Transcript: Services and Supports for CARE Court Respondents

March 22, 2025

CLAUDIA CENTER: Good morning, everyone, I am Claudia Center and I am the legal director at Disability Rights Education and Defense Fund. And today we're going to talk about services and supports for CARE Court respondents. Next slide.

Our presenters today are Keris Myrick who is a great advocacy and leader for people who need supports and for people with significant mental illness or significant psychiatric conditions and so on. I already introduced myself. I am Claudia Center, legal director at DREDF. And I'm happy that we also have Kavya Parthiban, staff attorney at DREDF. Next slide.

I wanted to give you a roadmap of what we're going to review today. So, we're going to have the introduction that I'm doing right now, and then we're going to have Keris and Kavya talk a little bit about person‑centered planning. I think that with CARE Court, sometimes there's been an effort to kind of throw a lot of services at respondents and see what sticks, and we want to kind of take a step back from that approach and recenter ourselves on what would be most effective for the individual. Then we're going to go through the available services and supports. I don't think you all need to be experts on each of these, but it's really important, I think, for folks who work in this space to understand some of the lingo so that you're armed with that lingo when you talk to the judge or to the county, Behavioral Health Services agency. Then we're going to talk about advocacy for a dismissal or for graduation from CARE Court. And then we have a number of resources that we know, we don't have time to go through today, that we've put into an appendix, and you're always welcome to reach out to us about any of the resources listed in the appendix.

Next slide.

This says introduction. Next slide. Okay. I'm going to pass it to my colleague, Keris.

KERIS MYRICK: Okay. Hello, everyone. This is Keris speaking. And I am happy to be here again to help just spread some knowledge, that's what I do, drop some wisdom, as I like to call it. And I want to start here because CARE Court is for a particular type, a particular person, and sometimes when we talk about that person, it tends to be about that group of people. People with SMI. People with schizophrenia. People with schizophrenia who are unhoused. And then the story becomes more of a stereotype.

So I like this quote from Chimamanda Adichie. "The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story. The consequence of the single story is it robs people of dignity. It makes our recognition of our equal humanity difficult. It emphasizes how we are different rather than how we are similar. And so I want us to think about when we're working with a CARE Court respondent, that they are an individual and we're going to work with them as an individual, not as a stereotype of serious mental illness or psychosis or schizophrenia. Next slide, please.

I always was thinking about how CARE Court started. And what problem we were trying to solve. And even today, after a year of being implemented, still becomes sort of, "What is it that we're doing with CARE Court and what problem are we trying to solve?"

So a lot of what was talked about initially was about housing and ensuring people were housed. It was initially from the elected officials a solution to homelessness.

Now, of course we know that that isn't the case as we continue to support people who are CARE Court respondents. And now what I'm hearing is a lot about things related to ensuring a person is in treatment, is taking their medication. Those seem to be sort of the top things. So let's go to the next slide.

So, a lot of what I'm hearing relative to how CARE respondents are doing, especially those that are doing well in the program, the first conversation is around, oh, and they're taking their medication. And so let's talk a little bit about medication and medication adherence. So, one of the goals is to help people adhere to medication. But what does that really mean? So when we use the term "medication adherence," we're talking about taking medication in the right amount, at the right time, in the right way, and for the right duration. It's not just taking your medication. So, how well do people take their medication in all of these areas? And I want you to think for a moment, if you've ever had to take medication for a chronic condition or even something like the flu where you have to do a course of medication, how well do you and/or people in general, not people with schizophrenia, not people who don't believe they have a mental health condition, but how well do you take your medication? And let's also talk about how well people with chronic conditions take their medication. Next slide.

So, the World Health Organization has done studies on medication adherence, particularly ‑‑ particularly for people with chronic conditions. Now, here is something that helps us kind of see what happens for every 100 prescriptions. And you see, there's, like, a fall‑off. And this is just general public, like, you know, they get the prescription, 50‑70 of those prescriptions are filled, 48‑66 are picked up, 25‑30 are taken properly, and 15‑20 are refilled. So you can see there's a natural dropoff just for the general public. Now, if we talk about people with chronic conditions, including schizophrenia, depression, asthma, diabetes, all sorts of chronic conditions, 50% of people are not able to ‑‑ or do not adhere to medications as prescribed, those four areas related to medication adherence. So, that means that we have to pay particular attention to what is the meaning of taking medication for people? Knowing that medication ‑‑ taking their medication today may mean that person may not take that medication tomorrow. And there may be really good reasons for it. So we just can't have this expectation or conversation that people are taking their medication or not taking their medication. There has to be a broader discussion with folks about what does it mean to take medication? What is it going to be like when you come off that medication because you've chosen to come off it? Asking a person about that does not mean they will come off medication. It's no more different than asking a person about if they have concerns about harming themselves. That is not put into their head this idea oh, now I'm going to harm myself or I'm going to end my life. So talking about medication does not put into their head suddenly oh, I can come off my medication where I want to come off of my medication. What it does is it supports people in being able, in what we call medication empowerment. So, that's just a place that I want to start, to think about some of the things that we're centering on, but there are broader things that we need to think about to support people who either are CARE respondents and going through the process or people who also may be not wanting to go through the process of CARE Court. So I'm going to turn it over to, I think is it Kavya? For the next slide.

