treatment. This reversed approach does not pass muster under California laws governing incompetency to make medical decisions.

C. Requiring a lack of capacity as a necessary element of ordering a person to CARE Court effectively eviscerates the proposed legislation.

The premise of CARE Court is that a person can "choose" to enter a court-ordered treatment plan that they have participated in developing. However, this is failed logic if a prerequisite for an order to CARE Court is that a person lacks capacity to make medical decisions. Requiring a lack of capacity as a necessary element of ordering a person to CARE Court completely undermines the framework, inasmuch as SB 1338 presumes that individuals are capable of actively participating in the development of their treatment plans, specifically requires that they be afforded the opportunity to do so, and does not contemplate the appointment of a substitute decisionmaker to consent to the plan.[27]

VI. Use of the terms "Supported Decision-Making" and "Supporter" in the context of a coercive court-ordered treatment scheme reflects a serious misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court.

[26] Probate Code § 4609. "Return to Main Document"

[27] See Matter of K.L., 1 N.Y.3d 362, 369 (2004). "Return to Main Document"

SB 1338's use of the terms "Supported Decision-Making" and "Supporter" to describe certain court-ordered components of the CARE Court process is so inconsistent with well-established definitions of those concepts that the usage is not just inaccurate. It is misleading and problematic.

Supported Decision Making (SDM) is a practice that has been recognized and endorsed by the Administration for Community Living of the U.S. Department of Health and Human Services, (which funds the National Resource Center for Supported Decision-Making),[28] the American Bar Association Commission on Law and Aging,[29] and the United Nations Convention on Rights of Persons with Disabilities.[30] Across the board, these entities have used the term SDM to refer to a model or practice that enables individuals to make choices about their own lives with support *from a team of people they choose*. With SDM, individuals *choose people they know and trust* to be part of a support network that helps them understand their issues, options, and choices. The role of the supporter is to offer guidance and advice, but to ultimately honor and help carry out the choices made by that individual, regardless of whether the supporter thinks they are in the person's best interest.[31]

Contrary to SB 1338's statement of findings and declarations, the new "CARE Supporter" role will not advance and protect self-determination and civil liberties of Californians living with severe mental illness. More troublingly, the "CARE Supporter" role is not just acting within a coercive system but also has the potential to be an agent of that system. If a person "fails" or does not comply with their "CARE plan," they risk being forced into a conservatorship based on reports from the "CARE Supporter" about whether the person followed their plan. Therefore, because these "CARE

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[28] American Bar Association, *Guardianship and Supported Decision-Making* (https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/). "Return to Main Document"

[29] National Center on Law & Elder Rights, *Legal Basics: Supported Decision-Making* (https://ncler.acl.gov/pdf/Legal-Basics-Supported-Decision-Making1.pdf). "Return to Main Document"

[30] United Nations Department of Economic and Social Affairs/Disability, *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities Chapter Six: From Provisions to Practice: Implementing the Convention – Legal Capacity and Supported Decision-Making* (https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html). "Return to Main Document"

[31] Center for Public Representation, *About Supported Decision Making* (https://supporteddecisions.org/about-supported-decision-making/) (accessed April 8, 2022). "Return to Main Document"

Supporters" are appointed for the express purpose of assisting with decisions as part of the CARE Court process, they are more accurately "court-appointed navigators," and should be recognized as such.

Because a person's choice of their own supporters is at the heart of SDM, it cannot exist within a framework of a coercive court-ordered treatment scheme where a judge appoints a navigator whom the individual has never met and has no reason to trust.

Disability Rights California and Disability Rights Education and Defense Fund—signatories to this letter—are co-sponsors of AB 1663 (Maienschein), the Probate Conservatorship Reform and Supported Decision-Making Act, which seeks to codify SDM as part of the Probate Code. AB 1663 passed out of this committee with a vote of 10-0. The bill makes clear that SDM allows a person with a disability to choose *voluntary supports* to help them with decisions, *as requested*. SB 1338's misappropriation of these concepts and proposed statutory language from AB 1663, without using the appropriate definitions of the terms, undermines the true meaning and value of SDM.

VII. Many critical terms and concepts are not defined by SB 1338 or anywhere else in California law.

SB 1338 does not adequately define critical terms and concepts necessary to provide adequate understanding of the parameters of CARE Court. This lack of clarity will result in confusion and inconsistent application of the law across the state. These terms and concepts include, but are not limited to:

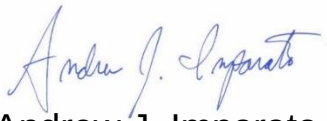
- "Not clinically stabilized in on-going treatment with the county behavioral health agency" (§ 5972(c));
- "Qualified behavioral health professional" (§ 5975(g)(1));
- Criteria for "graduation" from CARE Court (§ 5977(h)(1));
- Criteria for "reappointment" to CARE Court (§ 5977(h)(1));
- Criteria and process for finding that a person is "not participating in CARE proceedings" or "failing to comply with the CARE plan" (§ 5979(a));
- Criteria and process for terminating a participant from CARE Court 5979(a));
- Criteria and process for finding that a county is not complying with court orders (§ 5979(b)); and

- Criteria and process for finding that a county is "persistently noncompliant" (§ 5979(b)).

VIII. Conclusion

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face homelessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court.

Sincerely,



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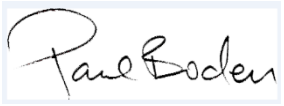

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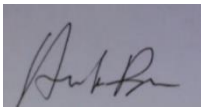

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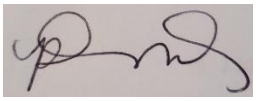

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cc: The Honorable Members, Senate Judiciary Committee
The Honorable Members, Senate Health Committee
Zach Keller, Legislative Director, Office of Senator Umberg
Allison Meredith, Counsel, Senate Judiciary Committee
Reyes Diaz, Principal Consultant, Senate Health Committee

AGENDA ITEM 7

Information

July 28, 2022 Commission Meeting

Full-Service Partnership (FSP) Multi-County Collaborative Innovation Project Update

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear an update from Third Sector (Contractor) related to the Full-Service Partnership Multi-County Collaborative (FSP).

Innovation Incubator Background: In 2018 the Legislature authorized the Commission to establish an innovation incubator and allocated $5 million in one-time funds to work with counties to reduce the potential for criminal justice involvement among people with mental health needs.

The Commission has allocated about half of those funds to support several multi-county collaboratives including the FSP Multi-County Collaborative.

Background: A total of eight Counties are participating in the Full-Service Partnership (FSP) Multi-County Collaborative. The Counties participating include Fresno, Lake, Sacramento, San Bernardino, Siskiyou, Stanislaus, and Ventura. San Mateo County is participating in the FSP Multi-County Collaborative utilizing CSS funding. The total Innovation investment to date for this Multi-County Collaborative is $7,333,642.

Third Sector is working collaboratively with the above Counties by administratively guiding counties through development and implementation of sharing data driven strategies and providing critical technical assistance. This project is aimed at improving service delivery, operations, data collection, and FSP service evaluation.

The value of the project is being examined through a statewide evaluation that will enhance meaningful outcomes and improve client experiences. The data-driven project goals will help with consistent implementation of FSP programs service eligibility, enrichment of client experiences and service delivery; moreover, providing structure to share newly created data-driven opportunities and learning to promote ongoing programmatic improvements. The project will allow shared data-driven criteria to be evaluated, standardized, and implemented to provide consistency of FSP services for all counties in California**.**

Counties Approved:

County	Total INN Approved Funding	Duration of INN Project
Fresno	$950,000	4
Sacramento	$500,000	4.5
San Bernardino	$979,634	4.5
Siskiyou	$700,001	4.5
Ventura	$1,681,861	4.5
Stanislaus	$1,757,146	4.5
Lake	$765,000	4.5
Total:	**$7,333,642**	

* *San Mateo County is participating utilizing CSS funding.*

Enclosures (3): (1) Biography for Third Sector Presenter; (2) California Multi-County Full Service Partnership Innovation Project, Progress Report, March 2021 (Year 1) (3) California Multi-County Full Services Partnership Innovation Project, January 2022 (Year 2)

Handout (1): PowerPoint will be presented at the meeting.

Mental Health Services
Oversight & Accountability Commission

Third Sector/Multi-County Full Service Partnership (FSP) Innovation Update

Presenter: Nicole Kristy:

Nicole Kristy is a Director at Third Sector, a 501(c)3 nonprofit technical assistance organization that advises government agencies on effective ways to reshape policies, systems, and services toward better outcomes for all people. Nicole leads Third Sector's Behavioral Health practice and assists state and local governments in improving mental health services and contracts. She is currently leading the multi-county collaborative of eight California counties seeking to build more data-driven full service partnerships. Prior to joining Third Sector, Nicole worked in healthcare consulting where she helped hospital administrators, physicians, and other key stakeholders to promote collaboration and data sharing, optimize pricing strategies, and support change management processes in an effort to improve health outcomes for entire communities. Nicole holds an M.B.A. from the Kellogg School of Management at Northwestern University and a Bachelor's degree in Finance from Miami University.

THIRD SECTOR

California Multi-County Full Service Partnership Innovation Project

Progress Report

MARCH 2021

Project Overview

Since the passage of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those living with mental illness.

In particular, Full Service Partnership (FSP) programs support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to partnering with individuals on their path to wellness and recovery. Currently, over 60,000 individuals are enrolled in an FSP program across the state.

Full Service Partnerships represent a $1 billion annual investment in public funds and have tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs. FSP programming, however, varies greatly from county to county, with different operational definitions and lack of consistent data processes, which makes it challenging to understand and tell a statewide impact story. The Multi-County FSP Innovation Project aims to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties will leverage the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.

For more information, please contact:

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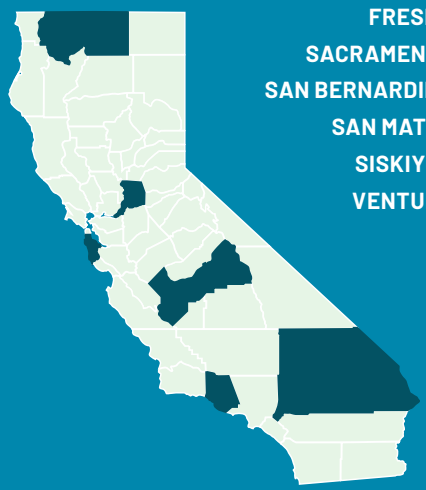


FRESNO
SACRAMENTO
SAN BERNARDINO
SAN MATEO
SISKIYOU
VENTURA

In partnership with Third Sector and the Mental Health Services Oversight and Accountability Commission (MHSOAC), a cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura — are participating in a 4.5 year Multi County FSP Innovation Project that will leverage counties' collective resources and experiences to improve FSP delivery across California. Additional project partners include the California Mental Health Services Authority (CalMHSA) acting as the fiscal agent and RAND Corporation providing consultation on measurement and conducting the project's post implementation evaluation. This project furthers the efforts of LA County's Department of Mental Health FSP transformation, building on their initial groundbreaking data and outcomes efforts to new geographies and localities with a statewide perspective.

Project Purposes & Goals

The Multi-County FSP Innovation Project aims to shift the way counties design, implement, and evaluate FSPs to a more outcomes-oriented approach by:

01

Developing a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.

02

Increasing the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.

03

Improving how counties define, collect, and apply priority outcomes across FSP programs.

04

Developing a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.

05

Developing new and/or strengthening existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

Progress To Date

Gathering Context & Building a Vision

Counties began this effort with a comprehensive Landscape Assessment phase (January - September 2020) to understand FSP programs, assets, and opportunities. Via a combination of meetings, working group sessions, document review, and stakeholder engagement (see below), counties developed a comprehensive understanding of similarities and differences across FSP service design, populations, data collection, and eligibility/graduation practices.

Understanding that county mental and behavioral health agencies often work with limited financial and staffing resources, Third Sector and the counties leveraged the six-county "cohort" to gather and compare information in an efficient manner, sharing resources, templates, and toolkits. Regular cohort-wide meetings provided an opportunity for counties to learn from each other, sharing solutions and ideas that could be relevant for their peer counties.

These six-county cohort meetings were essential to building a collective vision and aligning on priorities for the Implementation Phase. Counties and Third Sector identified almost 30 implementation options that would respond to stakeholder feedback and identified challenges. Over the course of both county-specific and cohort-wide meetings, each county and the collective group narrowed in on a feasible set of implementation activities that would create more data-driven FSP programs and build increased consistency in the way FSPs are designed, operated, and assessed.

> "This process has revealed that every FSP program was its own island, each operating in a unique way. But the lack of an overall framework caused inconsistency. To more effectively provide these services statewide, the provider community needs to learn from each other, in collaboration with the county and state. The ideas are out there."
>
> **— Fresno County FSP Provider**

Piloting Change: The First Steps

In October 2020, counties kicked off a 12-month Implementation Phase to build and operationalize three shared "cohort-wide" FSP improvements as well as locally customized "county-specific" changes. Counties and Third Sector will continue to gather stakeholder feedback to inform these changes from FSP service providers, clients, and clients' primary caregivers throughout the process.

