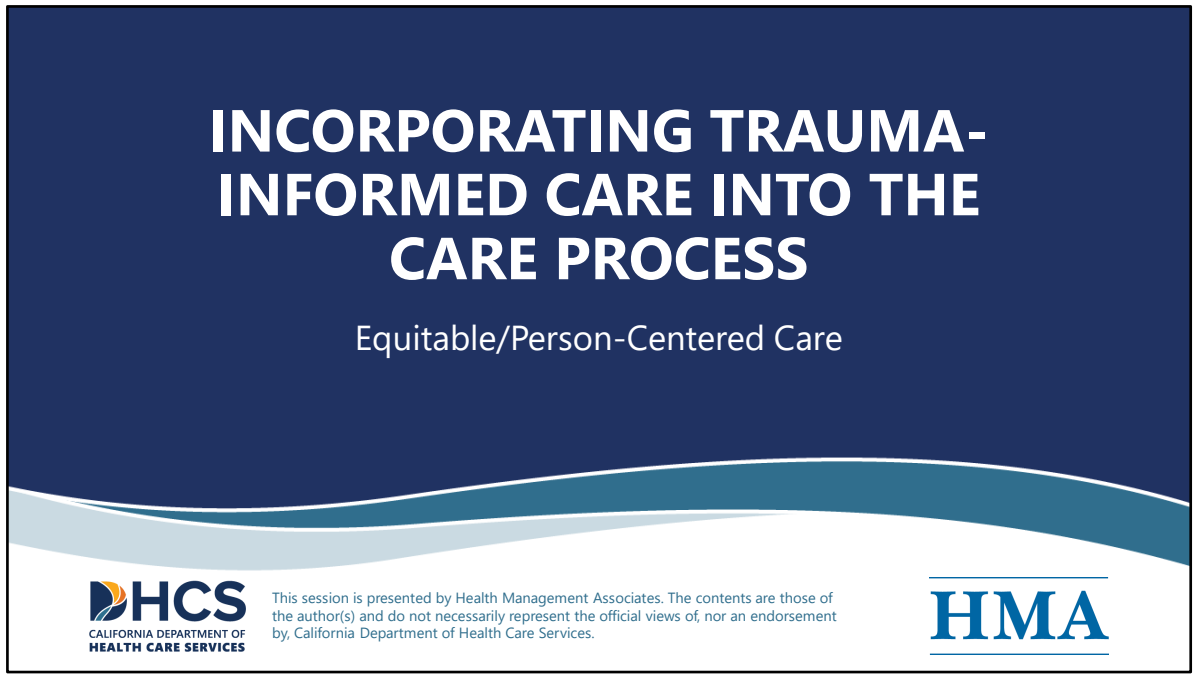

[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Presenters

KAREN LOUISE HILL, PHD, ANP-C, MSN, RN

PRINCIPAL
HEALTH MANAGEMENT ASSOCIATES

DEBORAH ROSE, PSYD

ASSOCIATE PRINCIPAL
HEALTH MANAGEMENT ASSOCIATES

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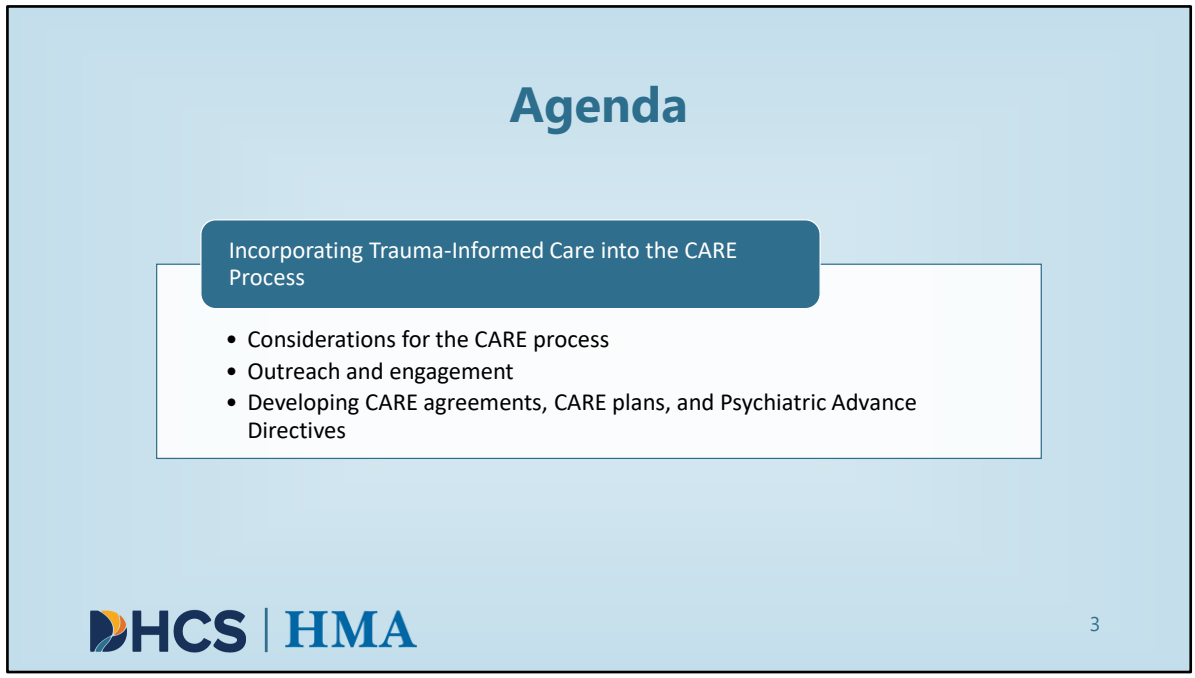
[Slide Image Description: This slide includes images of the presenters of this training on a light blue background.]