KAVYA PARTHIBAN: Hey, everyone, this is Kavya speaking. So, related to what Keris was talking about on how CARE Court has started focusing on people's medication adherence and hasn't really provided people the housing that they do need, let's talk a little bit about why respondents might oppose CARE Court. The first reason is loss of autonomy. CARE Court, the process starts because somebody, outside of the person, petitions a court saying that they need services. And it might be based on what an outside person or outside entity thinks that a person needs to "rehabilitate." So respondents being pulled into a CARE Court process know they are going to have limited choice, even though it seems that CARE Court is offering them choice on services. The other reason is because CARE Court, you know, doesn't actually offer more housing options, and so people are stuck in the same cycles where they do not have support of housing. We also know that when people are engaged with voluntary community‑based services that they select, that's more effective than court‑mandated care and even though if they have the things they want to choose and do better, CARE Court still came into effect. The other pieces that even though CARE Court is meant to be a helping court, it's meant to provide people with the supports and services they need, like other helping courts, people know that if they do not receive the help that the Court requires them to engage with or they do not progress on that help in a way that people see is expected, that can have consequences, and we'll talk about what those consequences are in the next couple slides. But for now, I'm going to turn it back to Keris.

KERIS MYRICK: Okay. This is Keris speaking. Sorry, I had to take myself off mute.

So, let's talk a little bit about person‑centered planning. And this kind of goes back to that there's not a single story. We're working with individuals. And person‑centered planning, the goal is to work with that particular individual and get from them and work with them, to talk about what are their strengths, goals, and needs. Also, it helps advance or facilitate autonomy and choice and self‑determination. And the more autonomy a person has, the more they're able to participate in treatment, to participate in anything. Again, think about yourselves. How often has somebody taken away your choice to do something or told you you have to do something? Sometimes we even moan and groan because we have to pay taxes [chuckles]. We don't like it, but we have to do it. And that's one of those things where, again, we know what it feels like, just as individuals when we don't have a lot of choice and there's control. Also it creates opportunities for accessibility, ensuring that a person can go through any door to get the support and services that they need, that they're coordinated. And for them, they're easy to use. Not for how we see it, but for how they see it. Most importantly, it allows us to meet people where they are, not where we want them to be at the moment. So, we also want to remember that recovery is not just about the medical needs. World Health Organization talks about health not just being the absence of symptoms, but the presence of a lot of stuff. So here is what we're talking about, that it's not just about the medical needs, but it's also about recreation, transportation, friendship. It can include, yes, what kind of treatment do I have? What kind of housing do I have? And then if a person is interested in education or employment, what kind of vocational opportunities are there to support them for those endeavors? What kind of relationships do they want to build or rebuild with family and which family? What kind of social activities do they want to belong to? Also, if you wanted to put this kind of in a big ol' bubble or put it, like, around something, how do we do this in a culturally‑responsive and logistically appropriate way for the person? We also have to think about sort of balancing the dignity of risk ‑‑

CLAUDIA CENTER: Keris, I'm going to jump in here. Ally, can you forward the slide and pause and then forward the slide again?

KERIS MYRICK: Okay. Oh... thank you. Yeah. So, right here, this is a great example of what person‑centered planning doesn't look like when people ‑‑ thank you, Claudia ‑‑ when people focus on mental illness and professional care. But the person that you're working with who is CARE respondent is talking about, but, work is really important to me or education or going back to church or having relationships. And we say well, that's great, we'll get to that. But right now we want to focus on your mental illness and your healthcare and that happened to me in my care, everything is important, but people wanted me to make sure I took my medication and going to treatment. Okay. Next slide.

So, when we're talking about person‑centered planning, I needed people to meet me where I was, which was the thing that was most important to me at the time was maintaining the relationship with my family. Also being able to retain or go back to work. But I also, yes, did want to feel better. Actually I articulated it. The mental illness was still there and treatment was still there and we dovetailed that alongside things that were relevant and important in relation to family. Okay. Next slide.

