

CARE Act Training & Technical Assistance

**CAPACITY & INFORMED
CONSENT IN THE CARE PROCESS**

Serious Mental Illness & Evidence-Based Care



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.



[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.]

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Agenda

Introduction to Capacity and Consent

- Overview of capacity and consent, particularly in the context of schizophrenia spectrum and other psychotic disorders.
- Description of grave disability and decisional capacity.
- Considerations for mitigating bias.

Capacity and Informed Consent in the CARE Process

- Overview of CARE Act references to capacity and consent.
- Considerations for assessing capacity.
- CARE Act roles and supportive measures to encourage voluntary participation throughout the CARE process.

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

The agenda:

- Introduction to Capacity and Consent:
 - Overview of capacity and consent, particularly in the context of schizophrenia spectrum and other psychotic disorders.
 - Description of grave disability and decisional capacity.
 - Considerations for mitigating bias.
- Capacity and Informed Consent in the CARE Process:
 - Overview of CARE Act references to capacity and consent.
 - Considerations for assessing capacity.
 - CARE Act roles and supportive measures to encourage voluntary participation throughout the CARE process.

Objectives

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

- › Describe the concepts of capacity and informed consent in the context of the CARE Act.
- › Define the factors that ensure informed consent.
- › List strategies to support the respondent to give informed consent.

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

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Presenters



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J. RICHARD COUZENS

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

Today's training will be led by Dari Pogach, Marc Avery, and Judge Richard Couzens.

Dari Pogach, from Health Management Associates, has more than 15 years of experience working with clients, communities, nonprofit organizations, policy makers, and state and national government leaders. Dari has subject matter expertise in supported decision-making as a legal theory and its practical application. She has represented clients in completing supported decision-making agreements; written scholarly articles about supported decision-making; and conducted numerous trainings for national audiences. As a senior official with the District of Columbia's Department of Aging and Community Living, Dari led the agency's adult protective services, case management, and nursing home transition teams. At the American Bar Association's Commission on Law and Aging, Dari developed nationally lauded tools and programs for attorneys and other professionals; facilitated stakeholder engagement across the country; and led multimillion dollar projects dedicated to adult guardianship reform and decision-making supports. She has represented clients with psychiatric disabilities in a variety of advocacy matters.

Marc Avery, from Health Management Associates, is a board-certified psychiatrist and a recognized national leader in the subject of person-centered, integrated psychiatric care for high-needs and safety net patients. He has had the privilege and responsibility of providing (and overseeing) behavioral health care services to many hundreds of individuals with schizophrenia spectrum and other psychotic disorders including working with families, supporters, peer service providers, and other persons who assist in the care and treatment of persons with schizophrenia and related conditions.

J. Richard Couzens is currently a consultant to the Criminal Justice Services Office of the Judicial Council of California (JC). **He previously served in the Placer County Superior Court for 25 years before serving by assignment of the Chief Justice as the Assigned Justice Program for nearly 20 years.** Judge Couzens is a former faculty member with the California Judicial College and has co-authored several books around California law and procedures. In 2008, Judge Couzens was named Jurist of the Year by JC.



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

This section will cover an introduction to capacity and consent.

Context for Discussion

» **Focus is on CARE:**

- Versus Lanterman-Petris-Short (LPS) conservatorship or other forms of legal decision-making.

» **Specifically in CARE, discussion of:**

- Decisional capacity to give informed consent to psychotropic medications.
- Consent to participate in the CARE Act process.

» **Additional level setting:**

- Capacity and informed consent are fluid, interdependent concepts.
- Acknowledge the challenges in providing clear-cut definitions that resonate in real-world situations.
- Every individual is presumed to have capacity to give consent.

[Slide Image Description: This slide outlines the context for the training.]

Today's discussion is around the concepts of capacity, consent, and informed consent as they relate to the CARE Act, versus their relation to the Lanterman-Petris-Short (LPS) Act, LPS proceedings (including LPS conservatorship), or other forms of legal decision-making.

We will start with some definitions then move to a discussion of how these concepts apply in the CARE Act. Specifically, we will discuss the concepts of decisional capacity to give informed consent to psychotropic medications. We will also be discussing the notion of consent as it relates to the respondent's participation in CARE – calling out that this is a different concept from *informed* consent.

Additionally, we will be speaking to the fact that capacity is fluid, meaning it can fluctuate over time and based on the decision being made. In turn, capacity and informed consent are interdependent concepts.

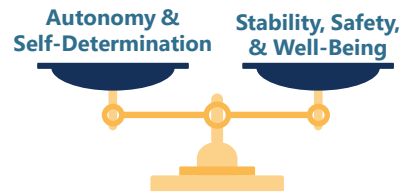
Also, as we provide definitions to you today, we want to acknowledge the challenges in applying clear-cut definitions to real-world situations, knowing that these definitions

are really meant to inform these different scenarios, and the challenge of how one might proceed in assessing for capacity and informed consent, and ultimately making the legal determination, as it applies in CARE.

Every individual is presumed to have capacity to give consent, which we will discuss more in a moment.

Keeping the Balance

- » The goals of autonomy/self-determination and well-being do not have to be mutually exclusive.
- » The CARE Act should work along with the respondent to support their values and preferences and reduce barriers to treatment and services.
- » It also requires a protocol for assessing capacity to provide informed consent, specifically related to medications, to support the goal of stability and well-being.
- » Overall, consistent, compassionate services can support both goals.



