Transcript: Services and Supports for CARE Court Respondents ‑ Part II held on Monday, April 21, 2025

CLAUDIA CENTER: Thank you. Hi, everyone, this is Claudia Center. And I am welcoming you to Services and Supports for CARE Court Respondents, Part II. This is the presentation we organized when we ran out of time for our presentation on March 25th. Both of these presentations will be available on our website, as in a video, and just so you know, we are putting together the process for giving people MCLE for self‑study, which means that your colleagues who aren't here today will shortly be able to watch our videos for self‑study MCLE, which gives another option for everybody. Not yet implemented, but soon. Next slide.

Our speakers today are Keris Myrick, who is the vice president of partnerships at Inseparable, very talented and knowledgeable about effective supports for people with different psychiatric or mental health diagnoses, labels, conditions, and so on. Myself, Claudia Center, legal director at Disability Rights Education and Defense Fund. And my colleague, Kavya Parthiban, staff attorney with DREDF. DREDF is a support center in the CARE Court system, so as you have problems with getting services for your clients who are CARE Court respondents, please reach out to me or Kavya; we're easy to find and we will do what we can to help. Next slide.

So, here are the topics that we're going to review today. And really, the ones on the left are mostly a recap of part I, we just want to reorient everybody or if there are people here who didn't go to part I, just a quick orientation; we will kind of be going through those quite quickly. So a number of concepts here is person‑centered planning, specialty mental health services, full service partnerships, peer support, and CalAIM. And we are going to talk about some services and supports we didn't get to last time. And those are on the right side of the slide, and include regional centers, in‑home of supported services, evidence‑based and informed practices, supportive decision making, some additional topics around peer support, and then we have some slides and information about Bridge Housing and CARE Court. Next slide. Okay. This is our colleague, Keris. Take it away.

KERIS MYRICK: Hello, this is Keris. Thank you for bringing me back here. I wanted to start in this place of moving beyond engagement and activation. A lot of times why CARE Court exists is people may be struggling with access and then we hear, oh, wow, now they're struggling with being engaged. Yet we actually also struggle with engagement and need to think about how do we move towards activation? So, let's think about this for a second. So what we know from research, and probably what we're seeing, is that about up to 1/3 of people were given serious mental illness diagnoses actually disengage from treatment. That's actually a lot. And then we also know that about 58% of people don't go to their follow‑up first appointment after discharge from in‑patient settings. So this is why it's really important for moving from just engagement to actually activation. And a lot of things that we're going to be talking about a bit later will actually aid in helping people in activation. So, let's think of it this way if we're going to define these two terms: Engagement is when I go and see the clinician. So I just went, I saw the clinician. That's considered engagement. Activation is when I act on mutually‑agreed upon treatment plans. And when we think again about CARE Act, there is a CARE plan and there is a ‑‑ I forget what the other one is called ‑‑ but there are two different types of CARE plans. But both of them are supposed to be created alongside the person who is in this process. So, those are supposed to be mutually‑agreed upon. Which is maybe one way that can help with engagement. But we'll talk about other ways related to those evidence‑informed practices that can actually help with moving from engagement to activation. That's the goal. And I think also your goal in your role as the person working with the respondent. How do you also move that person from, "I've just shown up to talk to you" to actually now they're engaged in their process of being able to identify what they want and how they want it in an activated way. So we'll talk more about that in a little bit as well. I just wanted to start by introducing those concepts and why they're so important.

CLAUDIA CENTER: Thanks, Keris. Now we're going to do some slides with Kavya.

KAVYA PARTHIBAN: This is Kavya. Can I get the next slide? We're going to briefly go over what person‑centered planning was. So person‑centered planning is a collaborative process where you are, and the person that's being worked with, is identifying what that person's strengths, goals, and needs are. We need to prioritize their choice, their control, and self‑determination in that. Think about accessibility. There's no ‑‑ there's no wrong door, meaning that, you know, you have to figure out what is most accessible for that person and what's the easiest for them to use. You meet people where they're at. And you don't just think about their medical needs, but you also think about things like recreation, transportation, how do we build relationships, housing therapies, social activities, their culture, et cetera. And also dignity of risk and we're allowing people to make choices that maybe they don't agree with and that's the dignity we give to everyone else. Next slide, please.

We also talked about specialty mental health services. So specialty mental health services is an intensive mental health support that can be given to a person. It's provided directly through a county's mental health plan. It gives you more than a typical managed care plan. More therapy options, day programs, et cetera. And you can apply through your county screen systems. And the link is on the slide for you all. Next slide, please.

And we also want to remind people that they have rights, if they're trying to access specialty mental health services. So when a person gets approved for specialty mental health services, they have something called a CARE plan, which sounds pretty similar to ours. And in that CARE plan, the person is saying what their goals are, the treatment objectives, and what services they want. These services are an entitlement and they have due process rights. So that means a client can file a grievance or they can file an appeal if they're getting a denial or reduction in services, et cetera. The county providing mental health services have to give information about how to file an appeal and how to seek a fair hearing. Next slide, please.