So, we had to, I think, do this balancing act of duty to care and dignity of risk.

A lot of times duty of care is way up and dignity of risk is way down, on this sort of balancing, if you think of a seesaw or teeter‑totter, I don't think what these things are called in the U.S., but dignity of risk is low and people are making sure that duty to care is there and providing care for that person rather than lifting up the dignity that a person has to make mistakes. We will make mistakes. We learn from those mistakes. And that's what we hope the care will help us facilitate, learning from, wow, that didn't go really well. What would you like to have done differently, such that that didn't happen? And that allows some dignity of risk, some learning, and that comes with allowing things like choice, control, and self‑determination. Okay. I'm going to turn it back over to Kavya.

KAVYA PARTHIBAN: This is Kavya speaking. And that relates to what we like to call, you know, the buffet table problem that we see in CARE Court and in a lot of other mandated‑court services. So if you look at this picture and you imagine yourself walking into an all‑you‑can‑eat buffet, you can see there's a lot of options, a lot of different things on the table. And at first glance, it might seem like a good time. But imagine if you were taken to that buffet and you're not even hungry or you don't think you're hungry. And everyone is forcing you to eat everything that's on the table, and then they get to determine the amount. That buffet doesn't seem like a good time anymore. It could be, instead, overwhelming, stressful, and coercive. Next slide, please.

And so if we understand the buffet table as people trying to, you know, encourage people to take all of these services, sometimes services like medication and mental health treatment as the primary focus, over what a person might think that would benefit them best, that would lead to people having a lot of confusion and stress around what's required of them. And also feeling like the services that are being given to them are not being supportive of them. And in those cases, it's important to streamline services and make sure what is provided to a respondent is comprehensive, it's necessary, and it's what they want, most importantly. If we mandate too many services and those services are uncoordinated or it's not focused on what the person actually says they need in order to feel better or rehabilitate, then you're going to push a person into having to manage a bunch of expectations, respond to a bunch of calls that they may not see as necessary and it might set them up for failure. So if you think about, you know, the circle plate that Keris just showed, we want to give people that plate that allows them to pick the amount of portions that they want, what they want, so that then they can move forward. Next slide, please.

And with that note, you know, we've been hearing from some people who are working in CARE Court that respondents sometimes are fielding a bunch of different calls and they don't know who to respond to and there's a lot of services that they have to coordinate.

An idea that could be useful for folks is having a dedicated point of contact to help respondents keep up with the important appointments that they are consenting to, connect with the services with CARE and making sure they don't fall through the cracks because they have to respond to a bunch of different people. These points of contact could be a targeted case manager that the respondent is having a good relationship with. It could be a supporter or a family member or friend that they trust. But those points of contacts can work with respondents to help attend appointments, they can help provide transportation, they can help them fill out necessary paperwork or release this information. They can coordinate between the other providers to make sure everyone is on the same page and things are not duplicative. And they can also make sure that the individual's personal choice is respected because they know what's important to the respondent and what their individual goals and preferences are. In all of this, it's important to remember that the respondent is the client and make sure you check in with them and ensuring that the person who is their supporter is also a connection provider can help the respondent move towards graduation or leaving CARE Court. Next slide, please. And I'll turn it over to ‑‑

CLAUDIA CENTER: This is Claudia. So we're going to talk about available services and supports. You all know that our service systems and our healthcare systems are quite complex, so none of us are going to be complete experts on all of this, but it's important that you all have some of the lingo and information about the program so that you can advocate for your clients. Next slide.

So as we all know by now, I think, a CARE Court respondent can have a CARE agreement or a CARE plan, and we also know that there's no separate funding for CARE Court respondents or their services. The CARE Court model is based on existing programs, which include Medi‑Cal, existing housing programs, and other benefit programs such as SSI or IHSS or food stamps and so on. Next slide.

So, what does CARE Court provide, other than existing services that may not have worked so far? So, one thing is that CARE Court respondents have priority for Behavioral Health Bridge Housing Program, and that is interim housing projects funded by the State. And at the end of this slide deck in the appendix, we have some links that will help you figure out how many Bridge Housing dollars went to your county and that may help you advocate to get your client into one of these programs. Because they do have statutory priority. It also ‑‑ another important aspect of CARE Court is it's a way to get your client into full service membership, which is a service that we'll talk about in a minute. And there's not automatic eligibility for full service partnership, but the requirements to be in CARE Court are very similar to the requirements or the eligibility criteria for FSP. And again, there's no separate funding stream, which, you know, we all... [Sighs]... just are concerned about. But that's where we're at. Next slide. And I'm passing it back to Kavya.