Cohort-wide implementation activities:

Counties are embarking on a trailblazing journey to build shared population definitions, outcomes, process measures, and statewide data recommendations. As a result, the counties will have more comparable and actionable FSP data that can be used to identify and disseminate FSP best practices. Over the course of 12 months, the six-county cohort will focus on:

- **POPULATION DEFINITIONS:** Identifying and standardizing definitions for the following priority FSP populations: homeless; at risk of homelessness; justice-involved; at-risk of justice involvement; high-utilizers of psychiatric emergency facilities; at-risk of using psychiatric emergency facilities.

- **OUTCOMES & PROCESS METRICS:** Identifying 3-5 outcomes, 3-5 process measures, and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are. RAND is assessing how counties currently measure priority outcomes and examining relevant research literature in order to make recommendations for measurement that consider both county capacity and research evidence.

- **STATE REPORTING RECOMMENDATIONS:** Developing recommendations for revising the statewide Data Collection & Reporting (DCR) system. This may include suggested revisions to existing forms, metrics, and/or the format of reports that are shared with counties in order to increase the usefulness of statewide data and reduce reporting burden. This activity will begin in late Spring 2021 after the completion of the first two activities.

- **LEARNING COMMUNITIES:** Given the statewide implications of each of these cohort-wide activities, the six counties participating in the Innovation Project also plan to hold statewide "Learning Communities" in Spring/Summer 2021 to gather additional feedback from other counties across the state. Over time, counties hope to build these forums into a sustainable opportunity to share best practices and continuously improve FSP.

County-specific implementation activities:

Counties have each identified two or three priority activities for local implementation, simultaneously with the cohort activities. While multiple counties are pursuing many of the same county-specific activities, the results will vary somewhat across the state because of each county's unique population, geography, and needs. Counties can more efficiently and effectively tackle each of these improvements by sharing tools, processes, and ideas, benefitting from a cohort approach even as results show nuanced differences. These county-specific implementation activities include:

- **GRADUATION GUIDELINES (5 COUNTIES):** Standardizing graduation criteria that balance Individual Services and Supports Plans (ISSPs) and system-wide outcomes in making individual graduation decisions, including creating improved definitions of "stability" and "recovery."
- **SERVICE REQUIREMENTS (3 COUNTIES):** Developing minimum elements and service requirements of FSP to adopt as official guidance. These elements will depend on local context and priorities and could include the percentage of services that are field-based, telehealth options available, housing services offered, employment services provided, peer supports available, and so on.
- **REAUTHORIZATION PROCESS (3 COUNTIES):** Standardizing an FSP client reauthorization process and/or tools that can be used by counties to more regularly assess whether a client is ready to step down from FSP services.
- **ELIGIBILITY GUIDELINES (2 COUNTIES):** Revising county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.
- **DATA COLLECTION PROCESSES (2 COUNTIES):** Streamlining existing processes and/or developing new data collection reports or methods so that counties and providers can more effectively collect, access, and utilize FSP data to inform care decisions.
- **REFERRAL PROTOCOLS (1 COUNTY):** Developing protocols for FSP referrals between county entities that ensure a warm hand-off and that clients are not being served by multiple providers.
- **REFERRAL FORMS (1 COUNTY):** Creating a standardized FSP referral form to ensure consistent data collection across a county's FSP programs.
- **YOUTH-SPECIFIC REFERRAL & ENROLLMENT PROCESS (1 COUNTY):** Developing a standardized youth FSP referral and enrollment process in which the county is involved in processing and/or approving referrals to contracted FSP providers.

Initial Collaboration Lessons

This Multi-County FSP INN project is forging a new path for statewide, cross-county collaboration, and two valuable lessons have already emerged in this first project year.

Lesson One

Multi-county collaborations must balance appropriate levels of local customization, statewide consistency, and innovation. This FSP Innovation Project has made progress on identifying the most beneficial areas for statewide collaboration, as well as some areas that may be less appropriate for future collaborative efforts. Counties and Third Sector feel that the information-gathering worksheets and templates can be used to gather standardized information to compare FSP programs across the state in the future. Additionally, the full list of implementation activities could be used by future counties seeking inspiration for potential improvements to their FSPs. While all activities could be applied to any geography, the cohort has learned that there are three categories under which these activities fall into:

- Activities around outcomes definitions, metrics, and data collection are appropriate to be worked on collectively to achieve a unified result, such as shared state data reporting requirements (e.g., for the Data Collection Reporting, or DCR, system) to support performance management forums.

- Other activities related to eligibility, graduation, and service design are more appropriate to be developed locally, while following parallel processes that can yield peer learning and resource sharing. This helps counties balance their varying geographies, populations, and histories while increasing efficiency.

- Activities related to referrals, collaboration with local institutions (e.g., jails, hospitals, etc.), and community feedback mechanisms may not be appropriate for collective projects, given the high variation in each counties' local context and existing coordination processes.

Lesson Two

The timing of statewide feedback is crucial. While counties across the state have a valuable perspective to offer on FSP best practices, it can be difficult to identify specific areas for feedback at the early stages of a collective project. It may be more appropriate to gather statewide feedback at later stages of collective projects. After an initial Learning Community session with representatives from 11 other counties in December 2019, counties learned that it was more appropriate to hold off on further involvement until this core group made additional progress and had more specifics for statewide reaction. Counties hope to re-start the Learning Communities in spring/summer 2021 after further implementation progress is made.

88

client interviews with current or recently enrolled clients or their caregivers

80

digital surveys completed by Fresno and San Bernardino provider staff

17

provider focus groups with 108 individuals spanning all FSP programs and age groups across six participating counties, from both directly operated and in-house clinics

Stakeholder Insights

Effective stakeholder engagement leverages their knowledge and experience to provide a deeper understanding of challenges on the ground while translating stakeholder needs into tangible goals and solutions.

For the Multi-County FSP Innovation Project, these key stakeholders include FSP clients, clients' primary caregivers, and service providers. From July through September of 2020, Third Sector and participating counties engaged representatives from each of these groups to better understand FSP programs from their perspectives and used that information to prioritize which program challenges the Innovation Project will address over the next year.

Client feedback played an important role in understanding the goals and needs of those being served and will inform how counties design and execute each implementation activity in the year to come, resulting in more client-centered solutions. Recognizing some inherent selection bias within the interview process, FSP clients generally spoke highly of providers, and overall satisfaction was often based on their individual provider relationships. Individuals struggled with the implications of the COVID-19 pandemic and expressed feelings of loneliness, reduced access to services, and difficulty with telehealth. Clients also commented on staff turnover, workload, or stress level, and these observations sometimes drove feelings of confusion about who to talk to or trust in a new relationship. Despite their different geographies, individuals across the six counties hope to achieve many of the same goals in FSP, including increased independence, self-sufficiency, coping skills, housing, employment, education access, and increased social connections.

> "Recovery to me looks like happiness. I want to wake up happy and trust the world. I want small things – happiness, freedom, and to keep my life. Now I have good reasons to stay alive and active."
>
> **– Siskiyou County FSP Client**

Provider feedback played an important role in determining the implementation activities to pursue collaboratively across six counties and which to pursue individually within each county's local context. Providers in all counties were consistent in their desire to see improved data collection alongside timely data-sharing and reports, including clearer outcomes, reduced reporting requirements, and better data quality. Other key themes included the desire to clarify eligibility and graduation requirements, to further understand the "mission and vision" of FSP, to increase coordination with other county systems, and to receive additional training to improve culturally responsive services.

> "Staff have not been trained in interpreting the data we're collecting. I understand what I'm inputting to the system, but I'm not trained in how the data should be used to influence treatment."
>
> **— Ventura County FSP Provider**

Lessons Learned & Best Practices

- **Engage stakeholders early and often** in order to maximize the amount of time spent hearing from the community and ensure their voices are included in not only the design of the solution, but also the articulation of the challenge. Through early stakeholder engagement, Siskiyou County was able to shift its perspective from addressing basic client needs to learning about aspirational client goals and is now using those goals to identify which elements of their service delivery require robust guidelines, thus shifting direction even before the design process begun. This strategic direction would not have been identified without crucial feedback from clients and providers.

- **Utilize culturally competent engagement methods** to ensure all voices are elevated, including those of people who are harder to reach and/or underrepresented. Cultural competence also supports the retention of these key stakeholders throughout the process. For the first round of stakeholder engagement, interviews were offered in both English and Spanish, but Third Sector and participating counties plan to work with providers to include interviews in more languages and culturally specific engagement methods in the coming year, leveraging language translation services and additional expert feedback on the engagement mechanisms.

- **Offer multiple forums for feedback** to expand access and encourage diverse participation. While in-person forums were limited due to COVID-19, clients were offered individual interviews by phone or video conferencing and providers were offered individual discussions, focus groups, and in some counties, digital surveys. Fresno County received over 70 provider responses to an online survey that included representation from every FSP program and age group served.

- **Compensate clients for their participation** to recognize the value of their time and contributions. All clients were given a $35 Visa gift card for providing their expertise and additional resources for compensation will be identified for any and all future engagement efforts.

A Look Ahead

Third Sector will continue to work with counties to build and implement the cohort and local activities through fall 2021. This will include facilitation of cohort and county-specific workgroups; FSP client and provider engagement by survey, focus group, and interview methods; and Learning Community events to gather feedback from other counties statewide.

By the end of November 2021, the counties and Third Sector hope to have implemented new strategies and approaches to increase the consistency of FSP services; more effectively use data to understand who is being served, what services they are receiving, and what outcomes they are achieving; advocate for changes to the statewide FSP data collection system; and have a sustainable continuous improvement process to continue peer learning. By 2024, the aim is to have a clear understanding of the impact of this collaborative process on county policy and, more importantly, the individuals served by FSP.

In addition, this project hopes to illuminate and address racial disparities in outcomes and elevate voices and communities of color especially as they provide feedback to counties on FSP programming. Overall, the Multi-County FSP Innovation Project hopes that the strategies piloted will be useful on a statewide scale, and the lessons will be shared for future statewide collaborative efforts that can benefit California's most vulnerable individuals suffering from severe mental illness.

Project Partners

COUNTY PARTNERS

Fresno County Department of Behavioral Health: Fresno County is located in the heart of California's Central Valley. Fresno County Department of Behavioral Health serves individuals across 6,000 square miles, encompassing mountain enclaves, rural communities, and urban neighborhoods of California's fifth largest city. In partnership with its diverse community, the Department is dedicated to providing quality and culturally responsive behavioral health services to promote wellness, recovery, and resiliency for individuals and families.

Sacramento County Behavioral Health Services: Sacramento County has a population of more than 1.4 million individuals and is known for its multi-cultural diversity. Situated in the middle of California's Central Valley, Sacramento County extends from the low delta lands between the Sacramento and San Joaquin rivers north to about 10 miles beyond the State Capitol and east to the foothills of the Sierra Nevada Mountains. Sacramento County Behavioral Health Services' mental health system of care includes 260 programs/agencies involving county- and contract-operated mental health services that deliver services to approximately 32,000 children and adults annually. BHS pursues intentional partnerships with the diverse communities in Sacramento County and with the goal of improving the wellness of community members.

San Bernardino County Department of Behavioral Health: San Bernardino County is the largest county in the contiguous United States with just over 20,000 square miles of land that encompasses urban, suburban, rural, and frontier terrain. According to California Department of Finance estimates for 2018, San Bernardino County had a total population of 2,174,931 with a projected growth of 28% between 2020 and 2045. San Bernardino County's Department of Behavioral Health (DBH) aims to promote wellness, recovery, and resilience that includes the values of equity, community-based collaborations, and meaningful inclusion of diverse consumers and family members. As such, San Bernardino County DBH serves more than 150,000 individuals over a broad continuum of services each year.

San Mateo County Behavioral Health and Recovery Services: Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and the San Francisco Bay to the east. Within its 455 square miles, nearly three quarters of the county is open space, and agriculture remains a vital contributor to the economy and culture. Behavioral Health and Recovery Services (BHRS), a Division of San Mateo County Health, provides prevention, treatment, and recovery services to inspire hope, resiliency, and connection with others and enhance the lives of those affected by mental health, and/or substance use challenges. BHRS is dedicated to advancing inclusion, health and social equity for all people in San Mateo County and for all communities.

Siskiyou County Behavioral Health Services: Siskiyou County is a geographically large, rural county with a population of 43,724 persons located in the Shasta Cascade region of Northern California. Approximately 6,350 square miles, Siskiyou County is geographically diverse with lakes, dense forests, and high desert. Siskiyou County Behavioral Health (SCBH) is a small Behavioral Health program and is the sole provider of the Full Service Partnership Program (FSP). SCBH is committed to partnering with the participants of this Innovation Project to better define FSP criteria and improve the data collection points to assist our FSP consumers toward graduation and mental wellness. SCBH strives to deliver culturally, ethnically, and linguistically appropriate services to the community and recognizes the importance of these values in service delivery.