Promoting autonomy and self-determination while also protecting well-being.

[Slide Image Description: This slide describes balancing an individual's autonomy and intervention with an image of a balance scale and a blue callout box.]

In this training, we will be discussing concepts related to decisional capacity to provide informed consent and how those ideas intersect with the CARE Act process.

As we talk about these concepts, keep in mind that in every case, we want to get the right balance between honoring someone's ability to exercise autonomy and self-determination and intervening to ensure stability, safety, and well-being of a vulnerable population.

These goals do not have to be mutually exclusive. Capacity to make an informed decision is not always clear-cut, and we can and should work along with the respondent to support their stated values and preferences whenever possible. Use of advance directives can also help.

The CARE process provides access to the treatments and services that eligible individuals need most. It also requires a specific protocol for assessing for decisional capacity to provide informed consent at a key juncture, so that medication can be

prescribed and included in a CARE plan.

The overall idea is that consistent, compassionate services can support both goals of maximizing autonomy and protecting well-being of those with schizophrenia spectrum or other psychotic disorders.

Overview of Capacity

What is capacity?

- » A person's ability to...
 - Understand the nature and consequences of a decision.
 - Make and communicate a decision.
 - Understand its significant benefits, risks, and alternatives.

Who determines capacity?

- » Assessed by health care providers/prescribers or psychologists.
- » Can also be a determination made by a judge in a legal setting.

How does it change over time?

- » Can change over time due to factors like illness, medication, or temporary conditions. It can improve or deteriorate, necessitating re-evaluation.



Keep in mind that "capacity" and "competency" are not interchangeable terms.

For a definition of "capacity," see [California Probate Code \(Prob. Code\) section 4609](#).

[Slide Image Description: This slide summarizes "capacity" and shows an image of a woman filling out paperwork.]

"Capacity" isn't specifically defined in the CARE Act, but the California Probate Code defines it as:

"'Capacity' means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives." California Probate Code (Prob. Code) section 4609

What is capacity?

A person's ability to...

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- Make and communicate a decision.
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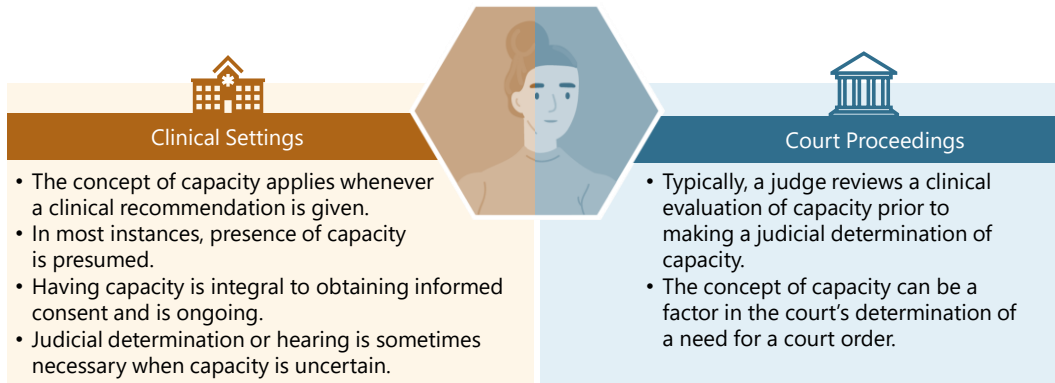
How does it change over time?

- Capacity can change over time due to factors like illness, medication, or temporary conditions. It can improve or deteriorate, necessitating re-evaluation.

Keep in mind that capacity and competency are not interchangeable terms. Capacity is a term used in clinical environments related to a clinician's assessment of an individual's ability to make specific medical decisions, and this decision-making ability can vary over time and context. Capacity can also be used in the legal context but still based on a clinical assessment that is submitted to a judge who then makes a determination of capacity. Competency is typically a term used in the legal system and in California is primarily used in relation to criminal proceedings. Just because someone may not have capacity – which is a more fluid condition – does not mean they are not competent.

Every individual is presumed to have capacity to give consent to treatment, regardless of diagnosis, unless they are evaluated, and it is determined that they cannot understand the information necessary to make a decision and/or cannot communicate their decision.

Capacity in Clinical Settings & Court Proceedings



[Slide Image Description: This slide describes capacity in a clinical setting in an orange textbox and court proceedings in a blue textbox.]

Capacity—or the ability to understand and make a decision—is considered in both clinical settings and in court proceedings.

In clinical settings:

- The concept of capacity applies whenever a clinical recommendation is given.
- In most instances, presence of capacity is presumed.
- Having capacity is integral to obtaining informed consent and is ongoing.
- Judicial determination or hearing is sometimes necessary when capacity is uncertain.

In court proceedings:

- Typically, a judge reviews a clinical evaluation of capacity prior to making a judicial determination of capacity.
- The concept of capacity can be a factor in the court's determination of a need for a court order.
- The court has a very specific role in the proceedings when capacity becomes an

issue. The court usually becomes involved whenever someone on the behavioral health team wants the respondent to do something – usually take a particular medication – but two things are evident: (1) the respondent refuses the course of treatment, and (2) it appears the respondent lacks sufficient understanding of the treatment to make an informed decision on whether to participate in the treatment.