Dr. Karen Hill, from Health Management Associates (HMA), is a nurse practitioner with more than 15 years of experience with adverse childhood experiences (ACEs) and trauma-informed care (TIC) training, implementation, and evaluation as it relates to provider operations and billing, design, communications, health literacy, precepting, mentoring, training, TIC, and curriculum development. As a Principal at HMA Karen has worked to help organizations provide TIC and crisis prevention and de-escalation techniques-based training for county employees through an evidence-based, culturally responsive, and collaborative care management model. Prior to HMA Karen worked as an Interim Vice President of Programs at the University of California, San Francisco (UCSF)/Glide Health Services where she focused on patient care and safety, providing evidence-based and patient-centered care, work organization and clinic flow, health promotion activities, and developing interagency relationships and community alliances.

Deborah Rose, PsyD from Health Management Associates, is a licensed clinical psychologist with a history of designing and scaling new initiatives in behavioral health services. She has extensive experience working with social service agencies,

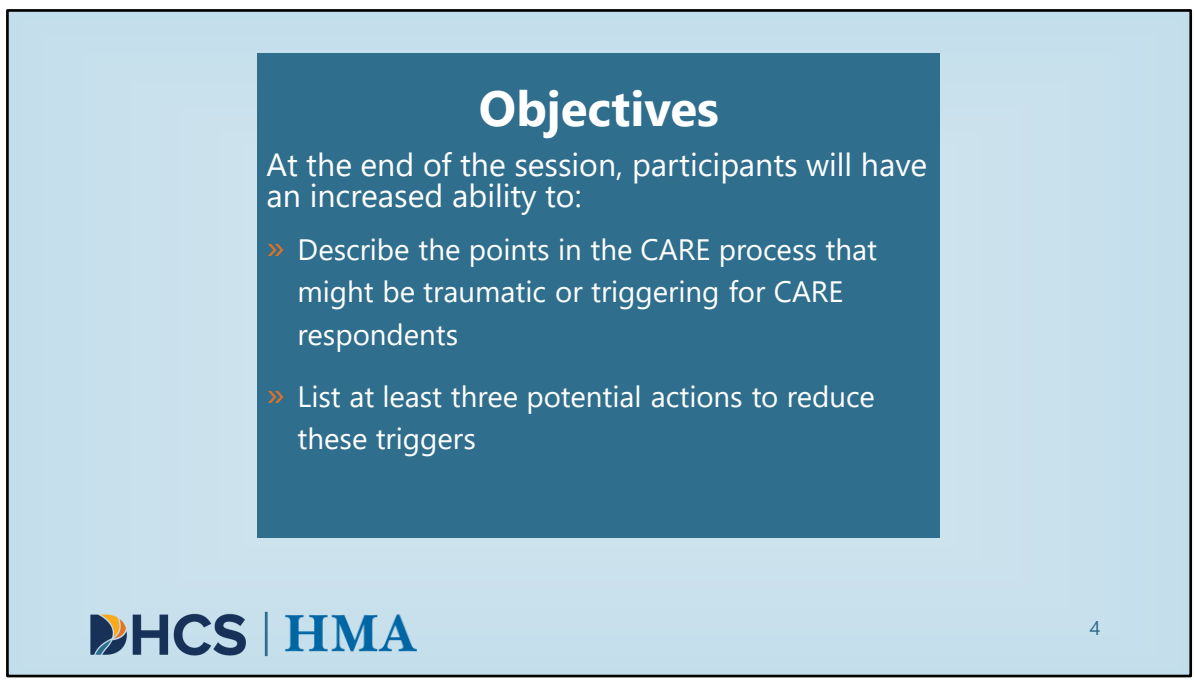
behavioral health centers, care coordination, supported housing, and services for unhoused populations. Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in community-based agencies and carceral settings. Earlier in her career, Dr. Rose oversaw Kendra's Law, an Assisted Outpatient Treatment (AOT) program in NYC. She was also Deputy Director of Behavioral Health across the Rikers Island jail system. She has strived to improve access to and delivery of person-centered services for adults living with mental illness, substance use disorders, and cooccurring conditions.