CLAUDIA CENTER: So this is for me. This is Claudia. So, full service partnership is a really important term for you all to know when you're interacting with your county mental health agency on behalf of your clients. The concept is it's a partnership between the person being served and the service providers, in which the client is offered a full array of services with a "whatever it takes" approach. The target or the population that is eligible for a full service partnership is very closely aligned with the people who are CARE Court respondents. It's people with significant mental illness who are unhoused or at risk of being unhoused, having involvement with the criminal legal system or have repeat hospitalizations. The person may get an individualized services and supports plan. FSP is a little different than mental health services, it's not an entitlement but it's in addition to the Medicaid services. And there's no strict rules how the county decides how to get an FSP slot, other than they have to prioritize people that are unserved and that gives you a role, as the lawyer, for the respondent to advocate to get your client a slot for FSP. Next slide.

So the FSP dollars come from, actually it's now been renamed, the Behavioral Health Services Act, previously the Mental Health Services Act and the idea that's important for you all is FSP provides not only mental health supports, but also non‑mental health supports. And we know that CARE Court respondents have a lot of unmet needs that are not about mental health supports. When the system is providing the mental health supports, they are going to be trying to use Medi‑Cal dollars as much as possible, because that's where you get the federal dollar match. And so when there are Medi‑Cal dollars being used, there is that entitlement and right to a grievance and so on. So, just to kind of keep that in mind. Next slide.

So an FSP, there is just a lot of flexibility about what FSP dollars can go for. It can go for supportive services in employment housing; it can be for a needs assessment; it can be for crisis intervention; it can be peer support. So, a lot of different mental health supports can be provided through an FSP using either Medi‑Cal dollars or the Behavioral Health Services Act dollars. But very broad list and there's citation on the slide. Next slide.

And this is the one, of course, that may be relevant for your CARE Court clients. It also can provide non‑mental health supports such as food, clothing, housing, housing, housing, and some out‑of‑pocket costs and respite care. Now, in practice, the housing that is provided by FSP is not really permanent housing over time; it can usually pay for some residential treatment housing or some short‑term, like first few months of housing or temporary housing. But even so, it's really important that that option is, at least theoretically, available. Next slide.

And wherever you're practicing, the reality is going to be very local. You want to know your county's mental health plan and phone number, you want to be connected with your county mental health agency, you want to develop relationships, regular communication. You want their e‑mails. You want to figure out who's the supervisor, who is the supervisor of who. Because you are going to have to advocate. Because, you know, people slip through the cracks. And when you look at this, you're going to want to know what skills and material resources are available; what are the lowest entryway supports; and how do people access supports. Next slide. And this is Keris.

KERIS MYRICK: Hi, yes, Keris here again. So, just a recap about peer support. Like, what is peer support? What do they do? So let's start off with peer support. So peers are people with lived experience or living experience of a mental health and substance use condition who supports another person who has a similar condition. In California, we both have certified peer specialists which are Medicaid reimbursable. They can provide Medicaid reimbursable services and then we have peer supporters who may not be certified and are still providing a lot of the types of peer support; they're just not billing Medicaid. For those billing Medicaid, I think it is a county opt‑in and there are only three or four counties that haven't opted in, but they still may have peer support. So I just want to make sure if you hear oh, they don't have peer support, it doesn't mean they don't have other types of peer supports. Peers are very effective in engaging people in collaborative and engaging relationships. They inform information in skills, wellness and recovery and other things, they serve as an example of a person who may be struggling what the possibilities are. We may meet a person who may not have another person who experiences other struggles they have with their mental health condition and/or substance use condition so seeing someone well and working is an example of them what the possibilities are that maybe they didn't think was actually possible. So there's great evidence around peer support. And their effectiveness in helping people reduce hospitalization and have longer tenure in the community, as well as being able to remain in treatment, and that's part of that activation thing I was talking about earlier. So, I'll go ahead and turn it over to the next slide.

CLAUDIA CENTER: Okay. This is me. This is Claudia. So, we have a new Medicaid waiver in California called CalAIM, and it's basically a Medicaid waiver that provides enhanced care management benefit. So, this is a managed care waiver that is supposed to give people much more case management and the option of having a trained provider coordinate and manage care for the client. And this, we know, is very important when clients or CARE Court respondents are overwhelmed by the number of appointments and the phone calls and the systems. And so CalAIM is supposed to be an approach for coordinating all of those services and making sure that the client gets a lead CARE manager that supports access. There's also an optional community service benefits waiver that many of the counties have opted into. And this provides supports around housing. But, again, it's somewhat limited, it's about short‑term housing, finding housing and deposits. And the LAO report says people are frustrated because of the lack, and I'm sure the respondents and clients are even more frustrated about the lack of housing options that exist in the real world. But this can be an important option. The LAO report also describes how there's a lot more room to have more people enrolled in this program and their capacity, they're still underenrollment and they're still trying to get their client this service. Next slide.

KAVYA PARTHIBAN: This is Kavya. I'm going to briefly talk to you all about regional centers and what services they can provide to your clients. Next slide, please.

So why are we talking about the regional center? The most recent California health policy report that came out stated that between 6‑17% of folks who are experiencing homelessness have a developmental disability in California. And this is important to note, because most of our CARE Court responses ‑‑ CARE Court respondents may also have housing instability and their developmental disabilities might not be being checked or accommodated. A developmental disability is typically a condition that starts in childhood. And it affects how a person learns or interacts or grows. And it can even include a wide‑range of disabilities, like intellectual disabilities, cerebral palsy, epilepsy, autism, and other conditions and how they use that treatment if we don't give them those proper services. Next slide, please.