KAVYA PARTHIBAN: This is Kavya speaking. We wanted to briefly just level‑set with the group and talk about what the difference between a CARE agreement and a CARE plan is. Because when we see those two words, they're both meant to say what services a respondent needs to engage in, and also what services the county agency is supposed to provide. But, there is some nuances between the two and those nuances might matter for a respondent. I'm going to start by talking about the CARE agreement. So, you know, after the initial hearing, when the Court says, okay, I want the respondent and the county to come to an agreement about what services this respondent is going to be engaged in and what the county is saying that they're willing to provide, they set, you know, a case management hearing where a CARE agreement can be proposed.

Think about it as, like, similar to a settlement conference. So there, you know, the respondent and the county are kind of seeming like they're more on the same side and saying this is what we agree to. The Court will probably read that and approve of it. They might ask for some modifications and set off that case management hearing a little longer. But once the Court approves of that agreement, it's court‑ordered still, and it's reviewed only once, after 60 days. The risks of that I'll get to after I describe the CARE plan. The CARE plan is after the initial hearing at the case management hearings, the respondent counsel and the county are not able to reach an agreement about what services are going to be provided and engaged in, and if the Court thinks there's not going to be a chance that an agreement is going to be reached, they will order, one, a clinical evaluation of the respondent that's going to detail the diagnosis, whether they meet the CARE Court criteria and see if the person can consent, if necessary, medication. And, like, also recommend what that behavioral agency doing the evaluation can recommend for services for the respondent. And then after eventually a CARE plan needs to be proposed and the Court orders that CARE plan. On paper, what services might be provided might not look the same, but this one is where the Court is saying I'm stepping in and I'm ordering that this is going to happen, if this person meets the CARE Court criteria. And it has to be reviewed every 60 days after the CARE plan is put into effect. The risk for the CARE plan is that if a respondent, you know, fails to graduate or fails to progress in their CARE plan, those facts can be used later in an LPS conservatorship case and probably can show that this person was not able to benefit from services in the community and that a conservatorship is a better case for them. So a CARE plan kind of could be used to restrict a person more in the future. The CARE agreement, when I say the risks aren't clear, it's not clear, you know, if the same facts can be used for an LPS conservatorship but it seems like the statutes are pointing more towards the plan to be able to be used for the facts of an LPS conservatorship. As counsel, it's more beneficial to have a CARE agreement than a CARE plan. Next slide, please.

And here it talks about why, you know, the CARE plans are risky. There's a clinical evaluation. The Court may order medication as a component, if they find, like, clear and convincing evidence that the respondent lacks capacity to give informed consent to the administration of medically‑necessary stabilization medication. And this part is important where folks with a lot of mental disabilities might say medication is not the best fit for them. But if you're pushing for more invasive information to be collected on a respondent through a clinical evaluation, that pushes the risk towards, like, kind of not forcing, but forcing someone to take medication if they don't think that's a good fit for them. Next slide, please.

Now we're going to talk about specialty mental health services which are services that are not provided distinctly from CARE Court, but are services that your clients might need and to be connected to. Next slide, please.

So what are specialty mental health services? Specialty mental health services are a package of Medi‑Cal benefits that are available to a subset of beneficiaries who have a mental health condition that's serious enough that it causes significant impairment.

It is organized through your county's mental health plan, which is approved by the State Department of Mental Health. It defers to mental health plans and Claudia will go into that. And counties might provide this themselves through county workers or might contract to outside agencies to help with that mental health service. Next slide.

So here is a flowchart that kind of talks about the difference. I know Claudia is going to hop in to talk about managed care a little bit, so I'll let her weigh in first.

CLAUDIA CENTER: Sure. So this is Claudia. And a lot of times, CARE Court respondents, a lot of their services are provided by the county mental health plans rather than the Medi‑Cal managed care plans. But later I'm going to talk about a new benefit under Medi‑Cal that's called CalAIM, A‑I‑M, and those are administered by the managed care plan. So the managed care plans may play a role in your client, given how CalAIM works. Okay. Back to Kavya.

KAVYA PARTHIBAN: This is Kavya speaking. So the specialty mental health services are through county mental health plans and the idea is that you're offering more intensive support for mental health services. These services are supposed to be able to be provided more in your community in a more timely manner. CARE Court respondents, if they meet CARE criteria, they're likely going to meet the criteria for specialty mental health services. Next slide, please.