[Slide Image Description: This slide shows the major sections of this training on a light blue background.]

The agenda includes a section on Incorporating Trauma-Informed Care into the CARE Process with specific information about:

- Considerations for the CARE process
- Outreach and engagement
- Developing CARE agreements, CARE plans, and Psychiatric Advance Directives



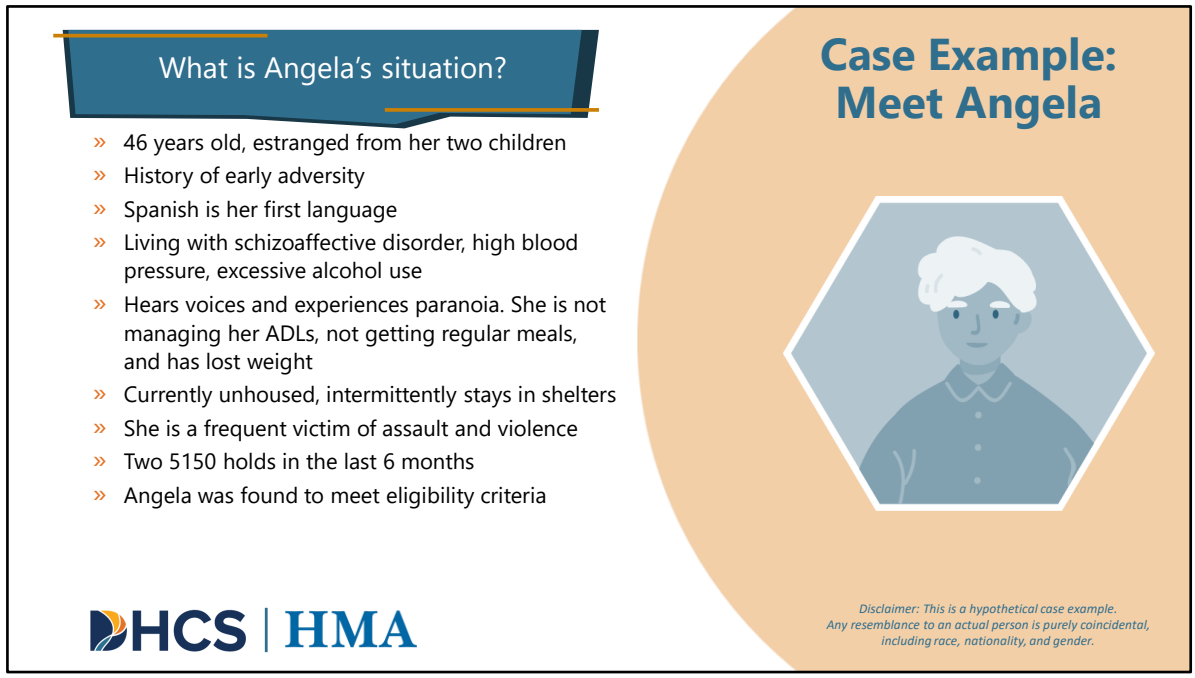
[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Describe the points in the CARE process that might be traumatic or triggering for CARE respondents
- List at least three potential actions to reduce these triggers

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In the last presentation we looked at organizational considerations for trauma-informed care. In this training we will look at incorporating trauma-informed care into the CARE process.



[Slide Image Description: This slide shows an icon image of an individual representing Angela with a description of Angela's current situation.]