So some developmental disabilities qualify for services and supports through the regional center under the Lanterman Act and under this act, the regional center is used to support people with developmental disabilities to live full productive and independent lives and they honor what a person states they want and help them live the life they want to live. Under the Lanterman act starts before the age of 18 and includes one of five conditions: Cerebral palsy, epilepsy, autism, intellectual disability, and other conditions closely related to intellectual disability, and related to the substantial disability. And what means you have to have three of the five characteristics showing the disability affects you living independently or manage your finances, et cetera. Next slide, please.

If a person qualifies for a regional center, the regional center must evaluate and decide if a person is eligible, first of all. Then they must coordinate services for that person. They develop something that's like a contract called the individual program plan, an IPP, with the consumer, where the person acts the regional center that these are the goals that I have, these are what services I think would help me reach my goals, and the regional center looks at that and player needs to get them a service plan. And they have to ensure that all consumers receive all the supports and services that are listed in that contract. Next slide, please.

So, in the case of housing instability, what the Lanterman Act says is the regional center must provide emergency in crisis services to a person to help them stay in their home or help them get housing. And if those services are unsuccessful, they must provide emergency community housing. I'll get to that. Next slide.

So regional centers, when they're working with a client, they typically provide services that are not available elsewhere. So when the regional center is working with your client, they might see if Medi‑Cal can provide them the services or another agency can provide them the service, but they cannot drop the ball and say I'm going to wait for the other county agency to give you the service and they're filling in the gaps even though there might be long wait lists. Although it might be difficult for someone to get regional services later on in life, a person can still apply, as long as they have some sort of records or ways to show that their disability is a qualifying developmental disability and it started before the age of 18. They might be regional‑service eligible. And, you know, if you're in doubt of whether or not your CARE Court respondent qualifies for the regional center, it's still worth trying to apply, because there's more services and housing options that become open and available for someone if they are a regional center eligible. Next slide.

CLAUDIA CENTER: And this is me, Claudia. And I wanted to add to the regional center point, is sometimes somebody may have been qualified as a young person and then the regional center lost track of the person. And so you may also find that your person is actually already qualified; there's just been a disruption in the service and it's an important option.

So, IHSS, next slide, is ‑‑ stands for in home services and supports and it's a Medi‑Cal program that pays for caregivers for people with disabilities. Most caregivers are family members, but there are also people who make this their job; they become certified as an IHSS provider and get clients who aren't family members. And this can help a person stay organized and on track in a way that can be helpful to recovery. And often the caregiver is a trusted supporter, typically, so covered services might include housework, laundry, meals, dressing, bathing, assistance with medications, assistance with money management, IHSS can prevent homelessness. Now, one thing to know is IHSS cannot be provided to someone who is completely unhoused; like if they're in an encampment. But there are some ‑‑ there is an option for IHSS to be provided to people who are marginally housed, such as in a shelter or an RV. It's called an alternative living arrangement. So we have some links to those there. So this is really a support that's most relevant for CARE Court respondents who are housed in some way. Next slide. Okay, back to Keris.

KERIS MYRICK: Okay. Thank you. And I want to say something about IHSS, if that's okay. I actually was an IHSS ‑‑ what do you call it? ‑‑ client and I cannot say how much that helped me when I was really struggling with being able to stay in my home. And it was not a family member, it was somebody who did this as a job. And it was so helpful in keeping me organized, as you said, Claudia, being able to help me with getting my groceries. Because I just couldn't do those things. And it really ‑‑ it was a lifesaver is all I can say. And it's something in mental health that we don't hear much about, but we know about it through other disabilities. That's how I learned about it and was able to advocate for it. So, yay for the IHSS is what I'm saying! [Chuckles]. Living example. So, let's talk about evidence‑based and evidence‑informed practices. Let me define evidence‑informed because that might be a term that folks might not quite be familiar with, in our field we talk about evidence‑based practices and EBPs. Evidence‑based practices generally have undergone rigorous studies, usually some kind of random‑control trial. And many times, may not include populations that are underserved or just not served, basically. So, we might not find a lot of studies related to people who identify as LGBTQ; we may not find a lot of studies with, you know, populations that are Black and Brown or people of color or who are non‑English speaking. So, we have to ask ourselves sometimes, "Well, who are those EBPs evidences on?" Where evidence‑informed practices help us and help providers think about the context, the person, the person's preferences, and they have some evidence behind them, but they may not meet that, as of yet, gold standard of having random controlled trials, et cetera, to be considered, quote‑unquote, evidence‑based. But they still have evidence to work with particular populations and particular people, et cetera. So I'm going to talk about a few evidence‑based/evidence‑informed practices, medication empowerment, wellness recovery action plan or WRAP, psychiatric advanced directives, and also recovery‑oriented cognitive therapy or CT‑R for short. Okay. Next slide.