Ventura County Behavioral Health: Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles counties. The county offers 42 miles of beautiful coastline along its southern border, and the Los Padres National Forest makes up its northern area. Ventura County Behavioral Health works to promote hope, resiliency, and recovery for our clients and their families by providing the highest quality prevention, intervention, treatment, and support to persons with mental health and substance abuse issues.

Project Partners

THIRD SECTOR: Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported 20+ communities to redirect over $800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health (LACDMH) to align over $350M in annual MHSA FSP and Prevention and Early Intervention (PEI) funding and services with the achievement of meaningful life outcomes for over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track monthly performance relative to peers and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services. For more information, please visit **thirdsectorcap.org/Multi-County-CA-FSP-INN/.**

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA): The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) of the County and City public mental health departments that provides program management, administrative, and fiscal intergovernmental structure for its members. A central component of CalMHSA's vision is to continually promote systems and services arising from a commitment to community mental health. CalMHSA administers local, regional, multi-jurisdictional, and statewide projects on behalf of the County and City public mental health departments.

CALIFORNIA MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION (MHSOAC): In enacting Proposition 63, the Mental Health Services Act, California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care. The Commission was designed to empower stakeholders, with members representing consumers and their families, service providers, law enforcement, educators, and employers. The Commission put consumers and families at the center of decision-making. The Commission promotes community collaboration, cultural competency, and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

RAND: The RAND Corporation is a nonprofit, nonpartisan research organization headquartered in Santa Monica, California. RAND Health Care is a research division within RAND dedicated to promoting healthier societies by improving health care systems. We provide health care decisionmakers, practitioners, and the public with actionable, rigorous, objective evidence to support their most complex decisions. RAND has an extensive portfolio of mental health research and evaluation. Notably, we have been conducting independent, county-funded evaluations of the MHSA for almost a decade, including an evaluation of LA County DMH's FSP program and extensive work evaluating CalMHSA's statewide PEI programs. For more information, you can access over 80 reports on RAND evaluations of MHSA-funded programs at **rand.org/health-care/projects/calmhsa/publications.**

THIRD SECTOR

California Multi-County Full Service Partnership Innovation Project: Year 2

Summary Report

January 2022

Project Overview

Since the passage of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those living with mental illness.

In particular, Full Service Partnership (FSP) programs support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to partnering with individuals on their path to wellness and recovery. Currently, over 60,000 individuals are enrolled in an FSP program across the state.

Full Service Partnerships represent a $1 billion annual investment of public funds in the well-being of the people of California. This investment has tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration and prolonged suffering by Californians with severe mental health needs. FSP programming, however, varies greatly from county to county, with different operational definitions and inconsistent data processes that make it challenging to understand and tell a statewide impact story.

In partnership with Third Sector and the Mental Health Services Oversight and Accountability Commission (MHSOAC), a cohort of six diverse counties[1]—Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura—are participating in a 4.5-year Multi-County FSP Innovation Project that leverages counties' collective resources and experiences to improve FSP delivery across California. Additional project partners include the California Mental Health Services Authority (CalMHSA) acting as the fiscal agent and RAND Corporation providing consultation on measurement and conducting the project's post-implementation evaluation.

The Multi-County FSP Innovation Project implements a more uniform, data-driven approach, enhancing counties' ability to use data to improve FSP services and outcomes. The project advances the efforts of LA County's Department of Mental Health FSP transformation, scaling their initial groundbreaking data and outcomes efforts to new geographies and localities with a statewide perspective. Counties leveraged the collective power and shared learnings of a cohort to maximize FSP program impact and ultimately drive transformational change in the delivery of mental health services.

For more information, please contact:

- Nicole Kristy, Director, nkristy@thirdsectorcap.org
- Marissa Williams, Manager, mwilliams@thirdsectorcap.org

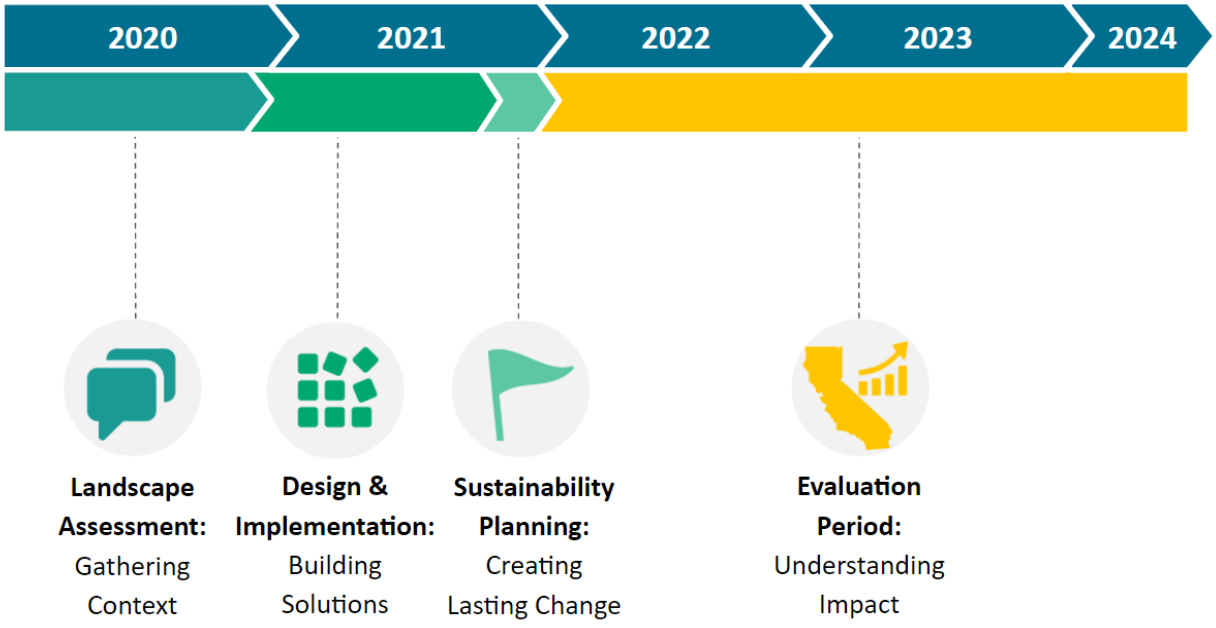
[1] Lake County and Stanislaus County joined this effort in August 2021 and will be implementing changes on a different timeline than the original six counties.

Project Purpose and Goals

The Multi-County FSP Innovation Project aims to shift the way counties design, implement, and evaluate FSPs to a more outcomes-oriented approach by:

1. Developing a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework;
2. Increasing the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders;
3. Improving how counties define, collect, and apply priority outcomes across FSP programs;
4. Developing a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools; and
5. Developing new and/or strengthening existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

Progress To-Date



Landscape Assessment: Gathering Context & Building a Vision

In the beginning of 2020, counties began this effort with a nine-month Landscape Assessment phase to understand FSP program assets and opportunities. Understanding that county mental and behavioral health agencies often work with limited resources, counties created a 'cohort' structure in which the six

counties met regularly to share information, resources, and ideas to promote cross-county learning and plan cross-county activities so counties could more effectively deploy their resources. Through a combination of cohort meetings, conversations with county staff across departments, document review, and stakeholder engagement, counties developed a comprehensive understanding of their similarities and differences across FSP service design, populations, data collection, and eligibility/graduation practices.

The six-county cohort structure was essential to the counties building a collective vision and aligning on project priorities. By the end of the Landscape Assessment phase, the cohort narrowed in on a feasible set of implementation activities that would create data-driven FSP programs and build increased consistency in the way FSPs are designed, operated, and assessed. In addition to work counties underwent together as a cohort, counties also selected activities that were specific to their individual county context.

> **"We need to clarify what FSP stands for and how to implement it in a more detailed fashion. There is a lot of misunderstanding and lack of engagement with what FSP is and how it gets implemented." —Ventura County staff**

Design & Implementation: Building Solutions

In October 2020, counties conducted a 12-month Implementation Phase to build and operationalize three shared **"cross-county"** FSP improvements that counties worked on as a cohort, as well as county-specific "**local county initiatives."**

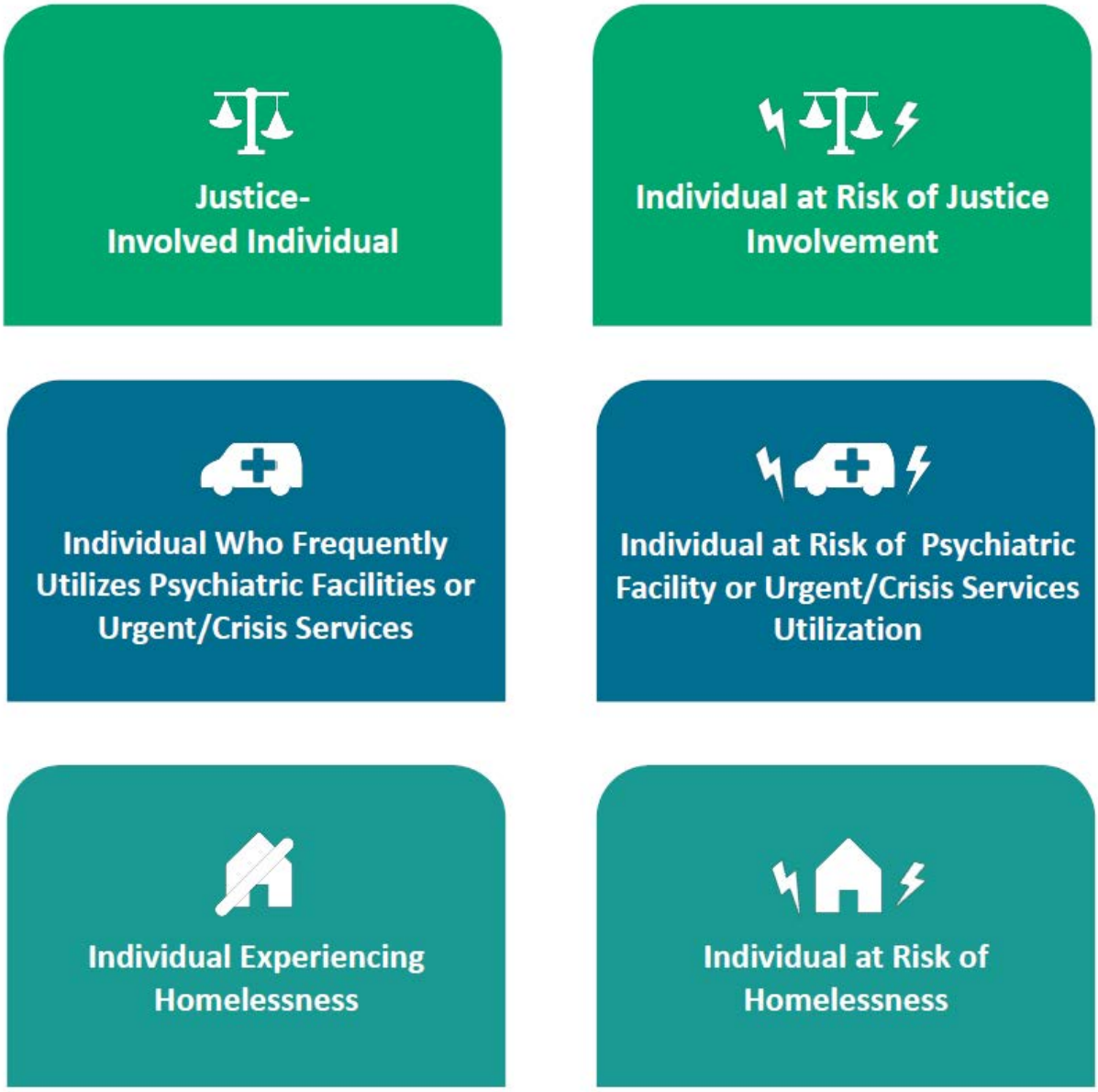
Cross-county activities: Counties embarked on a trailblazing journey to build shared population definitions, outcomes, process measures, and statewide data recommendations, holding more than 30 meetings with more than 25 behavioral health staff. As a result, counties now have more actionable FSP data that they can use to compare and share outcomes across counties and with a broader group of stakeholders, including the service providers and the people that they are serving.

- **Population Definitions:** Counties shared concerns that the lack of standardized definitions for FSP focal populations, both within and between counties, was preventing counties and providers from 1) having a consistent understanding of who is eligible for FSP, and 2) comparing how effectively providers are serving these populations For example, if one county considers a motel stay to be a form of stable housing and another county considers a motel stay to be homeless, it will be difficult to compare outcomes or share best practices for serving individuals experiencing "homelessness").