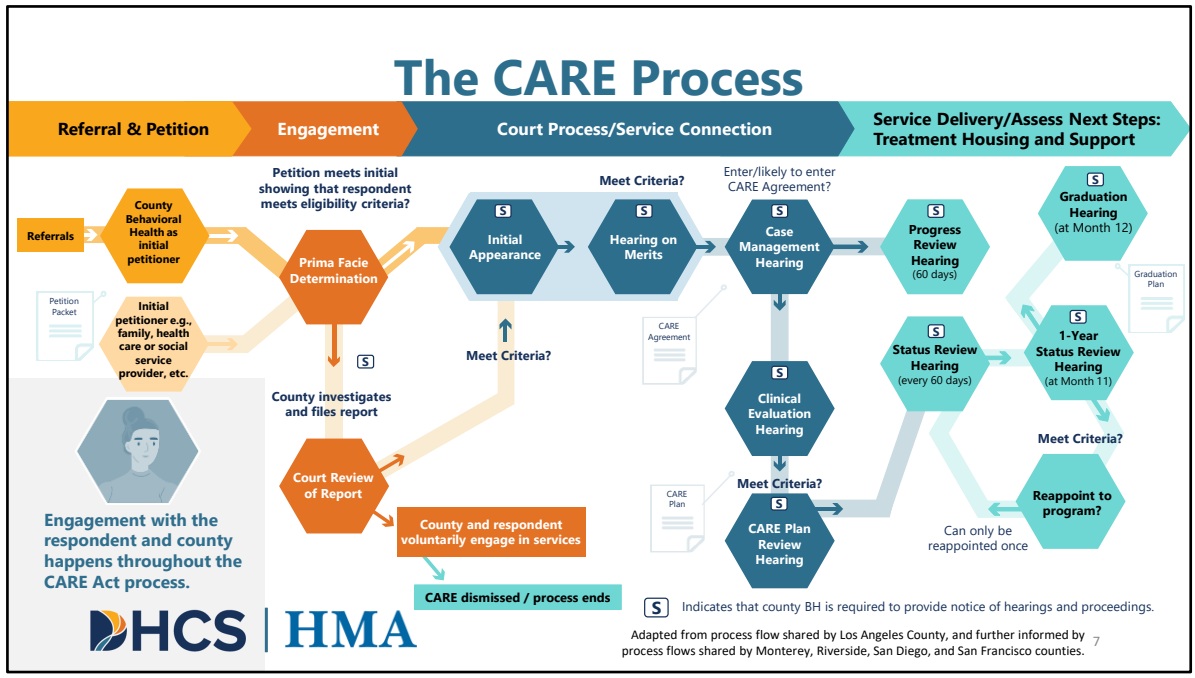
Before we jump into the content, we are going to re-introduce Angela. Angela is a fictional case for us to consider as we discuss TIC and the CARE Act. She is not real, but her situation may sound familiar to you. We are going to go over incorporating trauma-informed care into the CARE process. We will revisit this case example throughout.

What is Angela's situation?

- 46 yrs. old. She has 17- & 22-year-old children. They are not on good terms, and they lived with extended family. Perhaps due the Angela's mental health condition and living situation or partner.
- History of early adversity (absent father, domestic violence in the home)
- Spanish is her first language
- Has schizoaffective disorder, type 2 diabetes, high blood pressure, and smokes cigarettes

- Currently hearing voices and experiencing paranoia and is not currently connected with mental health or medical treatment
- She is in an abusive relationship and has experienced numerous assaults
- Evicted from low-income housing related to her symptoms; she is unhoused and intermittently stays in shelters (where she is now)
- Hospitalized on a 5150 in the past 4 months
    - A "5150" refers to a 72-hour involuntary psychiatric hospitalization when someone is evaluated to be gravely disabled or a danger to themselves/others
- Angela was found to meet eligibility criteria.
- Keep in mind that Angela is more than her adversity, however, and she has many strengths. Angela comes from a rich cultural tradition, and she values her language (Spanish), though at times she feels that it's disrespected by the dominant English-speaking culture. In the past, she has enjoyed preparing traditional foods for holidays and special occasions. She also has enjoyed her religious community, and she has attended Catholic mass off and on her entire life.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.



[Slide Image Description: This slide shows a process flow with an example of pathways through the CARE Act process.]

Now let's begin to identify inflection points in the CARE process where the trauma-informed approach is critical in preventing additional trauma or triggers during this process. These inflection points primarily include the different CARE hearings, but there are also other key elements of the process that a trauma-informed approach is important, starting with the outreach and engagement efforts by the BH agencies. The trauma-informed approach is also critical with regards to the activities of developing CARE agreements, CARE plans, and graduation plans, in that the goal is to have the respondent feel comfortable enough to participate in all of these activities, and be able to voice their preferences, priorities and goals.

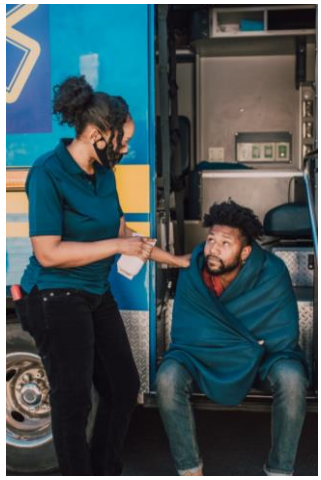
By recognizing which parts of the CARE process that may be traumatic or triggering for CARE respondents, you or your organization may be better prepared to support those individuals, like Angela.

Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH)

agency.

2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a Prima Facie Determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.
    - If they do not voluntarily engage in services and the county BH report finds that the respondent meets the criteria, they will progress to the initial hearing.
4. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the Initial Appearance).
5. If the respondent still meets the criteria, then there will be a Case Management Hearing.
    - If it is determined in this hearing that a CARE agreement is likely to be reached, then there will be at least one progress review hearing (but potentially there could be more).
6. If it is determined at the Case Management Hearing that a CARE agreement is not likely to be reached, the court will order a Clinical Evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
7. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
8. There will then be a status review hearing at least every 60 days.
9. At month 11, there will be a one-year status review hearing to determine next steps:
    - The respondent will graduate (and have a graduation hearing at month 12).
    - The respondent will be reappointed to the program, which can only happen once.



Outreach & Engagement during the CARE Process

- How you approach the CARE respondent and build trust is key.
- Be thoughtful and patient in making that first connection, so as not to re-traumatize the individual.

Potential Triggers	Potential Actions
Unknown people Formally dressed individuals Hospitals Health care personnel Police Certain neighborhoods Authority figures People, places, sounds	✓ Learn as much as possible about the CARE respondent ✓ Transparency in communication ✓ Involve in treatment options ✓ Explain pros and cons ✓ Seek to understand ✓ Withhold judgement ✓ Intentionally rebalance power

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[Slide Image Description: This slide shows an image of an individual putting their hand on another seated individual's shoulder. Ways to outreach and engage during the CARE process are given along with a blue-colored table that lists potential triggers for and potential actions to take when a respondent is triggered.]

When doing outreach and engagement with individuals in the CARE process, keep in mind how you can use a TIC approach. Keep in mind:

- How you approach the CARE respondent and build trust is key.
- Be thoughtful and patient in making that first connection, so as not to re-traumatize the individual.

Consider what triggers they may have:

- Unknown people
- Formally dressed individuals
- Hospitals
- Health care personnel
- Police
- Certain neighborhoods
- Authority figures

- People, places, sounds

Consider potential actions you could take to reduce these triggers:

- Learn as much possible about the CARE respondent
- Transparency in communication
- Involve in treatment options
- Explain pros and cons
- Seek to understand
- Withhold judgement
- Intentionally rebalance power, such as intentionally giving them choices and perhaps having them sit in your seat behind the desk or other gestures that communicates to them that they can have an active say and power.

What do you think we should keep in mind in engaging with Angela?

Court Hearings

Hearings and court appearances may be traumatizing or triggering for CARE respondents.

Potential Triggers	Potential Actions
Even though it's a civil court, may feel punitive, and reminiscent of a criminal proceeding	✓ Clarify that this is civil, not criminal ✓ Involve in treatment options ✓ Seek to understand ✓ Withhold judgement
Formal settings with authority figures (e.g., Judge, bailiff, lawyers) can be stressful and intimidating	✓ BH agency, counsel and judge provides the context to clarify the purpose of the process ✓ Balance the "Black Robe Effect" with compassion and collaboration

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[Slide Image Description: This slide shows an image of the CARE flow process. A blue-colored table lists potential triggers for and potential actions to take when a respondent is triggered in court hearings and appearances.]

Here we have highlighted the different potential hearings that a CARE respondent may or may not experience throughout their journey in CARE.

Hearings and court appearances may be traumatizing or triggering for CARE respondents for the following reasons:

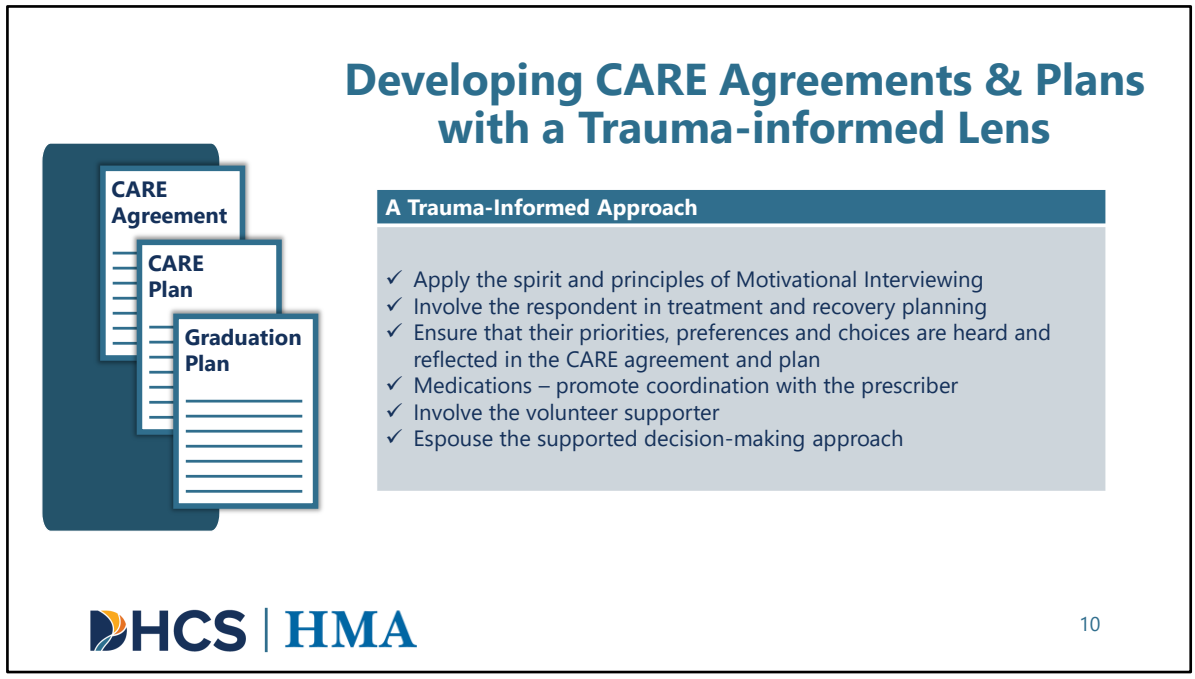
- The individual may associate this court with a criminal proceeding.
- With CARE court, we need to remind these individuals that they are not here because they have done something wrong; and we should also remind them that this process is not associated at all with the criminal courts/system.
- We remind them that they are here because they have been identified as persons who may benefit from additional services and resources, including housing.

These formal court settings with a judge and lawyers can be stressful and intimidating to the respondent.

- It's important that all the parties – the BH agency, counsel and judge - provide the

context to clarify the purpose of the process

- There is this concept that is called the “black robe effect.” This refers to the impact on the respondent when a judge is providing direction to the individual, and the fact that this may increase the likelihood of the respondent’s adherence to the recommendations.
- This concept is well-understood in the collaborative courts and has been leveraged to promote adherence to the outpatient court order.
- It is important that in addition to leveraging this “black robe effect” the court also approaches the respondent with a collaborative approach, that ensures the respondent is asked what his or her preferences are, and their voice is heard in the process



[Slide Image Description: This slide shows a graphic of with several papers, showing a CARE agreement, CARE plan, and graduation plan.]

- Think about the process of creating a CARE agreement, CARE plan, or a graduation plan. Consider how you could take a trauma-informed approach:
    - Individuals experiencing trauma may have negative connotations associated with the development of these agreements and plans, especially if they had not been asked to be a part of the development of these plans – rather, were "told" what a treatment plan would include.
    - The trauma-informed approach is about working to include the client/respondent in the CARE planning process as much as possible.
- Approaching a CARE agreement and plan with a trauma-informed lens would look like:
    - **Applying the spirit and principles of Motivational Interviewing**, which is a nonconfrontational approach to build rapport based in active and reflective listening. Consider asking open-ended questions and withholding judgement.
    - **Involving the respondent in treatment and recovery planning.** This can potentially be empowering to a respondent, in developing a plan to providing services and supports to support their self-determination and goals.

- **Ensuring their priorities, preferences, and choices are heard.** It is about including the client's voice in the treatment planning work, reflecting their preferences, their priorities, and their goals.
- **Promote coordination with the prescriber.** Medications are a key component of the CARE agreement and plan. This is another area to ensure that there is coordination with the prescriber/psychiatrist related to ensuring that the client/respondent's preferences are heard, and they are able to ask questions with the prescriber.
- **Involve the volunteer supporters**. If the client/respondent has a volunteer supporter, including this person in the development of a CARE agreement/plan supports a trauma-informed approach, in that this person's role is also to ensure that the individual's preferences/choices are heard.
- **Espouse the supported decisionmaking (SDM) approach.** The supporters have been offered trainings in supported decision-making – which is an approach that promotes the voice of the client/respondent, their self-determination, autonomy, and choice. Along with encouraging the supporter to use this approach, you should also consider taking this approach when working with the respondent.

Psychiatric Advance Directive (PAD) with a Trauma Informed Lens

A Trauma-informed Approach

Working with the client/respondent to
- ✓ Ensure their treatment preferences are reflected in their PAD
- ✓ Incorporate their "triggers" to bring awareness to providers and first responders
- ✓ List activities that have worked to reduce stress levels
- ✓ Note preferred crisis and psychosocial approaches
- ✓ Incorporate any personal needs (e.g., pets, finances)
- ✓ Plan to use several sessions, proceed patiently and revisit the PAD regularly
- ✓ Help the client with other Advance Health Directive forms, including identifying a Power of Attorney

For more information, see the Psychiatric Advance Directives training on the CARE Act Resource Center and the PADs MHSA Multi-county Innovations Project.