So who's eligible for these specialty mental health services? You can qualify if you're under the age of 21 and above the age of 21. I'm going to talk about 21‑plus because that's going to be most of the CARE Court respondents. For people above the age of 21, you need to have a functional impairment, which means significant impairment that can be distress, disability, or dysfunction, in social, occupational, or other important activities, or you have a reasonable probability of significant deterioration in an important area of functioning and that this functional impairment is due to a mental health disorder, either diagnosed or suspected. The criteria for people under the age of 21 is a bit more broader. Information such as being involved in child welfare or the juvenile justice system is things that can weigh in favor of giving a person under the age of 21 specialty mental health services. The piece that's also important to know with the eligibility is that when you're eligible for specialty mental health services, you may qualify for a wide range of services that are provided under specialty mental health, but that doesn't mean you're entitled to all of them. So we'll get to that piece when we talk about grievances. Next slide.

So, the types of services that can be provided through specialty mental health services include targeted case management, that can go towards that provider connection piece that we were talking about earlier. It can go to licensed psychiatrists and psychologists for treatment and diagnostic services. We can provide you rehabilitative mental health services, and we'll talk more in detail in the next couple of slides. It includes coverage for psychiatric and in‑patient hospitals and also for nursing and in‑facility services. Next slide.

So these are, you know, the types of services that can be covered under specialty mental health services. I'm going to talk a little bit more about rehabilitative mental health services. Next slide.

So these are services that help you improve and maintain and restore skilled and daily living, and it goes beyond just that medication and mental health treatment.

It can include mental health services like counseling, whether individual or group; it can include support with medication or day rehabilitation or day treatment intensive programs. Those are programs that, you know, a person can go to for at least three hours, but less than 24 hours, and they provide, you know, services and support, and includes crisis intervention and crisis stabilization. Adult residential agreements and psychiatric in‑patient hospital services. Again, you may qualify for all of these, but you might not be entitled to all of these. Next slide.

This is a slide that's been provided by Keris and I love this slide, because I think it just delineates that there's all these providers and things that they may provide, but it's helpful to know specifically what a provider does offer before you opt in for a specific service. Keris, if you want to weigh in a little bit more on this slide, I will let you hop in.

Okay. Next slide.

So people get specialty mental health services by applying through their county, because the county is the one who manages these plans. Different counties screen in different ways. You can find out what your county's process is through the access line, the phone numbers are published online and there is a link for you to click on. Specialty mental health services must be provided in a timely manner, that means if you are having an urgent need for specialty mental health services, urgent meaning if you don't get the services, there might be a psychiatric emergency, you need to get a response within 24‑48 hours. And if it's non‑urgent, you should get support within, like, 10‑15 days. They can't just deny you or ask you to call back at another time because of a long wait list; you are supposed to be getting these services in a timely manner, if you qualify. Next slide.

Once a person's approved, they're entitled to a CARE plan and, you know, you work with your county to see what services they're willing to provide and that you can get.

And the CARE plan includes the goals and objectives and the services to be provided.

It's good to know what are each services so you can advocate for a specific service that you think is beneficial. Next slide.

You have due process rights when you qualify for specialty mental health services. Like I said, just because you qualify doesn't mean you're entitled to all of the services, and so if you do not get a service that you want because the county says you don't need it, but they offer you others, you can go through a grievance process, you can file an appeal if they deny you. The way that you get that information is through the county. You can also ask your providers or the places that you're getting treatment at. Next slide. And I'm going to pass it to Claudia.

CLAUDIA CENTER: Hi, everyone, this is Claudia again. I'm going to talk a little bit about full service partnership. And I also want to let people know that we're pretty behind slide‑wise, so I think we're going to end up doing a Part 2 to this presentation, assuming I can get all of my panelists scheduled, and we'll try to do it as quickly as possible.

Next slide.

So full service partnership is the concept that counties are going to be given certain dollars to do whatever it takes to stabilize and serve a client that has significant mental illness, who are unhoused, or who have other high levels of functional impairment.

So the person must have a serious mental disorder and a high level of functional impairment. Next slide.

So, you can look at the Welfare and Institutions Code and see the specific level of serious mental disorder required to qualify for FSP. But it's typically going to be the same characteristics that you would see in a CARE Court respondent. Next slide.

And here is more detail on the level of functional impairment required for FSP.