- To require the respondent to pursue the course of treatment over their objections, it takes more than a clinical assessment to determine that the respondent is unable to make an informed decision – it also requires the court to determine whether the respondent lacks the capacity to make the decision.
- The court makes that determination with the benefit of the clinical evaluation and other evidence submitted by the parties.
- Having capacity means the ability to understand the nature and consequences of the treatment; make and communicate a decision; and weigh the risks, benefits, and alternatives.
- Capacity normally is presumed unless there is “clear and convincing evidence” to the contrary – which is the second highest burden of proof we have in the legal system. The judge must be very confident in the correctness of the decision. The bar is set very high because the court is considering taking away a valuable personal right of the person – the right to self-determination on treatment. If the court finds the respondent lacks capacity to make the necessary medical decision, the court is then empowered to order the treatment over the respondent’s objection.
- Having the court involved at this level helps ensure that the respondent and all the parties have a proper level of due process and an opportunity to be heard about their concerns.



Whereas **“consent”** refers generally to agreeing to participate, **“informed consent”** refers to a deliberate process to ensure someone understands and agrees to the treatment.

What is Informed Consent?

- » “Informed consent” refers to the legal and ethical requirement to obtain someone’s agreement to treatment recommendations after providing them with adequate information about the nature, benefits, risks, and alternatives of the proposed treatment.
- » Elements include:
 - Disclosure
 - Comprehension
 - Voluntariness
 - Capacity
 - Documentation

For the definition of “informed consent” outlined in the LPS Act, see [California Welfare and Institutions Code \(W&I Code\) section 5326.2](#). For more information on obtaining informed consent, see [Informed Consent Process: A Step Further Towards Making It Meaningful](#).

[Slide Image Description: This slide summarizes “informed consent” and shows an image of a man shaking hands with another person.]

“Consent” is the act of agreeing or giving permission for something to happen. Consent means that an individual is choosing to participate, and it does not require an assessment of capacity. With regards to the concept of consent in relation to the CARE Act, we are referring to the respondent exercising their choice to voluntarily participate and engage in the CARE process, regardless of their capacity. Consent is important to individuals’ self-determination and comfort with a procedure or medication.

“*Informed consent*” refers to a process that ensures a patient is fully educated about and understands the implications of a medical treatment before agreeing to it.

Informed consent in California law refers to the legal and ethical requirement for health care providers to obtain someone’s agreement to a treatment after providing them with adequate information about the nature, benefits, risks, and alternatives of the proposed treatment. It also requires that the individual understands this information. This principle ensures that individuals can make knowledgeable decisions about their health care.

Key elements of informed consent in California include:

- **Disclosure:** Health care providers must provide individuals with clear, comprehensive information about:
 - The diagnosis (if known).
 - The nature and purpose of the proposed treatment or procedure.
 - The risks and benefits of the treatment or procedure.
 - The risks and benefits of any alternative treatments or procedures, including no treatment.
 - The likelihood of success and potential complications.
- **Comprehension:** The individual must be able to understand the information provided. This means the explanation should be given in layperson terms, and consideration should be given to the patient's language, literacy level, and cognitive ability.
- **Voluntariness:** The individual's decision must be made voluntarily, without coercion or undue influence from health care providers or others.
- **Capacity:** As we just discussed, capacity is a person's ability to understand the nature and consequences of a decision; make and communicate a decision; and understand its significant benefits, risks, and alternatives.
- **Documentation:** While informed consent is primarily a process of communication, it is often documented through a signed consent form, which serves as evidence that the patient has been informed and has agreed to the procedure.

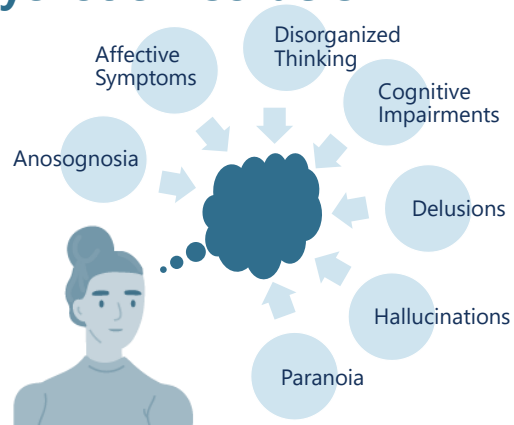
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For more information on obtaining informed consent, [see Informed consent process: A step further towards making it meaningful!](#)

Capacity, Informed Consent, and Schizophrenia Spectrum & Other Psychotic Disorders

Why is capacity and consent important in the context of schizophrenia spectrum and other psychotic disorders?

Symptoms of untreated schizophrenia spectrum and other psychotic disorders can impact people's decisional capacity to provide informed consent.



Concept adapted from the Los Angeles County Department of Mental Health and UCLA Wellbeing for LA Learning Center Training, found at [Strategies for Assessment and Engagement of Homeless Individuals with Psychosis](#).

[Slide Image Description: This slide shows a blue text box featuring a question and answer about capacity and consent in the context of schizophrenia spectrum and other psychotic disorders. Additionally, there is a graphic of an icon individual with a thought bubble listing symptoms of schizophrenia spectrum and other psychotic disorders.]

Decisional capacity and informed consent are important topics for all mental and physical health. But why are these concepts especially important for those with schizophrenia spectrum and other psychotic disorders? It is because the symptoms of schizophrenia spectrum and other psychotic disorders can particularly affect a person's abilities around capacity and informed consent.