  To address this challenge, counties drafted definitions for six key FSP populations using as a model Third Sector's work with Los Angeles County to define focal populations for both eligibility criteria and outcomes tracking, best practices from the California Institute for Behavioral Health Solutions (CIBHS), resources currently used by counties, and feedback from additional county staff and the FSP provider community.

THIRD SECTOR

FSP Population Definitions



Outcomes & Process Measures

- **Outcomes & Process Measures:** Because MHSA regulations are somewhat broad in their guidance for what FSPs should be aiming to achieve, participating counties worked together to identify standardized measures for tracking what services individuals receive and how successful those services are. Guided by more than 70 FSP participant interviews and recommendations around evidence-based practices from the project's evaluator, RAND, the counties selected and defined five measures to compare across counties for adult FSP participants.

Increased Stable Housing

Data Source: DCR

A) The number of days that each person experienced (i) stable housing, (ii) temporary housing, and (iii) unstable arrangements during the previous 12-month period

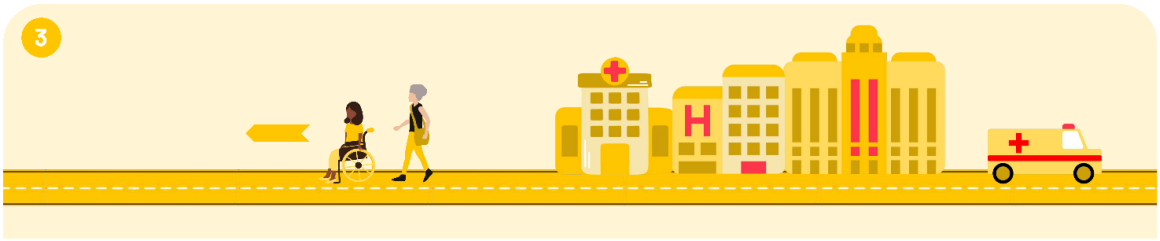
B) The number of times that each person experienced unstable housing/homelessness during the previous 12-month period

Reduced Justice Involvement

Data Source: DCR

A) Whether each person was incarcerated (yes/no) over the previous 12 months

B) The number of arrests that each person experienced during the previous 12 months



Reduced Utilization of Psychiatric Services

Data Source: EHR Systems

Measure #1: Reduced Psychiatric Admissions

A) The number of days hospitalized that each person experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care

B) The number of psychiatric admissions that each person experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care

Measure #2: Reduced Crisis Stabilization Unit (CSU) Admissions

The number of CSU admissions that each person experienced during the previous 12-month period

Increased Social Connectedness

Data Source: DCR

1-item measure: "How often do you get the social and emotional support that you need?" *[Response options include: always, usually, sometimes, rarely, never]*

Frequency & Location of Services

Data Source: EHR Systems

Number and location of the following services received: Individual Therapy, Group Therapy, Rehab Services, Medication Management, Case Management, Housing Services

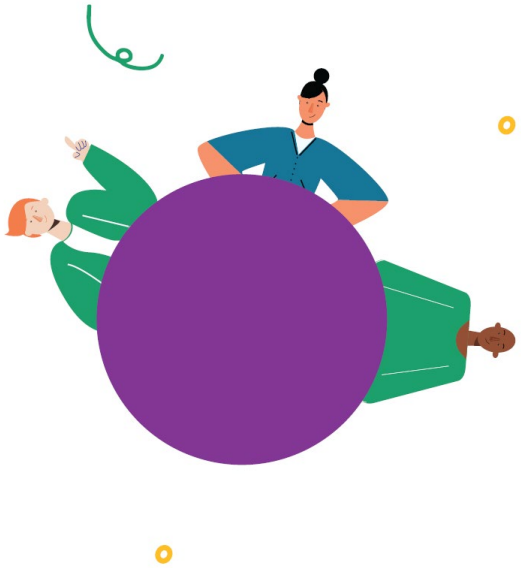
- **State Reporting Recommendations:** County and provider staff both expressed challenges with the current Data Collection and Reporting (DCR) system and articulated a desire for an advocacy initiative to address these challenges and advance efforts for more data-driven programming. To thoroughly understand unique perspectives from across the state, the six-county cohort launched a stakeholder engagement process that involved surveying 17 counties and convening more than 80 FSP providers and program administrators to discuss their experiences and ideas for enhancing the accuracy and functionality of the DCR. The data collected through those forums was compiled into a Data Collection and Reporting (DCR) Recommendations Memorandum that includes actionable system improvement recommendations. Counties then partnered with the County Behavioral Health Directors Association of California (CBHDA), which represents all 58 counties, to open a pathway of collaboration with the Department of Health Care Services (DHCS). Leveraging CBHDA to further the advocacy of this initiative has proven to be an effective strategy and conversations with DHCS are underway.

"We need to improve how we track data to make clinically-relevant, person-first decisions about clients and use clinical data to inform programmatic decisions—a uniform, consistent process to zoom out on length of stay, hospitalizations, and other outcomes."
—Fresno County staff

"All FSP clients have complex needs. We want to validate how hard it is to define success—but a question we're wrestling with is how we can use currently collected data meaningfully to inform our programs, and what information will demonstrate impact.
—Ventura County staff

Statewide Learning Communities and Workshops

- **December 2019**: More than 40 participants from 17 California county agencies and the state Mental Health Oversight Commission (MHSOAC) attended a statewide workshop focusing on building a collective vision for statewide FSP outcomes and discussed the future of FSP Learning Communities.
- **October 2020:** Third Sector, the MHSOAC, behavioral health and provider staff from Fresno and San Bernardino counties, and individuals receiving FSP services co-facilitated a public webinar to share efforts to date to develop shared practices for using data to create more successful FSP services and outcomes across six counties.
- **March 2021:** Third Sector, the MHSOAC, the Departments of Mental/Behavioral Health in San Mateo, Sacramento, and Los Angeles counties, along with individuals from their respective provider and participant communities, hosted a public webinar to share promising approaches to improving cultural responsiveness and reducing outcomes disparities in mental health services.
- **June 2021**: More than 80 participants from 36 California county agencies attended a statewide workshop focusing on 1) identifying the key challenges related to utilizing the DCR system to understand participant progress and develop date-driven service provision and 2) identifying potential solutions to address these challenges.



Local County Initiatives

Counties each identified 2-3 county-specific priority initiative to implemented locally at the same time alongside the cross-county initiatives. While multiple counties pursued the same local initiatives, results varied across the state because of counties' distinct populations, geographies, and needs. Counties were able to efficiently and effectively implement each of these improvements by sharing tools, processes, and ideas, benefiting from a cohort approach even as results show nuanced differences.

Local Initiative	Participating Counties
Graduation Guidelines Standardizing graduation criteria and/or guidelines that balance unique participant needs and system-wide outcomes in making individual graduation decisions, including creating improved definitions of "stability" and "recovery."	Sacramento, San Mateo, Ventura, San Bernardino, Siskiyou
Service Requirements Developing minimum FSP service requirements to adopt as official guidance. These depend on local context and priorities and could include the percentage of field-based services, the availability of telehealth options, housing services, employment services, and peer supports.	San Mateo, Ventura, Siskiyou
Reauthorization Process Standardizing an FSP reauthorization process and/or tools that can be used by counties to more regularly assess whether a participant is ready to stepdown from FSP services.	Fresno, Sacramento
Eligibility Guidelines Revising county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need individuals.	San Mateo, Ventura
Data Collection & Reporting Streamlining existing processes and/or developing new data collection methods and reports so that counties and providers can more effectively collect, access, and utilize FSP data to inform care and programmatic decisions.	Fresno, San Bernardino
Referral Process & Guidelines Creating standardized processes and guidelines around FSP referrals including developing consistent referral forms and protocols across providers, drafting a more centralized referral approval process, and/or ensuring a warm hand-off between referral and enrollment.	Fresno, San Bernardino

Fresno

Fresno's Department of Behavioral Health redesigned its processes for referral and enrollment, reauthorization, and data collection and reporting using input from FSP participants, caregivers, providers and cross-departmental county staff. These process improvements will equip staff to make more **data-informed decisions throughout participants' time in FSP**, from the point of referral until graduation.

Sacramento

Sacramento Behavioral Health Services created new guidelines and tools for FSP stepdown and graduation, including operational improvements that will help staff normalize graduation in conversations with participants and prevent individuals from getting "stuck in services." As a result, FSP staff have a shared understanding of "stepdown readiness," which will also **help graduating participants experience a smoother transition**.

San Bernardino

San Bernardino's Department of Behavioral Health developed new adult FSP referral forms, data reports, and graduation guidelines with input from more than 72 stakeholders. With these changes, individuals can access FSP services more quickly and participate in their own transition planning. FSP staff now have **data tools to understand program-level outcomes** (including population disparities) and inform programmatic decisions.

San Mateo

San Mateo Behavioral Health and Recovery Services designed new eligibility, service, and graduation guidelines across its child FSP system of care, leading to **more consistent and recovery-oriented programs** for young people living with SED or SMI. These program improvements will be reinforced with updated RFPs, provider contracts, and county policies in 2022.

Siskiyou

Siskiyou County Behavioral Health Services developed new guidelines for FSP services and graduation, building on Strengths Model case management to integrate a recovery-oriented approach. With this additional structure and clarity, staff are now equipped to prioritize individuals with the most intense needs and deliver services in a team environment, and participants have a greater role in **defining wellness and recovery** for themselves.

Ventura

Ventura County Behavioral Health developed guidelines for FSP eligibility, services, and graduation, leading adult programs to become more consistent, responsive, and better equipped to provide intensive wraparound care. These changes give staff **greater treatment flexibility and team support**, leading to better participant experiences and outcomes within FSP.

"Slowly ease me into the transition process, rather than abruptly changing services. Not, oh we're done with you. Hope you have a good life."

—Sacramento County FSP participant

"Service delivery guidelines are being written as we go along, adapting to the needs of program staff. Staff have freedom to be creative and we don't want to stifle this, but we've had staff changes, so there's definitely a need to actually write down service guidelines."

-Ventura County staff

Sustainability Planning: Creating Lasting Change

In October 2021, the six-county cohort began preparing for RAND's evaluation and ongoing cross-county data sharing and continuous improvement (CI) processes. During this time, a second wave of counties—Lake and Stanislaus—joined the Multi-County FSP Innovation Project and began attending meetings to offer additional insights into the cross-county activities and data processes they will eventually be implementing as part of the cohort.

This phase of the project has included efforts to customize the Enhanced Partner-Level Data (EPLD) templates that counties can use to standardize how they share and analyze state-reported DCR data. Counties will continue meeting monthly to discuss the progression and interim results of the evaluation and to further build out shared data reporting capabilities. Ultimately, these monthly meetings will transition into a recurring forum where participating counties can share outcomes data with one another, identify best practices, and strategize new operational improvements to pilot.

Evaluation Period: Measuring Progress

The six counties and RAND Corporation will continue working together on the project's two-and-a-half-year evaluation phase. RAND will conduct both quantitative and qualitative analyses to assess participant outcomes and plans to release final evaluation results in 2024. *Please see "A Look Ahead" on pp. 14 for more details.*

Stakeholder Insights

Effective stakeholder engagement leverages their knowledge and experience to provide a deeper understanding of challenges on the ground, while identifying goals and solutions that solve for the needs articulated by stakeholders. For the Multi-County FSP Innovation Project, these key stakeholders included FSP participants, participants' primary caregivers, and service providers. Third Sector and participating counties engaged representatives from each of these groups to better understand FSP programs from their perspectives. The project launched two iterative stakeholder engagement initiatives: one to learn about participants' experiences in FSP and prioritize challenges to address, and another to inform the design and implementation of solutions at the county and cohort level.

Stakeholder Engagement by County and Statewide

- **Fresno** - 32 participant interviews | 70 provider survey responses | 10 provider focus groups with 29 staff
- **Sacramento** - 32 participant interviews | 7 provider focus groups with 40 staff
- **San Bernardino** - 24 participant interviews | 10 provider survey responses | 4 provider focus groups with 23 staff | 2 peer and family advocate focus groups with 5 staff
- **San Mateo** - 27 participant interviews | 4 provider focus groups with 20 staff
- **Siskiyou** - 23 participant interviews | 2 provider surveys | 4 provider focus groups 30+ staff
- **Ventura** - 41 participant interviews | 8 provider focus groups with 48 staff
- **Cohort** - 57 survey responses from 17 California counties

Participant feedback played an important role throughout the project by helping counties and Third Sector understand the goals and needs of those being served. Participants were asked about their experience enrolling in or stepping down from FSP to a less-intensive level of service, services that were important for them, and goals they hoped to achieve. These participant insights became the basis for prioritizing cross-county outcomes and process measures.