The person must be unserved or underserved. They must be unhoused or at risk of becoming homeless. Involved in the criminal legal system. Frequent user of hospital or emergency room services. These are the types of criteria. And these are "ors" so you can demonstrate eligibility by showing one of these, although a lot of CARE Court respondents will have more than one. Next slide.

So, the full service partnerships are funded by the Mental Health Services Act which has been renamed the Behavioral Health Services Act, although a lot of people still call it MHSA money. We know that the money, the allocation of the money has changed. There is now 30% of this money is going to housing interventions, 35% are going to full service partnerships. And the idea is that full service partnerships, because they're state dollars and not through the Medi‑Cal program, they can fund things that Medi‑Cal can't fund. And, of course, you know, housing is the obvious example. So, it's not an entitlement, so Medicaid is an entitlement, but it's to the extent resources are available. Next slide.

So, there are no strict rules about how the county decides who gets an FSP slot, other than prioritizing people who are unserved. So this is where the advocacy by CARE Court counsel who are representing respondents come in. It's really important that you advocate with the county to allocate an FSP slot to a CARE Court respondent and to ask the Court that that allocation be done. Because while FSP is not a magic wand, it's a really critical benefit for CARE Court respondents. Next slide.

So, this is a flowchart that shows how the MHSA or Behavioral Health Services Act dollars work. So, the dollars go to the full service partnership and that full service partnership can provide mental health supports and critically non‑mental health supports. Because a lot of the non‑mental health supports are already funded through Medi‑Cal and it's the non‑mental supports funded by FSP and you're probably going to want to advocate for. Next slide.

So, here is a slide that delineates some of the mental health supports that can be provided through an FSP. And these include, and we have a regulatory citation here, these include things like peer support, alternative treatments, personal services, coordination and case management, crisis intervention, and so on. So a lot of things that are relevant to CARE Court respondents. Next slide.

And here, again, are the non‑mental health supports that, you know, FSP is really a critical funder for. So this includes food, clothing, housing ‑‑ ding, ding, ding, housing ‑‑ but I will give a caveat in a minute, and additional services. Next slide.

So, a full service partnership client gets an individual services and supports plan or an ISSP. Next slide.

And so here's my caveat on the housing: So, obviously I showed you that regulatory cite that says that an FSP can cover housing. But in practice, FSPs usually don't cover ongoing permanent housing. The dollars can be used to provide temporary housing. For example, like a rehabilitative, you know, mental health treatment bed. It can cover that kind of housing, and that can be really critical for a CARE Court respondent. Next slide.

All right. Back to Keris to talk about peer support.

KERIS MYRICK: Sure thing. So this is Keris speaking. Next slide.

I'm probably going to go through these pretty quickly, so we have some time, but I'm going to talk about peer support. And when I use the word "peer support," I'm talking about people who have been given a diagnosis of a mental health condition, supporting another, also family and/or parent or caregiver supporting another family, parent, or caregiver. Next slide.

So peer support, real quick, this is information from SAMHSA, and I'm going to be honest, I do not know if this website is still alive, so let's just remember what's happening at the federal level and that does kind of happen and hopefully that stuff is still there and if not, I'll make sure you have access to it. The documents tell what is a peer supporter is somebody trained to live their experience to support a person on their recovery journey and also the evidence of peer support. What's so fantastic about peer support for this particular population is the evidence when peer support services are included. So, for example, evidence is shown that there is less ‑‑ lower cost related to or lower usage of high‑cost services such as hospitals, ERs, less criminal justice involvement, longer and tenure in community and them remaining in treatment because of decision making and learning how to articulate their goals and work with those alongside their provider. Okay. Next slide.

SAMHSA, the Substance Abuse and Mental Health Services Administration that guide the states, states don't have to follow them but many do and you can see some of these core competencies here, like engaging in peer collaboration and providing support and shared lived experience, et cetera. And in California through the certified peer specialist program allows peers to build Medicaid or Medi‑Cal peer services has two extra core competences and we have cultural competency which is already included but alongside that, we have structural competency which is understanding that the structures that impede people's ability to participate in treatment and things like that. We have digital literacy, we found that people in community behavioral hull sometimes didn't know how to link to things like telehealth, et cetera, and use technology. We're the only state that has those two added core competencies. Next slide.

So, we also, through SAMHSA and the national association of peer supporters which is the guild for peer support set aside some national guidelines and this is so you understand what is the role of a peer supporter so they don't get out of scope, and you're not maybe thinking of telling a CARE respondent yeah, you will get that and manage your medication. No, they will not do that. This is to help understand what is the scope of practice of a peer supporter, and especially under areas that relate to things like if a person is in treatment involuntarily, for example. So, next slide.