This slide depicts features that can affect a person's decisional capacity to provide informed consent in different ways.

- **Anosognosia** means that someone lacks insight and/or awareness that they have a mental illness. This can impact their ability to understand the necessity of treatment and the implications of their choices, thereby affecting their capacity to provide informed consent.
- **Affective symptoms (some of which are sometimes referred to as "negative"**

symptoms of schizophrenia) such as blunted affect, lack of motivation, and social withdrawal can affect an individual's engagement in the decision-making process. These symptoms might lead to passivity or an apparent lack of interest in making decisions, which can be misinterpreted as consent or assent.

- **Disorganized thinking and cognitive impairments (such as impaired memory, attention, and executive function)** can impair a person's ability to engage in linear or reasoned thinking needed to process information correctly. It can also make it difficult to recall important details and process complex information.
- **Delusions, hallucinations, and paranoia** can all impair a person's ability to focus on the correct and relevant information needed to make an informed decision. These symptoms can cause an individual to have false beliefs about their condition, the proposed treatment, and the consequences of their decisions. For example, a person might refuse treatment because they believe it is part of a conspiracy against them.

Familiarity with the symptoms that we have just covered can be especially helpful when assessing an individual's decisional capacity and should certainly inform the clinician's approach with the individual during the assessment.

Concept adapted from the Los Angeles County Department of Mental Health and UCLA Wellbeing for LA Learning Center Training, found at [Strategies for Assessment and Engagement of Homeless Individuals with Psychosis](#).

Grave Disability and Decisional Capacity

» **“Grave disability” and “lack of capacity” are not synonymous terms.**

- An individual may be civilly committed under grave disability criteria under the LPS Act.
- Under LPS, the Riese Hearing is necessary if the individual’s capacity to consent is an issue, even if the person is detained because of grave disability.

“Grave disability is not a measure we operate under for capacity...one does not determine the other.”

– Judge Richard Couzens

» **Grave Disability and the CARE Act**

- Mentioned specific to eligibility criteria only, that services and supports are needed to prevent the individual’s deterioration that may result in them becoming *gravely disabled*.
- This highlights CARE’s intention to divert someone from further deterioration or decompensation that may impact their decision-making.

Sources: [DHCS – Rights for Individuals in Mental Health Facilities](#); [CARE Act Eligibility Criteria](#); [Senate Bill \(SB\) 43: Behavioral Health \(Digital Democracy.CalMatters\)](#)

[Slide Image Description: This slide details the difference between grave disability and capacity with a description of grave disability in the CARE Act. Additionally, a blue box is shown with a quote from Judge Richard Couzens.]

Behavioral health proceedings such as the CARE Act potentially involve the intersection of three terms: grave disability, capacity, and competency. Each of these terms are words of art in the law and are not interchangeable. While each can inform and be relevant to the others, a person can meet one definition without meeting the others—the finding of one does not mean the others exist. For example, a person can be gravely disabled but not lack capacity to make medical decisions. Each has their own standard and legal consequence.

As we continue to talk about the concept of capacity, we would like to touch on the topic of grave disability, which is often tied to capacity in discussions regarding civil commitment law. As noted, we want to dispel the misconception that grave disability is synonymous with lack of capacity. Simply put, grave disability is not a measure the court uses when determining capacity. One does not determine the other, and although capacity and grave disability are often used interchangeably, they are different terms.

So how are the ideas of grave disability and capacity referenced together in California? When an individual is civilly committed under grave disability criteria under the Lanterman-Petris-Short Act (LPS Act), the individual may undergo a capacity evaluation specific to medications. This process in LPS is referred to as a “Riese” hearing, wherein an individual is determined whether to have capacity to provide informed consent with regards to medications, even if the person is detained because of grave disability. Shortly, we will talk about a similar capacity determination regarding medications under CARE Act.

In relation to CARE Act and where grave disability is referenced, it is solely mentioned under the eligibility criteria and speaks to the risk of becoming gravely disabled without the necessary services and supports. This highlights one of CARE’s goals to divert individuals from further deterioration or decompensation by providing access to services that may not only positively impact their decisional capacity but also prevent them from needing a higher, or more restrictive, level of care.
(<https://www.courts.ca.gov/documents/CARE-Act-Eligibility-Criteria.pdf>).

On a final note, many of you are likely aware of Senate Bill (SB) 43, which expands the definition of grave disability to include individuals with severe substance use disorders (SUD) including co-occurring mental health and SUD. It also references an individual’s inability to make “reasonable decisions” regarding essential needs. This new law will go live across California in January 2026, with two counties in the state currently using this new definition.

Sources: [DHCS – Rights for Individuals in Mental Health Facilities](#); [CARE Act Eligibility Criteria](#); [Senate Bill \(SB\) 43: Behavioral Health \(Digital Democracy CalMatters\)](#)

Impact of Implicit Bias

- » **Bias** is a positive or negative tendency resulting in attitudes, decisions, behaviors, and actions that are prejudiced in favor of or against someone or a group.
- » **Implicit bias** is a form of bias that occurs without intentionally thinking about it.
- » Implicit biases can...
 - Impact our assessment of whether a CARE participant can make their own decisions.
 - Influence our behaviors toward—and our response to—CARE participants.
 - Limit our ability to think about an individual's unique situation, context, and path to recovery.
 - Impact client-provider relationships and treatment recommendations for individuals with schizophrenia spectrum or other psychotic disorders.