"I want to be a 'normal person.' I don't want to be labeled a mental health patient."
—San Bernardino FSP participant

"Social isolation is a problem for me in a small town with nowhere to go. This has made getting kind of meaningful social interaction really difficult to acquire."
—Siskiyou County FSP participant

"Success would be for me, at least a semester of school, getting my own apartment. And feeling like less of a mental health case, and more of a, I guess, normal person."
—Fresno County FSP participant

One key "win" from this process was the decision to put more focus on measuring increased social connectedness, an outcome that has been historically difficult to track but was consistently named by participants as critical to their recovery journey. Insights from FSP participants also served as the basis for building participant-centered step down processes and criteria in five counties.

Provider feedback also played an important role in not only determining which implementation activities to pursue, but also in determining which outcomes and process measures to prioritize, how adult FSP focal populations should be defined, and what changes would need to be made to state reporting to ensure that counties and providers could better implement data-driven programming and team operations. At the cohort level, provider feedback was largely collected through digital surveys; even so, providers in several counties participated in recurring workgroups to build county-specific solutions, including new referral processes, step down guidelines, and service guidelines. By co-designing these

innovations with behavioral health and provider staff, counties now have "buy-in" across their stakeholders to effectively operationalize new policies and processes.

Stakeholder Engagement Lessons Learned and Best Practices

1. **Ground decisions about policies and operational practices in FSP participant experience**, including data reporting and outcomes measurement.
2. **Engage stakeholders early and often** in order to maximize the amount of time spent hearing from the community and ensure their voices are included in not only the design of the solution, but also the articulation of the challenge.
3. **Compensate FSP participants for their engagement** to recognize the value of their time and contributions.
4. **Leverage both county advocates and third-party facilitators** as necessary to surface deeper insights and bridge potential trust gaps.
5. **Use trauma-informed and healing-centered techniques** to reduce harm and avoid re-traumatization, especially when discussing sensitive topics.
6. **Train staff in cultural competency,** equipping them with language and tools to facilitate discussions about identity and culturally specific needs with participants.

Cross-County Collaboration Lessons Learned

Cross-county projects involve significantly more stakeholders, adding complexity to coordination and decision-making processes. With thoughtful planning, flexibility, and human connection, these challenges can be successfully navigated and lead to powerful collaborations with far-reaching impacts.

1. **Consider which activities are appropriate for statewide standardization vs. local customization.** In other words, some areas are ripe for statewide collaboration: outcome definitions, metrics, and data collection are appropriate to pursue collectively to achieve a unified result, such as shared state data reporting requirements. Other activities should be customized to a local context. For example, counties can pursue parallel processes for eligibility, step down, and service design while still sharing resources and learnings across counties. This creates efficiencies while honoring counties' distinct geographies, populations, and histories.
2. **Maintain a flexible approach tailored to individual county needs while pursuing a shared vision.** State collaborations inevitably draw counties of varying sizes, structures, resources, and internal cultures. Recognizing these differences upfront can provide context and help mitigate challenges, allowing each county to pursue a shared vision while following a unique path.
    - ***Work-planning and meeting cadence:*** Counties range in their staff capacity and dedicated project resources, making a uniform workplan and meeting cadence infeasible. Mitigation strategies can include:

- Shifting scheduled meetings to independent work, allowing counties to work at their own pace;
- Sequencing activities so that staff are not managing multiple initiatives simultaneously (e.g. local county and cohort work);
- Adjusting the volume of activities based on counties' capacity. This requires participants to understand the anticipated workload and make clear commitments at the time they select activities to implement.

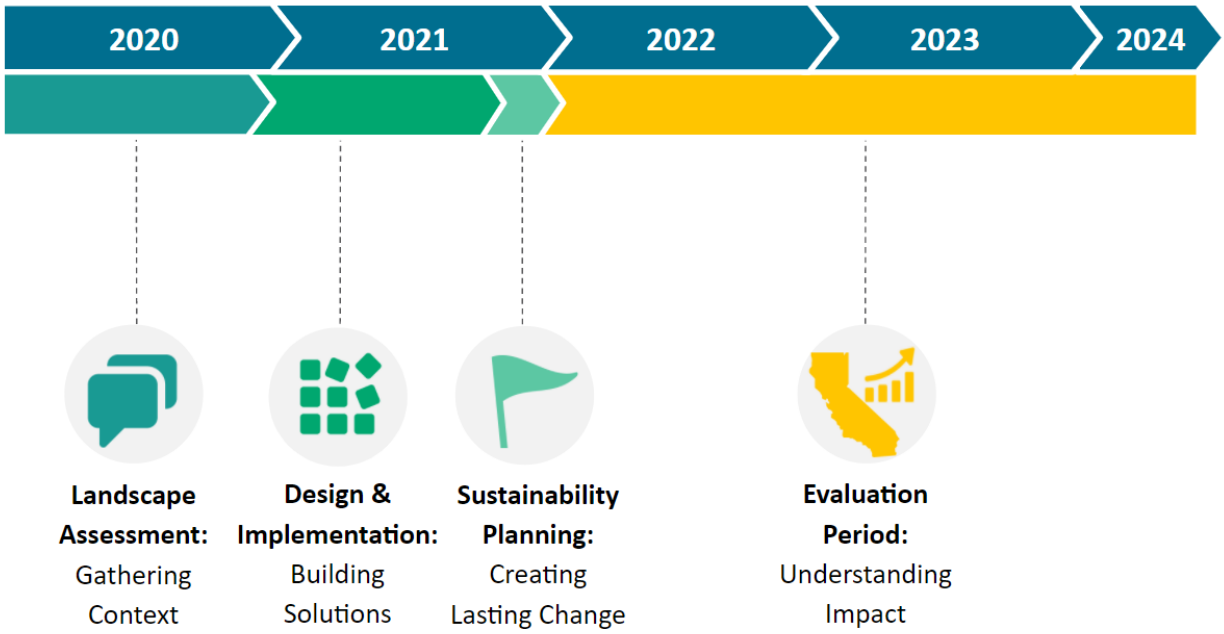
- ***Communication:*** When running multi-year projects with large numbers of stakeholders and many phases of work, one can expect a healthy amount of staff turnover and reorganization. Recognizing that this can create information gaps and challenges with the level of project buy-in from new staff, it is important to establish robust communication practices. Mitigation strategies can include:
  - Setting upfront expectations for an iterative process that will be regularly revisited based on external feedback from providers, individuals served, and other key stakeholders;
  - Clearly documenting group decisions and the rationale behind these decisions;
  - Continuously referring back to shared project goals to keep everyone aligned on the shared vision; and
  - Streamlining communications and centralizing action items in one place.

- ***Implementing new processes***: Counties with well-developed data infrastructure may face more challenges with innovating and operationalizing changes, compared to those with less infrastructure. For example, some counties were able to adopt new data fields with relative ease, while counties with established practices hesitated to change or replace their existing practices. Internal county administrative processes and decision-making culture also play a role when advocating for change. Mitigation strategies can include:
  - Facilitating conversations about the tradeoffs of standardizing data practices, which may involve changing and creating potential redundancies with counties' existing data infrastructure;
  - Ensuring county staff and department leaders can commit to implementing solutions; and
  - Clearly identifying areas where all counties are open to innovating their processes to align with each other.

3. **Value informal learning as highly as formal meetings and project structures.** While cross-county meetings were a structured forum for designing and delivering on specific cross-county activities, these touch points also served as a valuable opportunity for the six counties to informally learn from one another and share best practices. In addition to the regularly scheduled agenda topics, counties also used this time to exchange insights around streamlining data reporting practices, effectively leveraging flexible funding, and developing annual reports. Counties recognized the inherent value in these informal, peer-to-peer interactions, and plan to utilize the relationships formed during the project to continue meeting regularly and reaching out to one another for ad-hoc support.

Overall, there is tremendous value in a cross-county cohort model when counties are able to identify appropriate areas of standardization across initiatives and approaches and share knowledge continuously throughout the project and beyond. As the Multi-County FSP Innovation Project expands, new counties that join can expect to benefit from the expansive lessons learned from the original six-county cohort. New counties will also be able to adopt the standardized innovations developed by the original cohort; and while joining the project on a later timeline may limit the ability to modify some of the previously developed solutions, it can also provide greater flexibility in timeline and structure to pursue more locally customized initiatives.

A Look Ahead

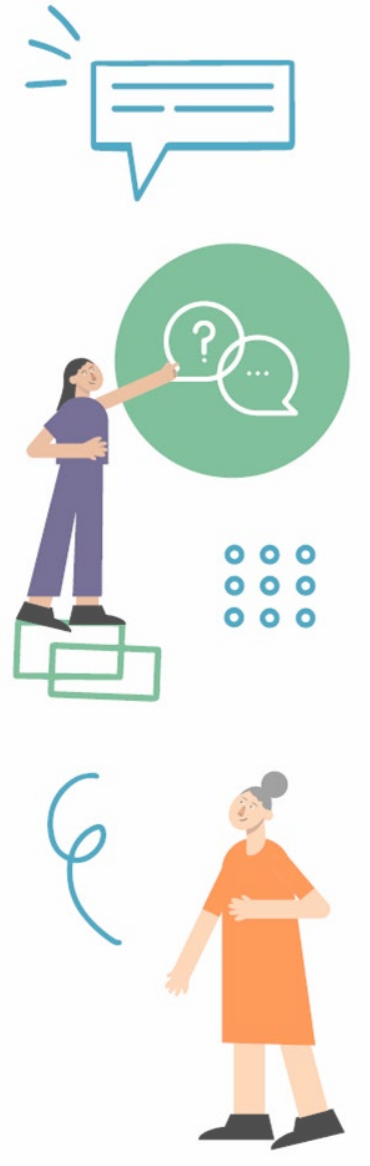


The original six counties and the evaluator, RAND, will continue working together through mid-2024 on the project's 2.5-year evaluation phase. The first pull of baseline data will take place in January of 2022 and data collection will continue every six months thereafter. RAND will also be conducting qualitative interviews to understand if and how participants perceive the changes that counties have made to their FSP operations as a result of this project's effort. Throughout 2022, counties will be meeting monthly to discuss the evaluation, troubleshoot data sharing and data cleaning challenges, develop consistent reporting practices across counties, share data on standardized metrics, and examine data trends that could lead to future operational improvements.

In addition to the ongoing evaluation and continuous improvement activities for the original six counties, the work of the Multi-County FSP Innovation Project will continue through a second wave of counties, Lake and Stanislaus, that joined the project in the fall of 2021. Lake and Stanislaus participated in the final

stages of the cross-county work undertaken by the six-county cohort and will adopt the outcomes, process measures, and population definitions as defined by the project. In 2022, these two counties will build on this work and identify several county-specific activities to pursue over the next year with Third Sector's technical assistance. RAND's evaluation period for these two additional counties will begin in mid-2023.

Third Sector and the eight participating counties believe the strategies piloted on the Multi-County FSP Innovation Project have the potential to increase the **consistency**, **quality**, and **effectiveness** of care across the state. Learnings from the project and its evaluation will be shared broadly with the intent to advocate for wider adoption and shape statewide policy and programming. The Multi-County FSP Innovation Project highlights the potential of cross-county collaboration to ignite a statewide movement dedicated to improving mental health services for individuals with the greatest needs.



Project Partners

County Partners

Fresno County Department of Behavioral Health

Fresno County is located in the heart of California's Central Valley. Fresno County Department of Behavioral Health serves individuals across 6,000 square miles, encompassing mountain enclaves, urban neighborhoods of California's fifth largest city, and rural communities. In partnership with its diverse community, the Department is dedicated to providing quality and culturally responsive behavioral health services to promote wellness, recovery, and resiliency for individuals and families.

Sacramento County Behavioral Health Services

Sacramento County has a population of more than 1.4 million individuals and is known for its multi-cultural diversity. Situated in the middle of California's Central Valley, Sacramento County extends from the low delta lands between the Sacramento and San Joaquin rivers north to about ten miles beyond the State Capitol and east to the foothills of the Sierra Nevada Mountains. Sacramento County Behavioral Health Services' mental health system of care includes 260 programs/agencies involving county and contract operated mental health services that deliver services to approximately 32,000 children and adults annually. BHS pursues intentional partnerships with the diverse communities in Sacramento County and with the goal of improving the wellness of community members.

San Bernardino County Department of Behavioral Health

San Bernardino County is the largest county in the contiguous United States with just over 20,000 square miles of land that encompasses urban, suburban, rural and frontier terrain. According to California Department of Finance estimates for 2018, San Bernardino County had a total population of 2,174,931 with a projected growth of 28% between 2020 and 2045. San Bernardino County's Department of Behavioral Health (DBH) aims to promote wellness, recovery, and resilience that includes the values of equity, community-based collaborations, and meaningful inclusion of diverse FSP participants and family members. As such, San Bernardino County DBH serves over 150,000 individuals over a broad continuum of services each year.

San Mateo County Behavioral Health and Recovery Services

Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and the San Francisco Bay to the east. Within its

455 square miles, nearly three quarters of the county is open space and agriculture remains a vital contributor to our economy and culture. Behavioral Health and Recovery Services (BHRS), a Division of San Mateo County Health, provides prevention, treatment and recovery services to inspire hope, resiliency and connection with others and enhance the lives of those affected by mental health and/or substance use challenges. BHRS is dedicated to advancing inclusion, health and social equity for all people in San Mateo County and for all communities.