So, I think one of the top ones that I like to point to is that peer support is voluntary. There are a whole bunch of other things here, like, it's hopeful, open‑minded, mutual, reciprocal, equal share of power, et cetera. These are practice guidelines. So let's go to that next slide around peer support is voluntary.

So for somebody who is under any kind of court orders, it means that if the respondent is told, hey, peer support is available to you, then they can voluntarily say yes, I would love to have some peer support services. Secondarily, peer support is part of ‑‑ should be part of the services under the CARE Act or CARE Court. So, peers are available or shall be available, I think is a way to put it. It is up to the respondent, however, to say that they want to work with a peer. They cannot be ordered to work with a peer. That's a nuance difference about what we mean when we say peer support is voluntary. And sometimes counties have put peer support services as a mandate for the CARE recipient, which then violates the peer being a voluntary service to the recipient. I hope that makes sense. Okay. Next slide.

So, we can also look at the different types of services and supports that are offered and the type of settings that they're offered in, and what kind of populations they're offered for. So, this, again, helps to see kind of where peer support is offered and if it's at home, if it's in recovery housing, if it's doing outreach and engagement. And what type of populations are folks working with? So, again, this helps you help the respondent think through oh, wow, yes, I could actually use a peer support and the peer support might be able to come to where I'm residing and help me maybe with, you know, cleaning my house, because my house has become messy, and that could become a problem. So there are lots of things that ‑‑ and peer support also can help people connect to transportation, et cetera. So, that's just an example there. So now let's move on to psychiatric advance directives. And I believe I'm turning that over to someone else or am I doing these?

CLAUDIA CENTER: That's still you, Keris.

KERIS MYRICK: Oh, it's still me, yay! Let's talk about psychiatric advance directives. Next slide.

So this is just a lovely graphic of what they are, they maximize autonomy, choice, definite determination, especially when a person is well. Let's move to the next slide.

They are a legal, written document that provides individuals with serious mental illnesses and other mental illnesses the opportunity to articulate preferences regarding, again, there are choices. This is reproductive choices. We want to make sure we're doing and talking about reproductive goals for people, that sort of gets left out sort of treatment decisions and conversations about people's goals. But a psychiatric advance directive just broadly allows people to document what their choices are in their psychiatric treatment when they are in crisis and not able to speak for themselves, they can appoint a health proxy. And a directive is for a person to work with their reproductive choices applied in obstetric emergencies, et cetera, when the person doesn't have capacity. So it's the same as the psychiatric advance directive but talks about the reproductive goals of the person, we leave it out it's not part of the mental care but part of the person's health including their mental health. And next slide, when we look at peers being able to work with people who have been compulsorily admitted into programs or into hospitals in the advanced psychiatric advance directive, in this particular trial, we found that after people participated in this work group, they experienced fewer compulsory admissions than the people in the control group, and what this does is supports the use of peer worker in psychiatric advance directives in order to prevent continuing use of things like CARE Court or LPS or 5150 or things like that because people are able to articulate their goals. Okay. Next slide.

CLAUDIA CENTER: So this is Claudia. We have made an executive decision to jump a few slides ahead to the CalAIM slides. Okay. So I wanted to give people an overview of CalAIM, which is a new waiver program that California is offering through Medicaid. Next slide.

So, the CalAIM waiver includes two sets of benefits. One is called enhanced care management and the other one is called community supports. And if you haven't heard of any of this, this makes sense, because even though it's fully effective across the entire State of California, the implementation has been tiny. The estimate is that up to 3% or even up to 7% of Medi‑Cal recipients are eligible for this benefit and it's been way under 1% so far. There's a lot of variation across the state and people ‑‑ and the counties that participated in pilot programs for this ‑‑ that were the predecessor programs to CalAIM, they are doing a lot better at offering this service. So, as I said, the ‑‑ previously, CalAIM is actually administered by the managed healthcare program, so they're not managed directly by the county, but by the insurers that the counties contract with. And so it's designed for the highest cost plan members, with the most complex needs. And there are some housing supports in the community supports benefit, but unfortunately, there's no housing in and of itself. And so one of the ‑‑ there's a new LAO report that's linked in the slides and one of the frustrations that the counties, of course, are reporting is that they have this sort of housing navigation service, but then there's no housing to navigate to. So, it's sort of this bridge to nowhere, which is frustrating for everywhere ‑‑ for everyone.

Next slide.