For more information, visit the [Addressing Implicit Bias for Behavioral Health Agencies](#) training materials.



[Slide Image Description: This slide shows the definition and impact of implicit bias, including a blue box noting “Remember: everyone has implicit biases” with six blue icon individuals above it.]

Bias is a positive or negative tendency resulting in attitudes, decisions, behaviors, and actions that are prejudiced in favor of or against someone or a group.

“Implicit bias” is one form of bias that occurs unconsciously. For example, let’s say I move to a new area and only seek out those who look like me to learn more about the area. I may not consciously be aware that the only strangers I speak to look like me, but if someone points it out to me, then I can reflect and recognize it. Biases (and the actions we take based on these biases) are developed through our life experiences, our cultural contexts, our learnings (e.g., parents, teachers, others in our environment), and the media. We are hardwired to have bias; it is a protective factor that is a holdover from early man. Safety came from people and things we understood, while danger was in the unknown. Remember: everyone has implicit biases.

Implicit biases can...

- Impact our assessment of whether a CARE participant can make their own

decisions.

- Influence our behaviors toward—and our response to—CARE participants.
- Limit our ability to think about an individual’s unique situation, context, and path to recovery.
- Impact client-provider relationships and treatment recommendations for individuals with schizophrenia spectrum or other psychotic disorders.

Examples of situations that may appear to someone to be impaired capacity might include:

1. A person with a history of trauma related to the mental health system (such as someone who has experienced distressing involuntary detentions or 5150s) who experiences panic when interacting with any behavioral health provider.
2. A recent immigrant to the US who has a history of receiving non-western or traditional health care practices rather than medication treatment.
3. A person with a different faith who holds religious beliefs that are unfamiliar.

For more information, visit the [Addressing Implicit Bias for Behavioral Health Agencies](#) training materials.

Mitigating Bias & Assessment of Capacity

Implicit bias can impact our assessment of whether an individual with schizophrenia spectrum or other psychotic disorders has decisional capacity. When evaluating for decisional capacity to provide informed consent, consider the following strategies to mitigate implicit biases.

- » Consider how an individual does have capacity.
- » Focus on ability to make decisions (not symptoms).
- » Consider the least restrictive alternative.
- » Account for preferences and values of the individual.
- » Consistently apply standards.
- » Consider the impact of your evaluation for legal and medical decisions.



[Slide Image Description: This slide shows an individual with a clipboard along with four other people.]

Implicit bias can impact our assessment of whether an individual with schizophrenia spectrum or other psychotic disorders has the capacity to make their own decisions. When evaluating for decisional capacity to provide informed consent, consider the following strategies to mitigate implicit biases.

- **Consider how an individual does have capacity.** Implicit biases may lead health care providers and others to underestimate the decision-making capabilities of individuals with schizophrenia spectrum and other psychotic disorders. This can result in a blanket assumption that they are incapable of making informed decisions, regardless of the severity of their condition or their ability to understand and weigh options.
- **Focus on ability to make decisions (not symptoms).** Biases can lead to an overemphasis on the presence of symptoms rather than an evaluation of decision-making abilities. For example, the presence of hallucinations or delusions might lead to an automatic conclusion that the person cannot make any rational decisions, overlooking periods of clarity and areas where they can make competent choices.
- **Consider the least restrictive alternative.** Due to implicit biases, there might be a

higher likelihood of recommending guardianship or conservatorship, which can unnecessarily strip individuals of their autonomy. This can be done without thoroughly exploring or implementing less restrictive alternatives, such as the CARE Act, that could support decision-making while preserving autonomy.

- **Account for preferences and values of the individual.** Bias can lead to a disregard for the individual's preferences, values, culture, and expressed wishes. Health care providers and caregivers might impose their own views on what is best for the person, sidelining the individual's own desires and choices. In contrast, the CARE process looks to bolster an individual's preferences, values, and expressed wishes. When assessing someone's capacity to provide informed consent, understand that you may not agree with their end decision, but you are looking for their ability to think through the choices and potential consequences in your assessment of capacity.
- **Consistently apply standards.** Implicit biases can lead to inconsistent application of standards when assessing decision-making capacity. For example, similar behaviors might be interpreted differently in people with schizophrenia spectrum and other psychotic disorders compared to those without the diagnosis, leading to biased conclusions about their decision-making abilities.
- **Consider the impact of your evaluation for legal and medical decisions.** In legal and medical contexts, biased assessments can influence court rulings and medical recommendations, potentially leading to restrictive measures that limit the individual's rights and freedoms. This can include decisions about treatment options, living arrangements, and financial management.

Addressing implicit bias requires continuous education and training for health care providers, legal professionals, and caregivers to ensure fair and accurate assessments. Emphasizing supported decision-making frameworks, which provide assistance while respecting the individual's autonomy, can help mitigate the negative impacts of implicit bias on decision-making assessments.

Ideas in Action

» What is the relationship between capacity and informed consent?
Why is understanding this relationship important for this population?



- To provide informed consent to treatment, the person must be evaluated for decisional capacity.
- Decisional capacity is fluid – it can come and go and change over time.
- Internal (e.g., psychiatric symptoms) and external variables (e.g., implicit bias, stigma) can influence both a person's capacity and the clinician's evaluation.

[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.]