So, we're going to talk about medication empowerment. And a lot of times, particularly for this population that we're talking about who may be respondents in CARE Court, there's a lot of focus on wanting the person to stick with their medication, which now we use the term medication adherence versus medication compliance. And sometimes it's really difficult. Many times people with chronic illnesses, according to research, have a hard time sticking with their medication. It doesn't actually matter what their diagnoses says. About 50% of people struggle to stick with taking their medication, as prescribed. So then we have to think about different ways to help people not get in the binary of they're taking their medication, they're not taking their medication. Take your medication, don't take your medication. It's probably far more nuanced than that and we have to work in having conversations with people about what does it mean to take medication to you? So, let's turn to the next slide.

So, medication empowerment designed by Dr. Pat Deegan, who has a whole host of things that she has developed as a psychologist, as a researcher, and also as a person who was given a diagnosis of schizophrenia, she's developed this thing called, or approach, called medication empowerment. And what it does is it helps people have a voice and choice in finding the treatment that's right for them. So, that it's not, again, about take it or don't take it. It's really about talking about the life that the person wants to have. What kind of life do you want to have? How do you want to get there? And what role does medication play in that is kind of where we're going with this. So, instead of thinking about it as a yes or no, it helps people identify, like, the challenges they may be having related to taking psychiatric medication, which exists in about nine basic areas. And so let's move to the next slide to talk a little bit about what this looks like.

Oh, no, we got rid of that slide. So let's go back. My bad! All right. So let me just keep talking about what this is. All right.

So, there are nine common areas related to, like, using psychiatric medication; it may be something like I can't remember to take my medication; I don't have the side effects of the medication, things like that. And so it also can be things like if a person is using substances, for example. So, when we think about medication empowerment, what we're trying to do is talk to people about, again, what is it, what is the life that you are trying to achieve? And how do you want to get there? So even you in your role as a lawyer, when you're talking to somebody, that might even be a question you ask, is, like, dig kind of deep into what is the person's goal? And helping them think about what is the role that medication may play, and what are the barriers that they have related to medication that then they can bring into the conversation with their supporters, their family, their treatment team. You can learn more about medication empowerment at this website. And you can also take some of the courses in order to fully understand medication empowerment and use some of the tools. There are worksheets and tools that folks can use. So I think that's really important to point out too. All right. Next slide.

So, the next thing I want to talk about is wellness recovery action plan. There are many, many peers in California who have been trained in WRAP, which is an evidence‑based practice, it has been studied. And well the wellness recovery action plan does is it helps you kind of break apart like thinking about when you're doing well and when you're not doing well. You didn't wake up one morning you're well and the next morning you're, like, wow, you're out on the street and you're not well. There's lots of things that happens in‑between. WRAP helps a person break it down and then develop simple tools along the way. So if they're doing well, what does that look like and what helps you stay well? Well, let's say that you're not doing as well. What things might you dig into those strengths and those things when you're doing well might help you when you're not doing as well? As you're developing this wellness recovery action plan and the reason that I bring it up is that it can also help you think about what you might put in a psychiatric‑advanced directive. A loss of times asking a person straight up, well, gee, what would help you stay well? They don't even know, right? So this kind of takes ‑‑ helps a person sort of break it apart into bits and pieces and then think about, okay, how do I gain and stay in control and have support as well in a time of crisis, because you've written it out? Let's go to the next slide, so I can talk about psychiatric advanced directive or PADs.

So, PADs are legal documents, in each state they're a little bit different, but basically they're like health proxies is a way to think about them. They are documents that help a person identify their preferences for future mental health treatment, especially when they're not able to speak for themselves when they are in a crisis. So, they're developed when a person is well enough to consider those preferences. That's were WRAP plans are really great, because you're already thinking about those things, and use when you become unable to make those decisions during a mental health crisis. And we have seen, in research, that peers who have worked and facilitated PADs with the client have shown fewer compulsory or forced, if you will, forced treatment rehospitalization, as compared to a controlled group. So we've done these studies in California and there's still work around how to ensure that peers can support others in completing a psychiatric advanced directive, especially during this process, so that it can maybe reduce use of further compulsory treatment. Okay. Next slide. All right.

So now we're going to talk about this thing called recovery oriented cognitive therapy. And CT‑R is going to be a lot easier to call it versus that long name. Okay. So let's go to the next slide.

So, recovery oriented cognitive therapy, or CT‑R, really helps people in their flourishing. And when I use the term flourishing, it's the same as using the term recovery, getting better, feeling better, feeling more well. And the reason that the term "flourishing" is used, is it's also used in physical health and it also maps against our mental health and substance use recovery principles. So a lot of times the things that people struggle with are the very same thing that people are struggling with who are respondents in CARE Court, which is they may have limited access to community resources, or maybe those resources themselves are limited. They can be disconnected from loved ones. A lot of isolation. They can feel stigma or be stigmatized. They may have restrictions in being able to work and/or challenges in that work. And when it says vocational, I'll say advocational too and they may have struggles connecting to things, you know, things they enjoy in their life, like hobbies and things like that, and particularly with our population, there is unstable housing. And sometimes even when they have, like, housing and are moving into some of these new areas, they have this adjustment to kind of their "new normal," if you will. All right. So let's go to the next slide.

