



March 23, 2022

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

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

RE: Comments and Recommendations Regarding Community Assistance Recovery and Empowerment CARE Court

Dear Governor Newsom and Secretary Ghaly,

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

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

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

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

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

### ***Recommendation #1: Services Should be Voluntary***

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

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

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

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

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

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

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

<sup>4</sup> Szmukler G (2015) Compulsion and "coercion" in mental health care. *World Psychiatry* 14, 259.

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

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

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

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

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<sup>5</sup> See Lee, M.H; Seo, M.K. (2021)

<sup>6</sup> Care Court Frequently Asked Questions, p.3 [https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt\\_FAQ.pdf](https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf)

<sup>7</sup> Maria C. Raven MD, MPH, MSc, Matthew J. Niedzwiecki PhD, Margot Kushel MD, Human Health Research, A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services, September 25, 2020. Available at <https://doi.org/10.1111/1475-6773.13553>

<sup>8</sup> Laura’s Law: Assisted Outpatient Treatment Project Demonstration Project Act of 2002 Report to the Legislature, Department of Health Care Services, May 2021 accessed at:

<https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf>

<sup>9</sup> Alison B. Hamilton, Ines Poza, Donna L. Washington, “Homelessness and Trauma Go Hand-in-Hand”: Pathways to Homelessness among Women Veterans, *Women's Health Issues*, Volume 21, Issue 4, Supplement, 2011, Pages S203-S209, ISSN 1049-3867, <https://doi.org/10.1016/j.whi.2011.04.005>.

<sup>10</sup> Kagawa, R.M.C., Riley, E.D. Gun violence against unhoused and unstably housed women: A cross-sectional study that highlights links to childhood violence. *Inj. Epidemiol.* 8, 52 (2021). <https://doi.org/10.1186/s40621-021-00348-4>

<sup>11</sup> Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime Prevalence of Trauma among Homeless People in Sydney. *Australian & New Zealand Journal of Psychiatry*, 34(6), 963–966. <https://doi.org/10.1080/000486700270>

<sup>12</sup> Rountree, J., Hess, N., Lyke A. Health Conditions Among Unsheltered Adults in the U.S.. California Policy Lab. Policy Brief. (10/2019) p.7 Accessed at: <https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf>

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

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

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

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

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

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

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<sup>13</sup> Mead S. Intentional Peer Support; 2001. [2020-02-28]. Peer Support as a Socio-Political Response to Trauma and Abuse [https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9\\_DbPm5kSST9\\_Q/edit](https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9_DbPm5kSST9_Q/edit)

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

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

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

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

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

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

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

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

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

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

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<sup>17</sup> Welfare and Institutions Code § 8255

<sup>18</sup> Welfare and Institutions Code § 8255 (e) and § 8256 (a)

<sup>19</sup> Davidson, C., et al. (2014) “Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use.” *Psychiatric Services*. 65(11), 65(11): 1318-24

<sup>20</sup> Aidala, A.; McAllister, W; Yomogida, M; and Shubert, V. (2013) *Frequent User Service Enhancement ‘FUSE’ Initiative: New York City FUSE II Evaluation Report*. Columbia University Mailman School of Public Health.

<sup>21</sup> Urban Institute (2021) “Breaking the Homelessness-Jail Cycle with Housing First, accessed at [https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first\\_1.pdf](https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first_1.pdf)

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

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

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

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

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

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

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

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

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<sup>22</sup> California Health Care Foundation, Behavioral Health Integration in Medi-Cal: A Blueprint for California, dated February, 2019. Accessed at: <https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf>

<sup>23</sup> California Health Care Foundation, Mental Health in California: For Too Many Care Not There, dated March 15, 2018.

<sup>24</sup> UCSF, Healthforce Center, California's Current and Future Behavioral Health Workforce, February 12, 2018.

<sup>25</sup> Ibid.

<sup>26</sup> Department of Health Care Services, Report to CMS: Annual Network Certification on Specialty Mental Health Services. 2020

<sup>27</sup> See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at [www.bsa.ca.gov/pdfs/reports/2019-119.pdf](http://www.bsa.ca.gov/pdfs/reports/2019-119.pdf).

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

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

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

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

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

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

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<sup>28</sup> Welfare and Institutions Code § 5500(a)

<sup>29</sup> California Behavioral Health Planning Council, Title 9 County Patients' Rights Advocates, highlighting resource, training, and retaliation issues in county patients' rights programs in California. 10/2017 p. 5

<sup>30</sup> Id. Page 8

<sup>31</sup> Durojaye, E., & Agaba, D. K. (2018). Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. *Health and human rights*, 20(2), 161–168.

<sup>32</sup> Silva, R., Pedroso, M. C., & Zucchi, P. (2014). Ouvidorias públicas de saúde: estudo de caso em ouvidoria municipal de saúde [Ombudsmen in health care: case study of a municipal health ombudsman]. *Revista de saúde pública*, 48(1), 134–141.

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

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

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

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

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

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

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<sup>33</sup> See CARE Court FAQ #8, page 3 [https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt\\_FAQ.pdf](https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf)

<sup>34</sup> See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at [www.bsa.ca.gov/pdfs/reports/2019-119.pdf](http://www.bsa.ca.gov/pdfs/reports/2019-119.pdf).

<sup>35</sup> Ibid. page 1



In community,



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