What is the relationship between capacity and informed consent? Why is understanding this relationship important for this population?

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- Decisional capacity is fluid – it can come and go and change over time.
- Internal (e.g., psychiatric symptoms) and external variables (e.g., implicit bias, stigma) can influence both a person's capacity and the clinician's evaluation.



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

Californians suffering from untreated schizophrenia spectrum and other psychotic disorders face significant health and safety risks, including increased rates of homelessness, incarceration, hospitalization, conservatorship, and premature death. The goal of CARE is to provide these individuals with services they need to stabilize and thrive in community settings. The CARE Act incorporates specific tools and strategies for the respondent into the CARE process, such as legal counsel, supported decision-making, and the volunteer supporter role. These tools balance the opportunity for treatment through a civil court process, upholding self-determination and civil liberties for individuals with severe mental illnesses.

In this section, we are going to discuss how capacity and informed consent are a part of CARE proceedings. We will discuss:

- At which points in the process is a person's capacity to give informed consent and make decisions relevant?
- Who determines whether the person has capacity?
- What supports and services are available to strengthen or restore capacity when needed?

What is Mary's situation?

- » 47-year-old woman who is single.
- » Diagnoses of schizoaffective disorder and opioid use disorder (OUD).
- » Declined antipsychotic medication for the last six months.
- » Currently unhoused.
- » Mary's sister tried to engage with county behavioral health (BH), but they could not engage Mary on the streets to offer services.
- » Mary has chosen a peer supporter that she met at a shelter as her volunteer supporter.



Case Example: Meet Mary



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

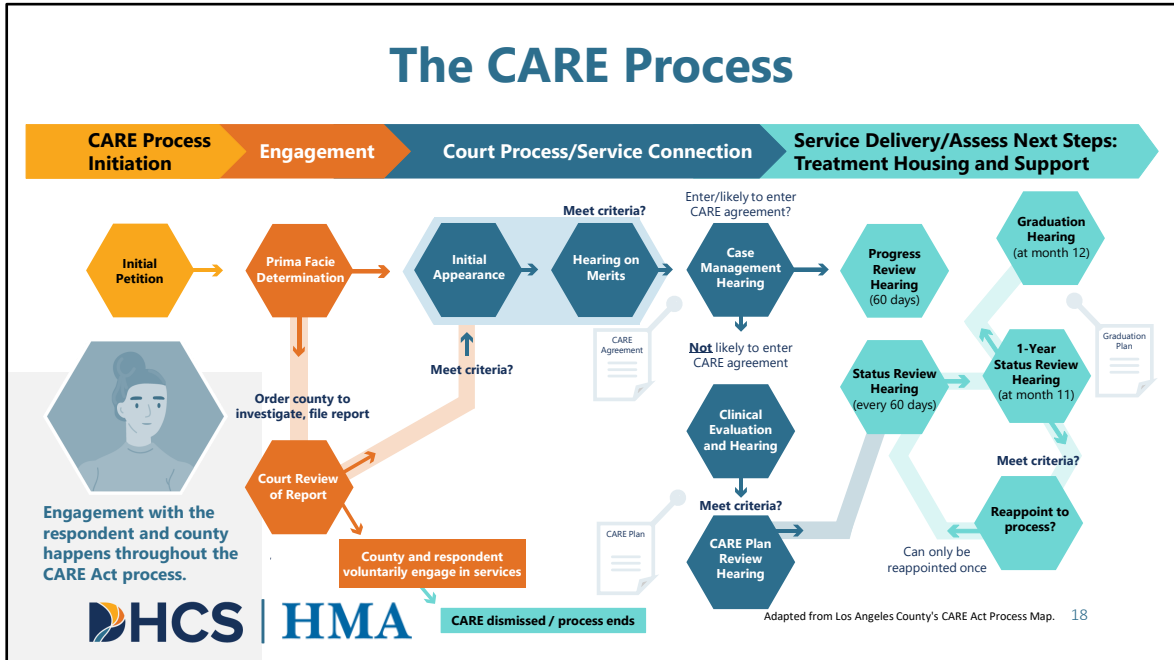
[Slide Image Description: This slide shows an image of an individual depicting Mary and a description of Mary's situation.]

During this section, we are going to discuss capacity and informed consent in CARE through the lens of a CARE participant: Mary.

What is Mary's situation?

- 47-year-old woman who is single.
- Diagnoses of schizoaffective disorder and opioid use disorder (OUD).
- Declined antipsychotic medication for the last six months.
- Currently unhoused.
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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.]

First, let’s look at the relevant points in the CARE process where a person's capacity to give informed consent and make decisions is taken into consideration. This slide shows an overview of the full CARE process.

Consent, broadly, comes into play throughout the CARE process, as an individual ideally consents to treatment, housing, and supports. Informed consent—including an assessment of capacity of that individual to provide informed consent—comes into play during the case management hearing; clinical evaluation and hearing; and the CARE plan review hearing. Let’s take a look more closely at that part of the process.

Description of flow:

1. Petitioner files a petition.
2. There is 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.
1. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present).
 2. 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).
 3. If it is determined at the case management hearing that a CARE agreement is not likely to be reached, then there will be a clinical evaluation and then a hearing to review that clinical evaluation. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
 4. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
 5. There will then be a status review hearing at least every 60 days.
 6. 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.

CARE Act References to Capacity and Consent



» **Case Management Hearing:**

If a CARE agreement has not been or is not likely to be reached, court will order county BH to conduct a clinical evaluation.