So, what does this look like? And this is kind of really interesting as far as some of the things that people are struggling with. And then how you, as lawyers, like maybe you're not going to practice CT‑R, but you certainly can use the framework to connect to people. So, a lot of times, people are not feeling very empowered. They feel very defeated. And they don't feel like they can actually achieve something that they would hope to achieve. So they become disengaged in participating in the community or taking action towards, like, the life that they want to live. This is also very much about what is the life that you want to live? And what are the challenges that are getting in the way of that? And I think many people can identify and relate to this on a personal level, whether you have a diagnosis of schizophrenia or any other mental health diagnoses. When you become self‑defeating. Well, that can really kind of happen to people whether they try something and they fail and they don't have the supports to help them give it another try again. So, it kind of becomes self‑defeating. They also, what they've tried to work on in CT‑R is helping people feel empowered and giving a try at something that they didn't try before. Also building upon liked experiences or skills that you already have. Finding out from people, like, what is it like when you're leading your best life? What does that look like? Do you remember what that looks like? Well, let's talk about that. So that it can get people back in touch with their life when it was going well. Sometimes when it's not going well, that's all we're talking about, how crap‑ass your life is, just being honest, right? And then you can remember, oh, yeah, that's right, I did do this, I did achieve that, to touch back into that person, so that they can use those innate skills and abilities in their recovery. So, it also helps the system change. When folks can see, whether it's providers, supporters, lawyers, whomever, people start to self‑actuate and it actually starts to have a belief that people who have been struggling for such a long time have this ability to recover. I think we still sort of struggle with that when we think about schizophrenia and recovery, we think maybe they won't recover, yeah, they will, and you see it and it's exciting when it starts to have culture change in the system. All right. Let's move to the next slide.

All right. So, let's talk about this identity that people are struggling with and why it's important. I'm sorry, let's go to the next slide. All right.

So a lot of times people are struggling with their own identity, and then they don't know, like, clinicians don't know how to work with that person when it's the other person's identity that they're struggling with, right? So it creates more internalized stigma and prolonged sort of lower functioning than really needs to be. So when I think about myself as a person who was diagnosed with schizophrenia, just giving an example, it was hard for anybody to work with me and understanding who I was as a full person, rather than as thinking about me and my symptoms and trying to [chuckles] reduce those symptoms. And it was sort of this prophecy, if you will, and low expectations and oh my gosh, she's really sick, and that sort of became my identity, but we don't know how to pop out of that. And that turns into self‑stigma, where a person that has their own internalized belief or self‑stigma about their inability to do certain things. Next slide.

So, here's some of the beliefs that it can kind of turn into. And it can also impact their family members. So, if I personally have this belief I'm broken or I'm a failure, I'm a burden to my family, family belief looks like oh my gosh, I'm going to be judged or things will never be the same, this is going to be my life and this is kind of a burden. So, collectively, we all have shame, embarrassment, and we move towards hopelessness. And the behavior then becomes sort of isolation and disengagement. It also can look like loss of family, identity, and activities. Even the language we use, consumer family, kind of segregates us from that family unit we want to be a part of and have a stigma, not just for the person, but for the family member. Next slide.

All right. So this is what it can kind of look like. And you might have seen these maybe in one of my previous presentations, I call them my recovery circles. So it's sort of been put together here so you can see what we're moving from, to what we're moving to. So, the focus generally, when we're working with people, is on their symptoms and symptom reduction and all of the care that they're going to get to reduce those symptoms. Well, they have all of these other things out there that they're really interested in or that have been moved to the back and they have been told well, we'll focus on those things later. It can be work, it can be school, community, family connections, et cetera. Right now we're going to focus on this treatment plan to get these symptoms down and that's what we're going to look at. If we sort of turn this on their head, which CT‑R does and working with the person and their lived experience, what is their focus? The focus might be I want to talk about my treatment plan and my medications. Ah‑ha. To what end? I want to really get back to work and maybe the medications will help me with my concentrations and get me back to work. Now, we're starting to put pieces together about the whole person's life and their identity and their personhood and that becomes the preferred focus. So when I was talking about the CARE plan or the CARE agreement, those are the kind of things that really help to, I would say, broaden and richen ‑‑ richen? ‑‑ enrich the CARE treatment. I'm just making up words! Let's go to the next slide.

We're putting together flourishing and other social determinates on this and putting it in one thing and that's what CT‑R does. And you're saying I'm a lawyer or social worker and supporting someone through this process, what does this mean for me? I'm just trying to give you a foundation of where all of this came from, and when we think about terms that we hear, like "recovery," there are domains of recovery, which is connection, control, feeling valued, contribution, and safety, which also match to social determinants of wellness. And that's, again, where the focus for CT‑R is. It's not on the symptoms and symptom reduction, it's actually on the opposite of that [chuckles], and I'll show you what that means in a second. So, next slide. All right.

So, our goal in CT‑R is to mitigate risks, if you will. Well, it's not really to mitigate risks, but that's one of the things that can happen. Because what we're trying to do is increase the connection, the whole purpose and empowerment so that we can reduce things like anti‑social kind of stuff that's going on. Housing instability, either due to symptoms or otherwise. Substance misuse. Poor family, marital relationships, and education, and then lack of pro‑social leisure activities, meaning you're doing leisure activities but they might be kind of dangerous for you. All right. So let's go to the next slide.