Siskiyou County Behavioral Health Services

Siskiyou County is a geographically large, rural county with a population of 43,724 persons, located in the Shasta Cascade region of Northern California. Approximately 6,350 square miles, Siskiyou County, is geographically diverse with lakes, dense forests, and high desert. Siskiyou County Behavioral Health (SCBH) is a small Behavioral Health program and is the sole provider of the Full Service Partnership Program (FSP). SCBH is committed to partnering with the participants of this Innovation Project to better define FSP criteria and improve the data collection points to assist our FSP participants toward graduation and mental wellness. SCBH strives to deliver culturally, ethnically, and linguistically appropriate services to the community and recognizes the importance of these values in service delivery.

Ventura County Behavioral Health

Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles counties. The county offers 42 miles of beautiful coastline along its southern border, and the Los Padres National Forest makes up its northern area. Ventura County Behavioral Health works to promote hope, resiliency and recovery for FSP participants and their families by providing the highest quality prevention, intervention, treatment, and support to persons with mental health and substance abuse issues.

Technical Assistance and State Partners

Third Sector

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported 20+ communities to redirect over $800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health (LACDMH) to align over $350M in annual MHSA FSP and Prevention and Early Intervention (PEI) funding and services with the achievement of meaningful life outcomes for over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track monthly performance relative to peers and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

California Mental Health Services Oversight & Accountability Commission (MHSOAC)

In enacting Proposition 63, the Mental Health Services Act, California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care. The Commission was designed to empower stakeholders, with members representing FSP participants and their families, service providers, law enforcement, educators, and employers. The Commission puts FSP participants and families at the center of decision-making. The Commission promotes community collaboration, cultural competency and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

RAND Corporation

The RAND Corporation is a nonprofit, nonpartisan research organization headquartered in Santa Monica, California. RAND Health Care is a research division within RAND dedicated to promoting healthier societies by improving health care systems. We provide health care decision makers, practitioners, and the public with actionable, rigorous, objective evidence to support their most complex decisions. RAND has an extensive portfolio of mental health research and evaluation. Notably, we have been conducting independent, county-funded evaluations of the MHSA for almost a decade, including an evaluation of LA County DMH's FSP program and extensive work evaluating CalMHSA's statewide PEI programs. For more information, you can access over 80 reports on RAND evaluations of MHSA-funded programs at https://www.rand.org/health-care/projects/calmhsa/publications.html.

California Mental Health Services Authority (CalMHSA)

The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) of the County and City public mental health departments that provides program management, administrative, and fiscal intergovernmental structure for its Members. A central component of CalMHSA's vision is to continually promote systems and services arising from a commitment to community mental health. CalMHSA administers local, regional, multi-jurisdictional, and statewide projects on behalf of the County and City public mental health departments.

AGENDA ITEM 8

Action

July 28, 2022 Commission Meeting

Commission 2022-2023 Spending Plan

Summary: Each year, the Commission is presented with a mid-year report on the budget in January, which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provides a budget presentation in May, that coincides with the Governor's May revisions, and again in July at the beginning of the new fiscal year. The goal of these presentations is to support fiscal transparency and ensure Commission expenditures are in line with Commission priorities.

Background:

The Commission's budget is organized into Personnel and Core Operations funding, for staff, rent, and related Commission expenses, Budget Directed that is primarily one-time funds to support local assistance programs, and Local Assistance Funding, which includes the majority of its funding that is provided to counties and other local partners.

- **Personnel.** Funding is ongoing for permanent positions.
- **Core Operations.** Funding is ongoing with some exceptions, for one-time funding to support the Commission directed initiatives.
- **Budget Directed.** Funding provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant programs with one-time and ongoing funding that is allocated over multiple fiscal years.
- **Local Assistance.** Funding is ongoing and/or one-time funds provided in grants to counties or organizations over multiple fiscal years.

Budget by Fiscal Year and Specific Category

	Fiscal Year 2019-20	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23
Operations				
Personnel	$4,044,000	$5,528,000	$6,720,000	$8,100,000
Core Operations	$7,019,000	$5,256,000	$3,890,000	$3,168,000
Total Operations	**$11,063,000**	**$10,784,000**	**$10,610,000**	**$11,268,000**
Budget Directed				
Anti-Bullying Campaign*			$5,000,000	
COVID-19 Response*		$4,020,000		
Evaluation of FSP Outcomes				$400,000
Fellowship/Transformational Change*				$5,000,000
Innovation Incubator* ($5 m 2018/2019)	$2,500,000			
Mental Health Student Services Act Administration Augmentation*			$15,000,000	
Mental Health Student Services Act Admin./Evaluation*			$10,000,000	$16,646,000
Total Budget Directed	**$2,500,000**	**$4,020,000**	**$30,000,000**	**$22,046,000**
Local Assistance				
Community Advocacy Partnership	$5,418,000	$1,398,000	$5,418,000	$6,700,000
allcove (Youth Drop-In Centers) *	$14,589,000			
Children and Youth Behavioral Health Initiative*				$42,900,000
Early Psychosis Intervention*	$19,452,000			
Mental Health Student Services Act**	$48,830,000	$8,830,000	$188,830,000	$8,830,000
Mental Health Wellness Act/Triage	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Suicide Prevention Voluntary Tax ***			$239,000	
Total Local Assistance Funds	**$108,289,000**	**$30,228,000**	**$214,487,000**	**$78,430,000**
Total	**$121,852,000**	**$45,032,000**	**$255,097,000**	**$111,744,000**

*one-time funds

**one-time funds+ ongoing funds

*** transferred to the Department of Health Care Services

Personnel

As of Fiscal Year 2022-23, the Commission's budget has nearly doubled since 2019. The Commission received approval of $1.4 million from the Legislature and the Governor for its budget proposals this year for additional resources to support the Commission's current initiatives.

Core Operations

The Commission's Core Operations shows a decrease this year and funding from this category are shifted to Local Assistance for the Commission's Community Advocacy program. These funds were showing as part of the Commission's Core Operations and should have been listed as local assistance because the funding is allocated to organizations that provide advocacy, community engagement and training and technical assistance to specific populations.

Budget Directed

The Governor's Budget includes specific language that provides direction to departments on how funding can be spent. Funding is provided to engage diverse communities – including consumers and families from different cultural and social backgrounds, service providers, local governments, employers and other involved in the public and privately funded behavioral health systems – drive changes needed to increase access to high quality services and improve outcomes.

Over the last four years, the Commission received funding for specific one-time projects displayed in the chart above, this year the Commission received a total of approximately $22 million to support the Commission's budget requests and legislative proposals. The proposals include funding to support the following projects:

- **Full Service Partnerships.** $400,000 ongoing funds to report the outcomes for those receiving community mental health services under a full service partnerships, to strengthen full service partnerships to reduce incarceration, hospitalization, and homelessness, as required by Chapter 544, Statutes of 2021, Senate Bill 465.

- **Behavioral Health Fellowship.** $5 million one-time funds to establish a behavioral health fellowship designed to drive transformational change and reduce racial, ethnic, and cultural disparities in mental health outcomes. The funds will be used to launch a partnership between the Commission and an academic institution.

- **Mental Health Student Services Act.**

    - $16,646,000 one-time funds in 2022-23, available over five years, to support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program.

- $25 million one-time funds in 2021-22, available over five years, to support the successful implementation and evaluation of the Mental Health Student Services Act Partnership Grant Program. The Commission received position authority for 5 permanent positions for the next five years. These positions will support grants to 57 county mental health plans, regional collaboration meetings of grantees, information sharing, state reporting, evaluation of program effectiveness, and contract monitoring. Approximately $6.6 million is available for employee costs and $18.5 million for consulting and technical assistance contracts to support the program.

The Commission will be presented with a spending plan for these projects at a future Commission meeting.

Prior Year Funds

Funding in prior years was provided to support the following projects:

Anti-Bullying Campaign

Summary: The Budget Act of 2021 allocated funds for the Commission to launch a youth-focused anti-bullying initiative that leveraged social media to support youth. The project is part of a broader initiative targeting Anti-Asian hate. The Commission formed an advisory committee as directed in the budget to support this project.

Strategic Plan Objective 3c: Support youth-led efforts to advance and expand practices for consumer-led and consumer-centric services and expand access to youth-focused services.

Authorization: Budget Act of 2021 allocated $5 million one-time Mental Health Services Act funds for a social media campaign and $300,000 to provide support to the Commission for the implementation of this project, which has four significant themes: Anti-bullying, youth driven, focused on race/ethnic/language-focused communities and social media driven support for the mental health care. The budget also directed the Commission to finalize contracts no later than October 31, 2021.

Activities: The Commission entered into contract with an agency called Media Cause. Currently, Media Cause is nearing the completion of the discovery phase of their work, having done research, surveys, and interviews with youth and adult allies. The next steps will be to develop a comprehensive social media strategy leading into development and production.

COVID-19 Response

Summary: In response to the COVID-19 pandemic, the Commission re-prioritized $2,020,000 in available funding to support community response to growing mental health needs. In consultation with community stakeholders and county behavioral health leaders, the Commission focused its investment on addressing disparities and fortifying youth suicide prevention efforts in addition to offering more general support.

Strategic Plan Objective 1a: Promote school mental health as a prime opportunity to reach and serve at-risk children, families and neighborhoods.

Strategic Plan Objective 3b: Support implementation for Stiving for Zero, the State's suicide prevention plan for 2020-25

Authorization: The Budget Act of 2020, shifted existing funding available in the Commission's budget to provide support to address the mental health needs, exacerbated by the pandemic.

Background: The Commission has invested $880,000 to strengthen school mental health strategies targeting social emotional learning and suicide prevention. The Commission entered into contracts with five non-profit providers to enhance the support they provide for schools. Due to the urgent mental health needs in the communities, these contracts were provided to subject matter experts, through a sole source process.

The remaining funds were allocated through a sole source process, to support improved opportunities for county behavioral health programs to address disparities, the Commission has invested $1,140,000 in a project to support the replication of a successful Solano County innovation that targeted disparities reduction. Funding is available provide technical assistance to counties to better understanding the work of the California Reducing Disparities Project and to replicate that work.

Activities: The Commission has finalized contracts to strengthen school and mental health strategies, and that work is underway. The Commission is in the process of finalizing contracts with the University of California Davis and Solano County, and funding will be available in the next few months to provide support to the more than 40 counties that have expressed interest in participating in this project, which includes a learning collaborative focused on reducing disparities.

COVID 19/Suicide Prevention

Summary: The Commission is implementing *Striving for Zero*, the State's suicide prevention strategic plan.

Strategic Plan Objective 3b: Work with the Governor, the Legislature and community leaders to establish an Office of Suicide Prevention, expand training resources, better integrate suicide prevention services into health care settings, and encourage the renewal of community prevention plans.

Authorization: The Legislature directed the Commission to develop the strategic plan to develop a suicide prevention strategic plan. The Budget Act of 2020-21 shifted funds in the Commission's existing budget allocation and provided $2 million to implement urgent aspects of the plan in light of the ongoing COVID-19 global pandemic.

Background: In September 2020, the Commission authorized staff to execute multiple contracts to implement key action items from *Striving for Zero*, including contracts to accelerate school

adoption of standardized suicide risk assessment tools, training tools for risk assessments, and to support counties in developing and implementing new suicide prevention plans. Those contracts have been executed.

Activities: The Budget Act of 2021 established the Office of Suicide Prevention within the Department of Public Health to implement the *Striving for Zero* recommendations. The Commission's own implementation activities have included publication of a data dashboard to improve public awareness about deaths by suicide; linkage of public health vital statistics data with mental health client data to support further tracking and analysis of suicide deaths; and execution of technical assistance contracts.

Innovation Incubator

Summary: The Commission's Innovation Incubator deeply engaged more than 25 counties to build capacity for innovation and continuous improvement. An evaluation is underway, and the Innovation Subcommittee is reviewing recommendations for improving the Commission's Innovation Program.

Strategic Plan Objective 3a: Complete and oversee the projects of the Innovation Incubator and document the value of efforts to form and support collaborations to address specific issues.

Authorization: The Budget Act of 2017-18 provided $5 million in one-time MHSA funds to work with counties to find ways to proactively find ways to reduce the number of individuals with mental health needs in the criminal justice system.

Background: The Commission worked with community partners to develop a business model for the Innovation Incubator and then launched a series of projects to build the capacity for innovation and continuous improvement. More than 25 counties were involved in one or more learning collaborative, and nearly all counties participated in webinars and workshops to hear the results and how they could deploy the new practices. The Incubator also conducted an in-depth study on the innovation process, which produced an Innovation Action Plan.