» **Clinical Evaluation & Hearing:**

- Clinical evaluation to include diagnosis, an assessment of capacity to give informed consent regarding psychotropic medications, and recommendations.
- At the hearing, if the court finds the respondent meets the CARE criteria, the court will order the parties to develop a CARE plan.

» **CARE Plan Review Hearing:**

In a CARE plan, the court may order medication if it finds the respondent lacks capacity to give informed consent to administration of medically necessary stabilization medication. Medication order shall not be forcibly administered.

For more information, see [W&I Code section 5977, subdivision \(A\)\(5\)\(C\)\(II\)](#) and [W&I Code section 5977.1, subdivision \(d\)\(3\)](#).

[Slide Image Description: This slide zooms in on a section of the CARE process and where a CARE agreement and CARE plan fit.]

Let's look more closely at the process in which the assessment of capacity to provide informed consent comes into place.

- **Case Management Hearing:**

- At the Case Management Hearing, it will be determined if the parties are able to enter (or are likely to enter) a CARE agreement.
 - The W&I Code doesn't specifically mention capacity to provide informed consent at this hearing. It is possible that during the Case Management Hearing, it is evident the respondent's mental state prevents them from reaching a voluntary agreement, or the judge determines that the respondent simply lacks the capacity to agree to any particular plan.
- If a CARE agreement has not been or is not likely to be reached for whatever reasons, the court will order county BH to conduct a clinical evaluation.

- **Clinical Evaluation & Hearing:**

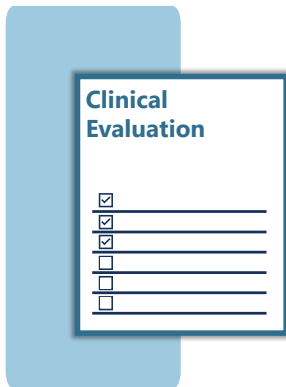
- Clinical evaluation to include diagnosis, an assessment of capacity to give

informed consent regarding psychotropic medications, and recommendations.

- At the hearing, if the court finds the respondent meets the CARE criteria, the court will order the parties to develop a CARE plan.
- **CARE Plan Review Hearing:**
 - In a CARE plan, the court may order medication if it finds by clear and convincing evidence the respondent lacks capacity to give informed consent to administration of medically necessary stabilization medication.
 - While the order does not authorize forced medication, it is an important component of the treatment plan and will justify non-forcible actions by behavioral health to encourage the respondent to take the ordered medications. Also, this legal measure helps overcome barriers to prescribing critical treatment for the CARE population (a point that we will touch on in a moment).

For more information, see W&I Code section 5977, subdivision (A)(5)(C)(II) and W&I Code section 5977.1, subdivision (d)(3).

Clinical Evaluation



Minimum Components of the Clinical Evaluation:

- » A clinical diagnosis.
- » Legal capacity to give informed consent regarding psychotropic medications.
- » Additional information to help the court make future informed decisions regarding care and services for respondent.
- » Analysis of recommended services and interventions that support the respondent.

For more information, see [W&I Code section 5977.1](#)

[Slide Image Description: This slide shows an icon of a clinical evaluation with a list of minimum components of a clinical evaluation.]

Broadly, a clinical evaluation is a comprehensive assessment process performed by health care professionals to understand a patient's health status, diagnose mental health conditions, and develop appropriate treatment plans. In the context of the CARE Act, the judge orders the clinical evaluation before the development of a CARE plan. Since this evaluation will include information about medications, it should likely be conducted—at least in part—by someone that is able to prescribe medications and/or is capable of having these conversations. Another licensed clinician (non-prescriber) can contribute to the clinical evaluation, as long as the assessment for decisional capacity related to medications is completed by a prescriber.

Minimum components of the clinical evaluation (according to W&I Code) are:

- A clinical diagnosis.
- Legal capacity to give informed consent regarding psychotropic medications.
- Additional information to help the court make future informed decisions regarding care and services for respondent.
- Analysis of recommended services and interventions that support the respondent.

Consider Mary’s situation. As she goes through the clinical evaluation, the clinician doing the assessment (in Mary’s case, a psychiatrist) will need to document a diagnosis, provide recommendations on treatment and services, and provide any other additional information that will be helpful to the court regarding Mary’s care. The doctor will also need to include an assessment of Mary’s capacity to give informed consent regarding psychotropic medications.

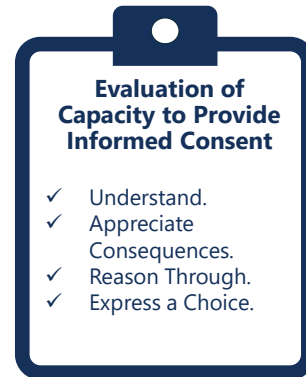
We will talk more about the relationship between the clinical evaluation, capacity, and consent in relation to medications in just a moment. But first, let’s take a look at questions that the psychiatrist could ask Mary during the clinical evaluation to help assess for capacity.

For more information, see [W&I Code section 5977.1](#)

Capacity Evaluation

Considerations essential to capacity evaluations include whether the individual can:

- **Understand:** aware of their mental condition and recommended treatments and services.
- **Appreciate Consequences:** able to understand the benefits, risks, and alternatives.
- **Reason Through:** can understand and knowingly evaluate the information and otherwise participate in the treatment decision by means of rational thought processes.
- **Express a Choice:** can express what their decision regarding treatment is and explain they are making it.