All right. So, what are we doing here? So, we are not focusing on symptoms and symptom reduction, we are focusing on life and getting people in the adaptive mode. So, as the lawyer, as the clinician, you want to learn about and access each person's best self. That's their adaptive mode. Everybody has it. You have it. Think when you've been your best self and when you haven't and then it's, like, you tap into that thing that helps you be yourself, your best self, in order to feel better and be better. Everybody has it, we want to tap into it. We want to engage people into meaningful engagement and activities within their community. Let's start with maybe a conversation you might have with someone and you're struggling because they're not really able to connect with you as the lawyer kind of related to this work. So, you might want to stop and say, you know what? Why don't you tell me about your best day. What did that look like? And the person might not know what that is, because it's been a LONG time before someone asked them. So give them some time. Maybe share your best day and share how that best day helped you live your best life and that's when you got into your adaptive mode. You do not have to use the word "adaptive mode" with them, I suggest not. Who talks like that? We don't. Talk best self. And that might help them think back to, yeah, I remember whether I used to skateboard, I was the baddest skateboarder on the block, I could do this, do that. And you can ask them what did that feel like? How did you do that? You didn't just get on the skateboard and do that. What did you do? And how you'll engage in something you'll see their whole body language change, you might hear them get a little bit more excited and now here's where you want to talk about well, now what do you want your best self to look like? And let's talk about what steps would you want in your treatment plan or in your CARE plan, if you will, to get you there? So you can use techniques within CT‑R in order to develop that relationship and help a person move into their adaptive mode, so it makes it easier for them to have connections and think about the things that they want to do in order to get to their best life. I'm hoping this all makes sense! Okay. Let's go to the next slide.

All right. So, many of you may have heard of CBT, which is cognitive behavioral therapy, developed by Dr. Aaron Beck. Dr. Aaron Beck was a brilliant man, he died at the age of 100 a couple years ago. He also, along with Dr. Paul Grant who is alive and much younger developed CT‑R, and what they realized is there were people who were stuck on the backwards, if you will, of hospitals and other types of programs who were not progressing and basically no one knew what to do. And that focus for those folks tended to be on the symptoms, if we give them more medication, oh, well, the symptoms won't get better, let's just live with it as it was. They really started to recognize that focusing on the symptoms, which is that positive thing in front of them, or that negative thing in front of them, they had to flip and they had to focus on what was getting in the way of that person achieving? And generally what they found out is that many of their symptoms were driving sort of an underlying or cognitive belief about what they wanted to achieve. So, quick example. It's not a real one, I'll just make up one, is someone believes they're a millionaire and they're continuing to steal and give the money to poor people. They're living in somebody else's house because they think that somehow as a millionaire they should be doing that [chuckles], I don't know why, but let's just say this is their belief. So, in cognitive ‑‑ in recovery oriented cognitive therapy, instead of trying to unpack that with cognitive behavioral techniques, which is, like, doing a lot of homework and reality testing, we're not going to do that. What we're going to do, though, is ask a person well, can you tell me why that's important for you to do that? Like, why ‑‑ sorry, my light just went out ‑‑ why is it important for you to steal money? Tell me what's good about that? And they might tell you, well, it's really good because I get to give it to poor people and I'm a millionaire because I get to help people. So the underlying belief is that person gets to help people. So, our job is to help that person help people without the need of the delusion. And to put them in situations where they may be helpful to others, to bring up when they may be helpful to others, so that it starts to diminish the need for the delusion or voices and increases the reality that they can actually do that. They're not failing at it, they actually are very good at it. So that's sort of the underpinning behind how CT‑R works. And I didn't even know this thing was called CT‑R and when I was ‑‑ I got to meet with Dr. Beck and Dr. Grant and realize that this is something that my psychiatrist was doing with me, even though we didn't have this terminology. But it was the same sort of approach. Helping me see that I was capable. Reminding me that the thing I loved was research and reading research and understanding research. So every meeting, if we had to change something that was in my treatment plan, he would bring research and we would sit and talk about the research. Now, granted, that was about my symptoms, but he was using my adaptive mode to pull me out of being a perpetual client and being the person that I really am, which is an analytical researcher. How cool is that? So that's what we're doing with CT‑R. We don't have CT‑R training in California, but, again, you can use this framework and hopefully we will bring CT‑R training in California. Next slide.

All right. So I'm going to turn it over to Claudia.

CLAUDIA CENTER: Hi, this is Claudia. And we wanted to mention one more evidence‑based or evidence‑informed approach, which is assertive community treatment. Next slide. ACT is a community‑based/team‑based service that typically includes mental health providers, as well as peers, in a team model, and provides services on a day‑to‑day basis, including 24/7 crisis intervention. In a lot of the Olmstead settlements across the country, ACT is one of the required components of the settlement, because it is a way to stabilize people, to help people not be rehospitalized and to, instead, have some services on a prompt basis where the client is, you know, geographically, in the material world. And can really help reduce rehospitalization and other forms of, you know, being forced to leave the community and be at really high levels of care. So, you can find out if you have ACT in your county and try and learn about that in case it's relevant to your client. Some additional practices that are evidence‑based and evidence‑informed are Housing First, which is trying to set up a connection to permanent supportive housing. There are a lot of California documents that say that California endorses Housing First, but it's really not the reality in the real world a lot of times. And then also volunteer peer support is another important thing to think about. And those are like peer support networks that exist outside of the formal mental health system. So it could be, you know, just like a depression support group or, you know, a drop‑in center, that kind of thing. Next slide. Okay. Kavya?