Activities: The Innovation Subcommittee, approved recommendations in the Innovation Action Plan, and staff is developing an implementation plan that is expected to prioritize activities that will improve the quality of innovation plans developed by counties, refine the system for the Commission to review and approve those plans, and to expand efforts to disseminate learnings across counties to accelerate the pace of innovation. The Commission staff will present the recommendations and implementation plan to the Commission in November 2022.

Long term issues: Among other outcomes, the Incubator strengthened the relationship with many counties and developed a shared understanding of the potential for technical assistance and multi-county learning collaboratives to support continuous improvement. The evaluation is exploring this and other results. Based on the evaluation, the Commission could consider seeking or dedicating more resources to this strategic approach to driving transformational change.

Local Assistance Programs

The Commission manages grant programs that resource essential and innovative services in ways that incentivize stronger partnerships, integrated services, braided funding, and the evaluation required for continuous improvement. The Mental Health Wellness Act (Triage), youth drop-in centers, the early psychosis intervention (EPI), and the Mental Health Student Services Act are examples of such grants. The Commission submitted and the Legislature and Governor approved funding and modifications to the following programs:

- **Immigrant and Refugees Advocacy.** $670,000 to augment advocacy efforts to support the mental health needs of immigrants and refugees in California.

- **Children and Youth Advocacy.** $670,000 to support outreach, engagement, and advocacy for children and youth with a focus on school mental health.

- **Mental Health Wellness Act/Triage.** Modifications to the Investment in Mental Health Services Act of 2013 language to better address the goals in the Act to improve crisis response, reduce hospitalizations and criminal justice involvement of mental health peers, and leverage public and non-public sources of funding to improve access to care and wellbeing.

The Commission will be presented with a spending plan for these programs at a future Commission meeting.

- **Peers in California State Government.** In Addition to the above items, the Commission requested funding to establish a leadership role for mental health peers in California state government. The Administration modified the Commission's request and shifted the responsibility to the California Department of Human Resources. The CalHR, in consultation with the Commission and other state agencies, will evaluate the feasibility, efficacy, and alignment with existing state personnel classification policies and goals of incorporating the role of behavioral health peers into the state civil service. The CalHR will report the finding of the evaluation to the Legislature by June 30, 2024.

Prior Year Funds

allcove (Youth Drop-In Centers)

Summary: In 2019, the Commission allocated $10 million to one county, two Health Care Districts, a California University, and one non-profit Community-Based Organization to support the establishment or expansion of integrated mental health youth drop-in centers which provide mental health and wellness services for individuals between 12-25 years of age and their families. The Commission also allocated $4,589,000 to Stanford to provide technical assistance to participating programs and to support collaborative learning among grantees, training, data and evaluation support and community outreach.

Strategic Plan Objective 3c: Support Youth-led efforts to advance and expand practices for consumer-led and consumer-centric services and expand access to youth-focused services.

Authorization: The program was established by Senate Bill 109, Chapter 363, the Budget Act of 2019, provided $15 million one-time Mental Health Services Act funds. The funds had to be allocated by the Commission through a competitive grant to counties, or other entities, if designated by the county, city, or multi-county behavioral health department. The Budget Act called for a focus on vulnerable and marginalized youth and populations of youth with known disparities e.g., LGBTQ, homeless, and indigenous youth.

Background: Counties are working in collaboration with Stanford to implement the allcove programs. The goal of integrated youth mental health centers is to increase access to vital services for youth at locations that are designed with youth and for youth and consider the needs of vulnerable and marginalized people. These programs will be equipped to meet the needs of youth, including mental and behavioral health needs, physical health needs, housing, education and employment support, and linkage to other services.

Activities: The Governor has proposed expanding state support for evidence-based youth drop-in centers through the Child and Youth Behavioral Health Initiative. The Budget Act of 2022 allocates $42.9 million for the Commission to expand programs for children and youth. The Commission Staff are working with the Health and Human Services Agency on a spending plan for these funds.

Children's Behavioral Health Initiative

Summary: The Governor's 2021 budget included $4.4 billion to support an array of projects to improve behavioral health outcomes for children. Those initiatives include $429 million to identify and replicate evidence-based practices, with a focus on early psychosis, youth drop-in centers, prevention and early intervention, reducing disparities, and meeting the needs of youth with complicated, high-end needs.

Strategic Plan Objective 3a: Support the Early Psychosis pilot to advance the transfer of knowledge and capacity building for more effective detection and response to early experiences with mental health.

Strategic Plan Objective 3c: Support youth-led efforts to advance and expand practices for consumer-led and consumer-centric services and expand access to youth-focused services.

Authorization: The Budget Act of 2022 allocated $42.9 million to the Commission to support the identification and adoption of evidence-based practices.

Activities: The Commission Staff are working with the Health and Human Services Agency to finalize an interagency agreement for these funds.

Early Psychosis Intervention

Summary: In August 2020, the Commission allocated $9,996,034 to five counties for grant programs and $3.9 million to the University of California at Davis for a training and technical assistance contract to support the grantees, as part of a competitive bid processes for its first round of Early Psychosis Intervention grants. Funding for the Early Psychosis Intervention Program supports community-level early psychosis and mood disorder detection and intervention programs for adolescents and youth adults and expands existing programs and brings them into fidelity with the Coordinated Specialty Care model.

Strategic Plan Objective 3a: Support the Early Psychosis pilot to advance the transfer of knowledge and capacity building for more effective detection and response to early experiences with mental health issues.

Authorization: Assembly Bill 1315, Chapter 414, Statutes of 2017 established the Early Psychosis Intervention Plus Program (EPI Plus) and the EPI Plus Advisory Committee. The 2019 Budget Act provided $19,452,000 to scale the initiative. The Commission has granted $10 million to five counties and $3.9 million to the University of California at Davis for training and technical assistance for grantees.

Background: In November 2020, the Commission approved the outline of a second Request for Application, based on recommendations from the EPI Plus Advisory Committee. In 2021, $4.0 million was allocated for new or expanded early psychosis programs, $1.0 million for public awareness efforts and workforce development and retention, and $565,000 for research initiatives to identify barriers and improve access to care for diverse, racial, and ethnic communities. All the funds address specific mental health disparities. The competitive bid was released in February 2021 and the grants were awarded in April 2021.

Activities: The Commission also has partnered with Kaiser Permanente of Northern California to evaluate the cost-effectiveness of the Coordinated Specialty Care model for early treatment of psychosis to encourage the commercial care market to incorporate these practices. Results are expected by early 2022.

Long term issues: The Governor has proposed expanding state support for early psychosis services through the Child and Youth Behavioral Health Initiative. The Commission is working in collaboration with the Health and Human Services Agency on the Children and Youth Behavioral Health Initiative.

Mental Health Wellness Act of 2013/Triage

Summary: In 2018, the Commission awarded its second round of the Mental Health Wellness Act/Triage grants to counties and allocated $76,000,000 for local assistance programs, and $7,000,000 to evaluate the programs. The current Triage grant programs will end in 2022, with the exception of a few counties that experienced program delays due to the pandemic and received additional time to provide services.

Strategic Plan Goal 1: The Commission will advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.

Authorization: In 2013, Senate Bill 82, established the Investment in Mental Health Wellness Act of 2013. The Commission's Budget includes $20 million in ongoing Mental Health Services Act funds.

Background: The Commission receives $20 million each year to support the Mental Health Wellness Act, also known as the Triage Program. The funding is available to county behavioral health departments through a competitive process to support their crisis continuum of care. Funds must be used to hire staff.

The Commission previously has allocated these funds for multi-year grant, by committing funding from multiple fiscal years. The Commission also has directed that a portion of the funds be set aside for specific goals, such as 50 percent for children, to support collaboration between county behavioral health programs and schools, adults, and transition-age youth.

Activities: The Commission in September 2021 heard from counties in a listening session about challenges encountered with hiring staff and delays due to the pandemic. In October 2021 the Commission reviewed opportunities for the next round of Triage grants, which included a presentation from the EmPATH program. Commissioners also have expressed support for the hospital-based EmPATH program.

Long term issues: The State and the counties need to determine how to make the programs financially sustainable and to improve results over time. The Commission's evaluation will help to inform those opportunities, including whether to seek statutory changes that would provide more flexibility and eliminate the requirement the funding be used solely for additional staffing.

Mental Health Student Services Act

Summary: Over the last three years, the Commission allocated a total of $255,320,000 to 57 counties for school-based mental health services, as required the Mental Health Student Services Act.

Strategic Plan Objective 1a: Promote school mental health as a prime opportunity to reach and serve at-risk children, families, and neighborhoods.

Authorization: Established by, Senate Bill 75, Chapter 51, Statutes of 2019 the Mental Health Student Services Act, provided $40 million one-time and $10 million ongoing Mental Health Services Act funds to implement partnerships between county behavioral health departments and local education agencies. The Budget Act authorizes these expenditures and defines the evaluation requirements. The Budget Act of 2021 augmented the Mental Health Student Services Act by $195 million, and $25 million to support the implementation and evaluation of the program.

Background: In 2018, the Commission dedicated $20 million to support four partnerships between county behavioral health agencies and local schools. In response, the Governor and the Legislature passed the Mental Health Student Services Act. In October 2020, the Commission published *Every Young Heart and Mind: Schools as Centers of Wellness,* which recommended a comprehensive approach to school-based mental health. In 2021, the Governor and Legislature expanded the Mental Health Student Services Act and authorized the expenditure of State Fiscal Recovery Funds for school-based mental health.

Activities: The Commission has allocated funds to counties for the school-county partnership grants and developing plans for gathering data and assessing the programs. The Commission is also working to hire additional staff to support the implementation of the Mental Health Student Services Act and its evaluation. The evaluation will develop a performance outcome monitoring system, provide consultation to grantees, Commission staff, and other partners, and conduct the evaluation to determine lessons learned, successful approaches, and additional needs of students.

Long term issues. The State and the counties need to determine how to continue their partnerships for stronger integration of school-based mental health services and to make the programs financially sustainable to improve results over time. The Commission's assessment will be one source to inform those deliberations and decisions.

Community Advocacy Partnership Program

Summary: The Mental Health Services Act calls for ensuring that consumers, families, and people facing disparities are engaged in decision-making. The Commission provides $5.4 million Mental Health Services Act funds annually to support the voice of community members through eight stakeholder contracts. Contracts are established through a competitive procurement process and focused on community outreach and engagement, education and training, and state and local advocacy. The populations targeted with these funds include clients and consumers, diverse racial and ethnic communities, families, immigrants and refugees, LGBTQ+ populations, parents and caregivers, transition age youth, and veterans.

Strategic Plan Objective 1b: Build capacity at the community level to coordinate resources and services to improve outcomes.

Authorization: The Budget Act authorize these expenditures and require that the allocation is through a competitive process.

Background: Welfare and Institutions (W&I) Code Section 5892(d) requires that the Mental Health Services administrative fund "include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, the structure of service delivery, or access to services."

The Commission is currently contracted with 12 local and state-level organizations to conduct advocacy, outreach, engagement, training, and education for eight specific unserved and underserved populations.

On February 27, 2020, The Commission awarded $12 million in contracts for Clients and Consumers, Diverse Racial and Ethnic Communities, Families of Clients and Consumers, LGBTQ+ Communities, Parents and Caregivers, and Veteran Communities. In 2019, the Commission awarded a $2 million contract for Transition Age Youth and $2 million in contracts for Immigrant and Refugee populations.

Activities: Commission staff meet with advocacy contractors quarterly to better understand the needs for each organization that receives funding. Contract deliverables are reviewed and approved by staff. Funding for current Immigrant and Refugee advocacy contracts will expire this fiscal year. In January of 2022 the Commission approved the outline of the Requests for Proposals for the next round of Immigrant and Refugee Advocacy contracts and authorized the Executive Director to enter into contracts with the highest scoring applicants. Four local level organizations and one state level organization were awarded contracts.

In the 2022 state budget the Governor approved an additional $670,000 to augment advocacy efforts to support the mental health needs of immigrants and refugees in California.

The Commission Staff will present options for consideration at the August 2022 Commission Meeting.

Presenter: Norma Pate, Deputy Director

Enclosures: None

Handouts: A PowerPoint will be made available at the Commission Meeting.

AGENDA ITEM 9

Action

July 28, 2022 Commission Meeting

Mental Health Crisis Triage Legislative Update

Summary: The Commission will hear an update on recent modifications made to the Mental Health Wellness Act (Senate Bill 82), consider approving funding to expand the use of the EmPATH emergency psychiatry program, and provide guidance on the priorities for future SB 82 funding opportunities.

Background: The Commission's budget includes $20 million per year to support the Mental Health Wellness Act, also referred to as the Triage Grant Program. Two previous rounds of Triage funding have been provided to behavioral health departments through a competitive grant process and were made available to support community behavioral health programs. Historically, these funds were limited to support personnel in crisis response programs and could only be made available to county behavioral health departments.