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[Slide Image Description: This slides shows a paper icon representing a psychiatric advance directive (PAD) with a blue-colored table lists a trauma-informed approach for PADs.]

The California Multi-county Innovations Project defines a PAD as:
- A self-directed legal document that details a person's specific instructions or preferences regarding future mental health treatment.
- It is used to plan for the possibility that someone may lose the capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.
- It allows a person in a mental health crisis to retain their decision-making capacity by choosing trusted agents to help advocate for their choices.

Think about the process of creating a PAD with a trauma-informed lens.

Again, the PAD is meant to be a tool to ensure that the client or respondent's preferences for treatment are known to the individual's providers, as well as others who may come into contact with the respondent during a crisis. This tool is meant to be used specifically during periods when the client or respondent is in an acute phase of their illness and may not have capacity to express these preferences but can also be

used to inform person-centered care outside of a crisis.

So, as the PAD is a trauma-informed tool that relays critical information to help prevent escalation during a crisis, the provider can assist the client or respondent in noting elements that promote their needs and preferences, and can prevent further escalation during a crisis

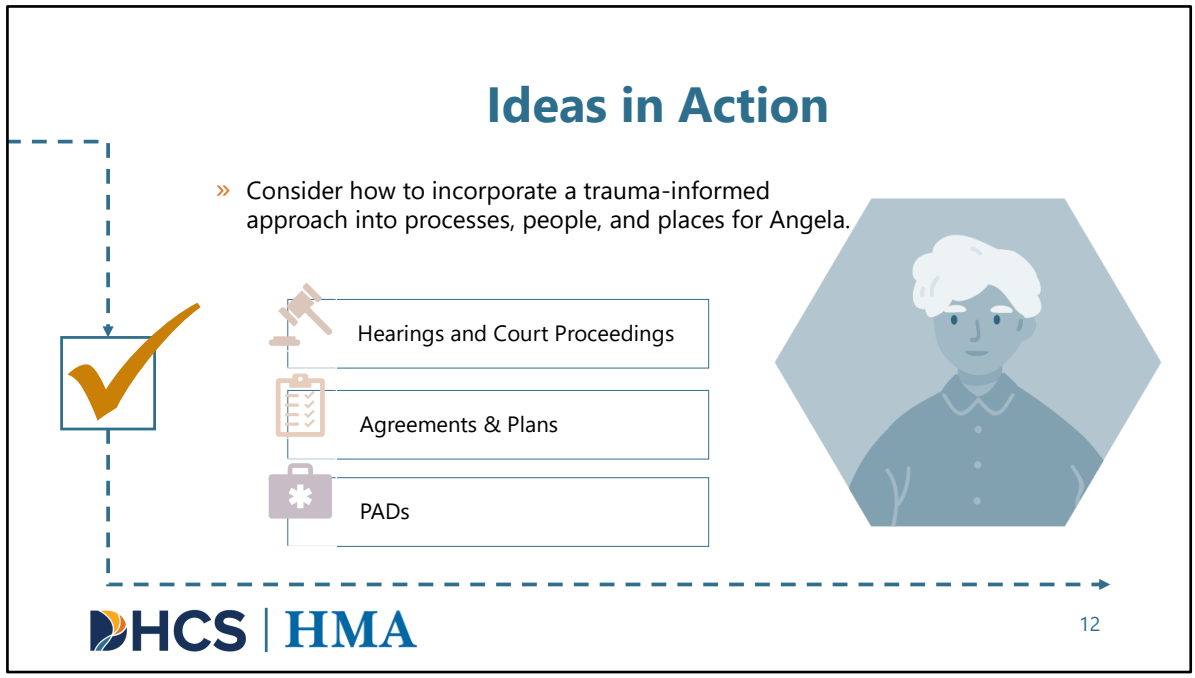
This includes having the client note their "triggers," their preferred "approaches" during a crisis (e.g. stance, eye contact), activities that have helped in the past to reduce stress, and their overall preferences regarding treatment and psychosocial approaches.

Additional trauma-informed tips are to proceed patiently when you are working with the client to develop the PAD. This can be completed over time, and should also be revisited, especially as the client may want to update any preferences or approaches that are helpful to them. In addition to helping with the PAD, this is also an opportunity to help them with Advance Health Directive forms, including identifying a POA.