And so we have used a lot of lingo here. And we want you to know the lingo so that you can advocate for your clients. But the reality is local, like, what benefits and services are available in the real material world is going to depend on your local county mental health agency. Their plan and their phone number is published online. It doesn't mean you shouldn't ask for things they don't have yet, because they're supposed to be providing all of these things in this slide deck, but just know that, you know, you're dealing with your local county mental health reality. So now we've also made an executive decision to advance our slides to ‑‑ Kavya, can you say what the words are at the top ‑‑ it's the fact partners.

KAVYA PARTHIBAN: Yeah. Could we go to what supports dismissal for CARE Court petition? So, you know, this is probably going to be a longer presentation at another point, but I wanted folks to know that there is an early implementation report on CARE Court and I think it gives us good information on how we can advocate for dismissal or graduation. According to that report, most, like, half of the petitions were dismissed. And, you know, dismissals are potential ‑‑ at potential many stages of CARE Court proceeding, it could be when it's first brought, after the county gives the report, after the county ‑‑ or when the person reached ‑‑ you know, tried to come up with a CARE agreement and it's not working and then there's a CARE plan and an evaluation. It gets harder to dismiss a CARE Court, you know, participation as the stages go on, but it does seem like dismissal is happening. And the reasons for that could be because the potential respondent voluntarily engaged in some sort of service that was seen as stabilizing prior to the CARE agreement coming to effect. Or because they were found ineligible. And, you know, this process takes time, so use that time to support your respondent and getting connected with whatever, so that they can move away from a CARE Court process. Because CARE Court, if you're ordered to have a CARE plan, you're required to be there for a year and it could be a hard process for some folks. Something else I think is important to know is that County Behavioral Departments and public conservators were the least likely to actually use CARE Court, they want to divert people not into that involvement, not in court, and that's something you can wield to your benefit. Next slide.

I'm going to just go over how you can advocate for dismissal. For example, you say the client's actively participating in some voluntary treatment. Gather information. Did they enter a mental health program? Are they looking at SSPs? Are they going to a daycare program? Are they engaging with a peer supporter on their own will? Use that to show that CARE Court is not the least restrictive option because the person is looking for other ways. When they are actively looking at eligibility, look what the eligibility is and use whatever you can to advocate against CARE Court participation. You can also say there's insufficient evidence that the person has a qualifying service mental health disorder. The next couple slides are case examples that have facts and pulls through different people's experiences and ‑‑

CLAUDIA CENTER: Kavya? Sorry, I'm going to interrupt. This is Claudia. We got a question in the Q&A that I would like Keris to answer: What are some examples of alternative treatment and culturally‑specific treatment approaches?

KERIS MYRICK: Yeah, thank you for that question. So, one that I'm thinking of that we actually don't have in California, I don't know if I'm allowed to bring up ones we don't have, but I'll start with a couple. One is recovery‑oriented cognitive therapy. That was actually developed by Dr. Aaron Beck who developed cognitive behavioral therapy. People may be well aware. So people can ask for things like CTR, which is recovery oriented cognitive therapy specifically for people with schizophrenia who really struggle in their recovery process. Usually people focus on the positive symptoms, which is symptom reduction. CTR focuses on the negative symptoms, which sometimes are the underlying driver of the delusion, voices, and things like that. So, that is one thing we don't have, which would be amazing if we could have our providers, peers, even family members, police officers, courts, trained in the approach of CTR. The other one is medication ‑‑ medication empowerment, which was developed by Dr. Pat Deagan, she also is a person with lived experience of schizophrenia who is a long‑time advocate of research and et cetera and which also have an evidence‑informed way to talk about the meaning of medication to a person so that a person can think through how to take their meds, if they want to continue to take it, how to have conversations with their providers and supporters about medication taking. And especially when they're thinking about coming off of medication, how do they have that conversation? What Plan B is in effect? How might they want to go back on the medication? So those are two things, actually, that I think are missing that can be asked for. And both of them are culturally‑based. Pat works really hard on ensuring she works with different communities and recovery‑oriented cognitive therapy. CTR was actually developed first in North Philadelphia which is an African‑American part of Philadelphia and Latino but this doesn't discount the need and support for African‑Americans to may be higher represented with diagnoses of schizophrenia and being unhoused. So those are just the two off the top of my head.

CLAUDIA CENTER: Thank you, everyone. This is Claudia. The evaluation link is in the chat. And clearly, we underestimated our ‑‑ the time we would need. But we do have a slide deck with lots of citations to the regulations, the statute, and so on. We will schedule a Part 2 where we will go through the content that we didn't have available ‑‑ I mean, today, because we ran out of time. Thank you for being with us!

[End of transcript]