KAVYA PARTHIBAN: This is Kavya. We're also going to discuss supported decision making with you all briefly. Next slide.

So, supported decision making is a voluntary and individualized arrangement where a disabled person works with someone that they trust to help them understand, communicate, implement, and act on their own choices. It is a great alternative to conservatorship or guardianship because in the case of conservatorship, we appoint someone else to make decisions for a person, but with SDM, a person can, with support, articulate and act on their own choices and not put it on someone else. SDM strengthens the capacity of a disabled person and it can be formal or informal. The trusted person is called a supporter and that supporter helps them understand their choices. In California, SDM is formally recognized under the Bill AB‑1663. Next slide, please.

So, what role can supporters play? If a client requests a supporter, the supporter can help the client figure out logistics and help them communicate. For example, a supporter might be able to respeech a client's word if their speech is difficult to understand and that person understands how that person communicates. They can help a client understand legal, medical, or other complex concepts. And they can enact the plan that was made in the supported decision making process. What's important for everyone to recognize and remember is that the client is the client, even this they have a supporter, you're not asking the supporter for their thoughts, you're asking the supporter to engage with the client so the client is the one in the driver's seat. Next slide, please.

And this is a beautiful graphic on supported decision making. It's up to you. Next slide. And I'll give it to Keris.

KERIS MYRICK: Okay, hi, this is Keris. Back again. Peer support. Yay! My favorite topic. Okay. Next slide.

So, we've generally talked about peer support as it pertains to the person who is living with a mental health and/or substance use condition and supporting another person with a mental health and/or substance use condition. Right now I want to remember that we also have family peer support, which is a parent, family, or caregiver who is providing support to another family, parent, or caregiver. So, a family peer supporter does not help a person with lived experience who is the CARE respondent, they may help the family member of that respondent. So think of it, those, that's the peerness, right. So, in California, we do have a specialization in a certification for family peer support. There's also volunteer groups, of course, that do family or parent peer support. And evidence shows that again it shows hope, guidance, advocacy, camaraderie and helps family members have more confidence in helping their loved one on their road to recovery. Next slide.

I want to talk a little bit about peer respites. We're probably going to skip over the audio on this, because I think it doesn't have captions, which it should, but I don't know. But anyway, what is a peer respite? This is someone talking about the power of peer respite. They run a peer respite in Wisconsin and in her testimony here, which is on my podcast, she was talking about when the community struggles with supporting people, then we have to have other places where in the community we can find that support. And peer respites are voluntary, they're home‑like, they have peer support in them, they're 24/7. They are not housing, they are exactly respite. So let's move to the next slide.

You might have to go twice, whoever is doing the slides. Okay, cool. All right. Whoop, no, back one; sorry, my bad. All right. So peer respites, again, it's voluntary, short‑term, overnight, and it provides a community‑based, non‑clinical crisis support for people to help them find a new way through the situation they're going through right now. And I think of many of our CARE respondents and how peer respite might be a place that will be helpful for them, either at the beginning, intermediate, at any time they feel like they need a little bit more support 24/7 so that they're in a home‑like environment around others and with the peer staff. So, they are not psychiatric emergency rooms, people are in charge of taking their own medications, they aren't locked and they are responsible for keeping them safe, and, yeah, let's go to the next slide so I can show you a little bit more here.

We have some of the outcomes from peer respites, which is about 70% are less likely to use in‑patient or emergency services. Respite days are associated with significantly fewer in‑patient and emergency services hours. They're also statistically significant improvements in healing, empowerment, and satisfaction. Respite guest also experience greater improvement in self‑esteem, self‑rated mental health systems and activities especially those cared for those that are in in‑patient facilities. Next slide.

So, in California, we have a number of peer respites and these are where they're located, so we wanted to make sure you had access to providing this information. It may be something that a person would want in their WRAP plan or in their psychiatric advanced directive or in their CARE agreement or CARE plan. I don't think we've added any new ones. There may be a new one in L.A., I don't know if it's opened yet in Hollywood, but these currently are the respites that are available in California. These are volunteer ‑‑ these are volunteer, outside of the specialty mental health directly‑operated. Generally the services within a CARE ‑‑ a peer respite are not Medicaid reimbursable, so they have other funding mechanisms, so you can see these are part of the system, but they are not part of the Medicaid system, if you will. So ‑‑ or the special mental health in that way. But they can be contracted with specialty mental health. Next slide.

CLAUDIA CENTER: Okay, back to me, Claudia. So, one thing to know is that CARE Court respondents have priority for Behavioral Health Bridge Housing Program, and so this is important because there are very services that are, you know, additional or special for CARE Court respondents. This is one of the few where CARE Court respondents theoretically have priority for these housing projects. And we have some links here where you can try to figure out where the Bridge Housing dollars are in your county and advocate for your client to have priority in one of those programs. We're also trying to figure out if there should be some Public Record Act requests to some of these, to kind of drill down on the ‑‑ where the dollars are and what housing is funded by these dollars, or if we can figure it out through existing public information. But that's sort of TBD. But here are the links that we do have. Next slide.