In October of 2021 the Commission began the process of identifying the best use of SB 82 funds and areas of priority for the investment of future funds. Challenges related to the constraints outlined in the statute were discussed. Those constraints included:

- Funds must be released through a competitive grant program to counties, unless – for children's services only - the counties authorize another local agency to participate in lieu of the county.
- Funds must be used to support the hiring of new personnel.
- Funding is focused on crisis-related strategies.

In October of 2021, the Commission heard testimony from Veronica Kelley, Director of the San Bernardino County Behavioral Health and President of the County Behavioral Health Directors Association, Scott Zeller, Vice President for Acute Psychiatry at Vituity, and Jackie Wong, Chief Deputy Director of the First 5 Commission on the opportunities to use SB 82 funding to support a broader scope of services in counties, expand EmPATH psychiatric ICU sites linked to existing ERs, and provide mental health crisis prevention and early intervention services for children 0-5.

In June of 2022 the Legislature passed and the Governor signed Senate Bill 184, Ch. 47, Sec. 60 which amended the terms of Senate Bill 82 and provided the Commission greater flexibility in using these funds. Under the revised statute, the Commission can use these funds to support crisis prevention and early intervention, in addition to crisis response strategies. The statutes also allow the Commission to execute contracts through competitive procurements or sole source contracts and funds can be made available to a broad array of community partners, in

addition to county behavioral health departments, including other local governmental agencies, community-based organizations such as health care providers, hospitals, health systems, childcare providers, early childhood education providers, and others, as determined by the commission.

Presenter(s): Toby Ewing, Executive Director

Link to material(s): Welfare and Institution Code 5848.5 Sec. 60 - Amended by Stats. 2022, Ch. 47, (SB 184) Effective June 30, 2022
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB184

MISCELLANEOUS ENCLOSURES

May 26, 2022 Commission Meeting

Enclosures (6):

(1) April 28, 2022 Motions Summary
(2) Evaluation Dashboard
(3) Innovation Dashboard
(4) Department of Health Care Services Revenue and Expenditure Reports Status Update
(5) Calendar of Tentative Commission Meeting Agenda Items
(6) Tentative Upcoming MHSOAC Meetings and Events

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
May 26, 2022

Motion #: 1

Date: May 26, 2022

Motion:

The Commission approves the April 28, 2022 meeting minutes.

Commissioner making motion: Commissioner Tamplen

Commissioner seconding motion: Commissioner Gordon

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☐	☐	☐	☐	☒
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☐	☐	☒	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☐	☐	☒	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
May 26, 2022

Motion #: 2

Date: May 26, 2022

Motion:

The Commission approves the Consent Calendar as presented.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Rowlett

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☐	☐	☐	☐	☒
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☐	☐	☒	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
May 26, 2022

Motion #: 3

Date: May 26, 2022

Motion:

The Commission approves Orange County's Innovation Project, as follows:

Name: Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice Involved Young Adult Men: A Randomized Controlled Trial

Amount: Up to $12,000,000 in MHSA Innovation funds

Project Length: 5 Years

Commissioner making motion: Vice Chair Alvarez

Commissioner seconding motion: Commissioner Gordon

Motion carried 9 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. **Commissioner Bontrager**	☒	☐	☐	☐	☐
2. **Commissioner Boyd**	☐	☐	☐	☒	☐
3. **Commissioner Brown**	☐	☐	☐	☐	☒
4. **Commissioner Bunch**	☒	☐	☐	☐	☐
5. **Commissioner Carnevale**	☐	☐	☐	☐	☒
6. **Commissioner Carrillo**	☐	☐	☐	☒	☐
7. **Commissioner Chambers**	☒	☐	☐	☐	☐
8. **Commissioner Chen**	☒	☐	☐	☐	☐
9. **Commissioner Cortese**	☐	☐	☐	☒	☐
10. **Commissioner Danovitch**	☒	☐	☐	☐	☐
11. **Commissioner Gordon**	☒	☐	☐	☐	☐
12. **Commissioner Mitchell**	☐	☐	☐	☒	☐

13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☐	☒	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the May Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 23,804.54
21MHSOAC023	$ 0.00
Total	**$ 0.00**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,834,627.24**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **$1,834,627.24**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/21 - 06/30/24

Total Contract Amount: $5,414,545.00

Total Spent: **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	In Progress	06/30/2022	No
Quarterly Progress Reports	Not Started	09/30/2022	No
Quarterly Progress Reports	Not Started	12/31/2022	No
Quarterly Progress Reports	Not Started	03/31/2023	No
Quarterly Progress Reports	Not Started	06/30/2023	No

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	09/30/2023	No
Quarterly Progress Reports	Not Started	12/31/2023	No
Quarterly Progress Reports	Not Started	03/31/2024	No
Quarterly Progress Reports	Not Started	06/30/2024	No

DHCS Status Chart of County RERs Received
July 28, 2022 Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated June 27, 2022. This Status Report covers FY 2019 -2020 through FY 2020-2021, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2020-2021 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2020-21 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Alameda	1/29/2021	2/1/2021	2/8/2021	1/26/2022	2/3/2022	2/8/2022
Alpine	7/1/2021		10/15/2021	1/26/2022	2/3/2022	2/15/2022
Amador	1/15/2021	1/15/2021	2/2/2021	1/27/2022	2/3/2022	2/10/2022
Berkeley City	1/13/2021	1/13/2021	1/13/2021	2/1/2022	2/3/2022	3/1/2022
Butte	3/2/2022	3/2/2022	3/11/2022			
Calaveras	1/31/2021	2/1/2021	2/9/2021	1/31/2022	2/4/2022	2/8/2022
Colusa	4/15/2021	4/19/2021	5/27/2021	2/1/2022	2/4/2022	2/15/2022
Contra Costa	1/30/2021	2/1/2021	2/22/2021	1/31/2022	2/4/2022	3/11/2022
Del Norte	2/1/2021	2/2/2021	2/17/2021	1/28/2022	2/7/2022	2/23/2022
El Dorado	1/29/2021	1/29/2021	2/4/2021	1/28/2022	2/4/2022	2/9/2022
Fresno	12/29/2020	12/29/2021	1/26/2021	1/26/2022	2/7/2022	2/16/2022
Glenn	2/19/2021	2/24/2021	3/11/2021	3/21/2022	3/22/2022	4/6/2022
Humboldt	4/9/2021	4/13/2021	4/15/2021			
Imperial	2/1/2021	2/1/2021	2/12/2021	1/31/2022	2/4/2022	2/15/2022
Inyo	4/1/2021	4/2/2021		4/1/2022	4/12/2022	
Kern	2/2/2021	2/2/2021	2/8/2021	2/3/2022	2/7/2022	2/17/2022
Kings	1/4/2021	1/4/2021	3/11/2021	2/22/2022	2/22/2022	3/11/2022
Lake	2/9/2021	2/9/2021	2/17/2021	2/1/2022	2/8/2022	2/23/2022
Lassen	1/25/2021	1/25/2021	1/28/2021	2/2/2022	2/8/2022	2/17/2022
Los Angeles	3/11/2021	3/16/2021	3/30/2021	2/1/2022	2/7/2022	2/22/2022
Madera	3/29/2021	3/30/2021	4/15/2021	3/25/2022	3/29/2022	5/19/2022
Marin	2/2/2021	2/2/2021	2/17/2021	1/31/2022	2/7/2022	2/9/2022
Mariposa	1/29/2021	1/29/2021	3/11/2021	1/31/2022	2/7/2022	2/25/2022
Mendocino	12/30/2020	1/4/2021	1/20/2021	2/1/2022	2/7/2022	2/24/2022

DHCS Status Chart of County RERs Received
July 28, 2022 Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Merced	1/11/2021	1/12/2021	1/15/2021	1/27/2022	2/7/2022	2/8/2022
Modoc	4/29/2021	5/4/2021	5/13/2021	4/27/2022	4/28/2022	4/28/2022
Mono	1/29/2021	1/29/2021	2/16/2021	1/18/2022	2/7/2022	2/17/2022
Monterey	2/24/2021	3/1/2021	3/11/2021	2/2/2022	2/7/2022	2/9/2022
Napa	12/23/2020	12/24/2020	12/28/2020	2/7/2022	2/8/2022	3/3/2022
Nevada	1/29/2021	2/16/2021	2/18/2021	1/31/2022	2/2/2022	2/3/2022
Orange	12/31/2020	1/20/2021	2/9/2021	1/31/2022	2/3/2022	2/17/2022
Placer	2/3/2021	2/22/2021	2/23/2021	1/31/2022	3/17/2022	4/13/2022
Plumas	2/25/2021	3/19/2021	3/25/2021			
Riverside	2/1/2021	3/31/2021	4/8/2021	1/31/2022	2/4/2022	3/11/2022
Sacramento	1/29/2021	2/1/2021	5/6/2021	1/31/2022	2/3/2022	3/11/2022
San Benito	7/28/2021	7/30/2021	8/3/2021			
San Bernardino	3/3/2021	3/4/2021	3/17/2021	3/23/2022	3/23/2022	3/29/2022
San Diego	1/30/2021	2/1/2021	2/4/2021	1/31/2022	2/3/2022	2/18/2022
San Francisco	1/29/2021	3/19/2021	3/22/2021	1/31/2022		2/4/2022
San Joaquin	2/1/2021	2/2/2021	2/11/2021	3/22/2022	3/23/2022	3/25/2022
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021	1/26/2022	2/2/2022	2/7/2022
San Mateo	1/29/2021	2/1/2021	2/16/2021	1/31/2022	2/28/2022	3/2/2022
Santa Barbara	12/29/2020	12/30/2020	1/5/2021	1/26/2022	1/26/2022	2/10/2022
Santa Clara	1/28/2021	2/11/2021	3/3/2021	1/31/2022	2/15/20222	2/18/2022
Santa Cruz	3/29/2021	4/5/2021	4/15/2021	3/25/2022	3/25/2022	4/4/2022
Shasta	1/14/2021	1/15/2021	1/19/2021	1/25/2022	1/26/2022	2/10/2022
Sierra	12/31/2020	3/10/2021	4/12/2021	1/31/2022	2/2/2022	2/28/2022
Siskiyou	2/16/2021	6/11/2021	6/15/2021			
Solano	2/1/2021	2/1/2021	2/25/2021	1/31/2022	2/2/2022	2/8/2022
Sonoma	1/29/2021	3/5/2021	4/12/2021	1/31/2022	2/3/2022	2/22/2022

DHCS Status Chart of County RERs Received
July 28, 2022 Commission Meeting

County	FY 19-20 Electronic Copy Submission	FY 19-20 Return to County	FY 19-20 Final Review Completion	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion
Stanislaus	12/31/2020	1/5/2021	1/5/2021	1/31/2022	2/2/2022	2/15/2022
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021	2/9/2022	2/10/2022	2/15/2022
Tehama	4/27/2021	n/a	5/21/2021			
Tri-City	1/27/2021	3/4/2021	3/30/2021	1/31/2022	2/2/2022	5/25/2022
Trinity	2/1/2021	2/2/2021	2/17/2021			
Tulare	1/26/2021	1/27/2021	2/10/2021	1/31/2022	2/2/2022	2/10/2022
Tuolumne	6/2/2021	8/11/2021	8/11/2021	1/31/2022		2/4/2022
Ventura	1/29/2021	2/2/2021	2/16/2021	1/28/2022	2/2/2022	2/14/2022
Yolo	1/28/2021	2/2/2021	2/2/2021	1/31/2022	2/2/2022	2/2/2022
Total	**59**	**57**	**58**	**52**	**49**	**51**

Mental Health Services
Oversight & Accountability Commission

Tentative Upcoming MHSOAC Meetings and Events

Updated 7/10/2022

AUGUST 2022

- **8/25: Triage Collaboration Meeting**
  - 10:00AM – 12:00PM
  - Closed

- **8/11: Cultural and Linguistic Competency Committee Meeting**
  - 3:00PM – 5:00PM
  - Public

- **8/17: Research and Evaluation Committee Meeting**
  - 9:00AM – 12:00PM
  - Public

- **8/25: August Commission Meeting**
  - 9:00AM – 1:00PM
  - Public

SEPTEMBER 2022

- **9/7: MHSSA Collaboration Meeting**
  - 1:00PM – 3:00PM
  - Closed

- **9/8: Cultural and Linguistic Competency Committee Meeting**
  - 3:00PM – 5:00PM
  - Public

- **9/22: September Commission Meeting**
  - 9:00AM – 1:00PM
  - Public

OCTOBER 2022

- **10/13: Cultural and Linguistic Competency Committee Meeting**
  - 3:00PM – 5:00PM
  - Public

- **10/27: October Commission Meeting**
  - 9:00AM – 1:00PM
  - Public

NOVEMBER 2022

- **11/10: Cultural and Linguistic Competency Committee Meeting**
  - 3:00PM – 5:00PM
  - Public

- **11/17: November Commission Meeting**
  - 9:00AM – 1:00PM
  - Public