The PAD is, overall, a tool to promote self-determination and choice in the individual's care, and again, can be used by providers to inform their overall treatment approach, even outside of a crisis.

Consider how you might introduce Angela to a PAD. How will this work with her CARE plan? Angela may not want to engage in a PAD at the time, but you may consider revisiting it later on.

For more information, see the Psychiatric Advance Directives training on the CARE Act Resource Center and the PADs MHSA Multi-county Innovations Project.

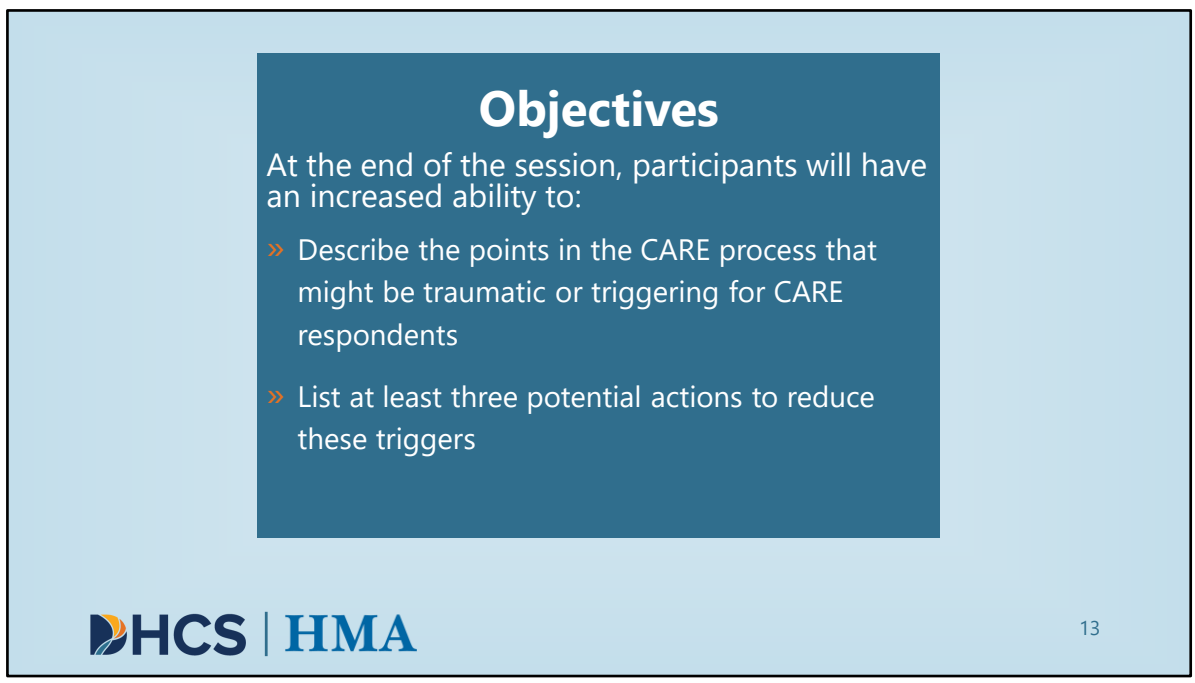


[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Consider how to incorporate a trauma-informed approach into processes, people, and places for Angela.

- Angela has been evicted and any type of perceived legal status may trigger her.
- English is not her 1st language, and she may be concerned that she won't understand.
- Authority is likely to intimidate her. She also don't know whether she is also contending with historical trauma. How she came the US and what she endured to get here.
- Using the pillars of trauma-informed care will be important: trust and collaboration.

How can we center Angela's experience in how we approach her?



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Describe the points in the CARE process that might be traumatic or triggering for CARE respondents
- List at least three potential actions to reduce these triggers

Next Steps

- Visit CARE-Act.org for resources (including recordings of past trainings) and to submit questions/TA requests.
- Review additional topics in this training series:
  - Part 1: Trauma-Informed Care & Organizational Considerations
  - Part 3: Workforce & Sustainability with Trauma-Informed Care

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[Slide Image Description: This slide shows bullets with next steps. It contains decorative arrows.]

Please let us know how we can best support your teams. Contact info@CARE-Act.org with questions, join the communications listserv, and submit requests and feedback for CARE Act TTA. Please also visit the CARE Act Resource Center website for training decks and recordings, which will be added two weeks after each training.

[Slide Image Description: This slide shows the CARE-act website and the email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing the CARE Act. The website is **CARE-Act.org** and our email address is **info@CARE-Act.org.**

[Slide Image Description: The slides shows a list of resources relevant to the presentation content.]

Resources include:

- Psychiatric Advance Directives training and materials
- Psychiatric Advance Directives Innovation Project in California website