We have a couple of CARE Court reports that we want today share with you. [Sighs]... you've probably read articles about, at least the early implementation report from November 2024. And we do have some questions, so I'm going to ‑‑ you all can read these on your own time. So I'm going to keep going. Next slide.

We had a request from Disability Rights California. CARE Court would like to hear directly from respondents from DRC to better understand how CARE Court is being implemented in different counties and on disabled people. And if you know CARE Court respondents who might be willing to talk to DRC, please refer them to Samuel Jain and his address is here and phone number is 916‑504‑5929. Next slide. Okay. We have four questions in the Q&A.

The first one is: Is anyone collecting statewide best practices that we can use to identify the practices that most benefit people who are CARE Court respondents? Keris, do you have an answer on that one?

KERIS MYRICK: It's 2025, and I'm still on mute ‑‑ I don't, off the top of my head, as part of the CARE Act Work Group and the Data Ad Hoc Work Group, this is not a requirement as per the Act. There are certain things that need to be or shall be collected, but I don't believe we are looking at collecting data about best practices. It's a great question. And the only thing I would say is that some of the things that I've even talked about today we don't have, but they are in other states working with this exact population. So, it's almost like well, what best practices are we missing [chuckles], which would be another interesting question to ask as well. But I can double‑check into that and, Claudia, get you an answer, if you're going to report back to ‑‑

CLAUDIA CENTER: Sure, we can do that.

KERIS MYRICK: Okay.

CLAUDIA CENTER: And also another thing I think is tricky is that I believe the CARE Court plans are probably using different terminology county‑to‑county and person‑to‑person. So I don't know how, you know ‑‑ I don't know. That's another question. Okay. What happens to individuals who lack immigrant legal status who are in CARE Court? So, I did see this question earlier and I'm gonna share a document from one of our support centers, the Immigrant Legal Resource Center in the chat, and there are protections that California tries to implement for people who are going to court, including CARE Court would be included, to try to protect them from immigration detention or other interference from immigration. You know, I can't say at this time how that's working for CARE Court respondents. I could reach out to ILRC and see if they've seen anything.

The next question is: Do we know in CARE courts are providing clients with translations of the services and the treatment plans? I know that they should be. If they aren't doing that for one of your clients, please do reach out to me or to Kavya and we will try to fix it for your client. I'm not saying we have a magic wand, but the laws say that the courts are supposed to provide language access to participants in state court. We have those citations. They should also be putting things in plain language, like fifth grade English, which they haven't done. So do reach out if you have a client with a particular need and we'll do what we can. Another question is: The psychiatric advanced directive, are they currently enforceable in California? And if not, why not? I don't fully know the answer to this and I'll pass it to Keris in a minute. I do know that there was a bill called AB‑2352 that failed that was about psychiatric advanced directives and that was in the '23‑'24 term for the California Legislature. So, it may be that that's why DRC removed the form it had. We do have, still have, a written advanced healthcare directive that we know is legally enforceable, so we can, you know, use that form and just try to adapt it, and it should be legally enforceable. But Keris, what do you know on this one?

KERIS MYRICK: Oh, it's complex!

CLAUDIA CENTER: Okay, sorry, yeah, I oversimplified, I'm sure.

KERIS MYRICK: Yeah, no worries, no worries. I think particularly that bill also had parts related to being able to use, like, an online database to store your psychiatric advanced directive which then became, wow, how do you keep it safe? Who has access to it? Those type of things. I'm not exactly sure why the form has been taken off of the website, but definitely we can get back to you on that as well. I didn't know it had been taken off, so, yeah...

CLAUDIA CENTER: There's another question: How can we advocate for youth and young adults to access these services? At least for full service partnership, the eligibility criteria are broader for youth and young adults. I forget if it's 18 and younger or 21 and younger, but it's a broader standard for younger people. We haven't fully prepared about youth and young adults for this session because CARE Court is 18 and older. But certainly the services should be designed appropriately for this population. Kavya or Keris, I'll let you all chime in.

KERIS MYRICK: Yeah, CARE Court is 18 and above. And I think advocating for appropriate housing because there had been some discussion about using nursing homes for 18, 19, 21‑years‑old, which might not be the best setting for young people. But, I think anything else, at least that I've talked about relative to wellness recovery action plans, recovery oriented cognitive therapy, peer support, we do have youth peer support and specialization for youth peer support, and also parent of a youth. So that parent peer support. Those are things that definitely could be put into a care plan already.

CLAUDIA CENTER: Our next question is: Do you know of any counties who have been pushing the language in the CARE Act that says if the county elects not to enroll the respondents into FSPs, the court may request the reasons for why not? I haven't heard of anything in particular. I just am reading some tea leaves, I have a feeling the counties are sort of eventually putting people in FSP before it gets that far, but Keris, I would love to hear your intel.

KERIS MYRICK: I have no intel on this as of yet.

CLAUDIA CENTER: Okay. The next question is: FEHA is in conflict with CARE courts on treatment plans that mandate specific housing. I actually am not sure I understand that one. Michelle, did you want to write me an e‑mail on that one?

Um, we have reached the end of our one hour and 15 minutes. Thank you all for being with us. And we will see you again, I'm sure. Oh, and please do reach out if you have any of the problems that we talked about today with a particular respondent and we'll do, DREDF as a support center will try to help you solve your problem. Thank you, everybody!

[End of Transcript]