[Slide Image Description: This slide shows an icon of a clipboard that lists the four qualifications for evaluation of capacity to provide informed consent.]

When evaluating if someone has the *capacity* to provide informed consent, the clinician must determine whether the individual has the cognitive or mental ability to understand the information provided and to make a reasoned decision. There are a few considerations essential to capacity evaluations:

- **Understand:** whether the patient is aware of their mental condition and recommended treatments and services.
- **Appreciate Consequences:** if the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed treatment and medication.
- **Reason Through:** whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given to patients whose informed consent is sought and otherwise participate in the treatment decision by means of rational thought processes.
- **Express a Choice:** if the patient is able to express what their decision regarding treatment is and explain they are making it.

Questions to Help Assess Capacity

Understand

- Can you explain your diagnosis to me?
- Can you explain to me what the treatment is?
- What is the purpose of this treatment?
- What are the potential benefits?
- What are the potential risks or side effects?
- Are there any alternatives?

Appreciate Consequences

- Why do you think this treatment is being recommended?
- How will this affect your health?
- What could happen if you decide not to go through with it?
- How do you think the benefits and risks apply to your situation?

Reason Through

- What are the reasons you might choose to take this medication?
- What are the reasons you might choose not to have this medication?
- How did you weigh the benefits and risks?
- Can you tell me what you think is the best decision for you and why?

Express a Choice

- Have you made a decision about whether you will proceed?
- Can you tell me what your decision is?
- Can you explain why you made this decision?

[Slide Image Description: This slide shows four colored quote boxes that list questions for the four qualifications for evaluation of capacity.]

Assessing decisional capacity to provide informed consent involves evaluating a person's ability to understand, appreciate, reason about, and express a choice regarding the information relevant to a decision.

Here are some key questions that could be asked to assess these aspects:

- Understand:
 - Can you explain your diagnosis to me?
 - Can you explain to me what the treatment is?
 - What is the purpose of this treatment?
 - What are the potential benefits?
 - What are the potential risks or side effects?
 - Are there any alternatives?
- Appreciate Consequences:
 - Why do you think this treatment is being recommended?
 - How will this affect your health?
 - What could happen if you decide not to go through with it?

- How do you think the benefits and risks apply to your situation?
- Reason Through:
 - What are the reasons you might choose to take this medication?
 - What are the reasons you might choose not to have this medication?
 - How did you weigh the benefits and risks?
 - Can you tell me what you think is the best decision for you and why?
- Express a Choice:
 - Have you made a decision about whether you will proceed?
 - Can you tell me what your decision is?
 - Can you explain why you made this decision?

Based on the individual's responses to these types of questions, the clinician doing the assessment would need to be able to state that, "Based on my evaluation, this person does or does not have capacity."

During her clinical evaluation, the psychiatrist discusses medication with Mary, which she declines. As the psychiatrist asks further questions, Mary indicates that she has refused medication because of paranoid beliefs about medical providers. She also states that she does not have a diagnosis of schizoaffective disorder and does not think that medication will improve her quality of life. Based on these responses and her other responses to the psychiatrist's questions, the psychiatrist determines that Mary does not have decisional capacity to provide informed consent; as at this time, she does not appear to understand her disease or the risks/benefits of treatment.

CARE Act References to Capacity & Informed Consent: Medications

- » Under usual circumstances, clinicians must obtain written informed consent before prescribing psychotropic medication.
- » Court orders allow clinicians to prescribe psychotropic medications legally when someone is found to lack capacity.
- » This legal measure helps overcome barriers to prescribing critical treatment for the CARE population.



Source: [W&I Code section 5977.1, subdivision \(d\)\(1\)\(3\)](#)

[Slide Image Description: This slide describes CARE Act references to capacity and informed consent for medications with a picture of a gavel and a gray text box that reads, "What is the purpose of a court order for psychotropic medications?"]

Under normal circumstances, a clinician is legally and ethically bound to obtain informed consent before prescribing psychotropic medication. In the case of prescribing medication, this can be a barrier for the CARE population to have access to a critical component of their treatment. If the prescriber finds that an individual lacks the capacity to provide informed consent but needs medication, the subsequent court-ordered medication can help overcome that barrier. Once it is court-ordered, a prescriber can in good conscience prescribe psychotropic medications. Note that a court order does not order an individual to take a medication; it orders the clinician to write a prescription.

Even though the medications may not be forcibly administered, the behavioral health provider is now legally able to prescribe medication with the court order, even if they feel they are not able to get informed consent. This reduces the obstacle to prescribing medication during an appointment if the respondent is refusing medications at that time and/or no next-of-kin or power of attorney is available at the time.

How does a clinician use or approach a court order for psychotropic medications for a person who lacks capacity, when the order does not allow for forcible medication?

- The respondent’s psychiatrist, advanced practice registered nurse (APRN), or other prescriber should be alerted to the presence of the court order, and it should be made available for reference at the clinical appointment. Prescribers who work in this field are often quite familiar with how to work with persons who may have partially impaired decision-making capacity. The court order can become an additional tool for the prescriber to use to prescribe needed medication, even if they feel they are not able to get informed consent at that time.
- Since the impaired capacity variable is often not absolute, the prescriber will usually still work to gain the person’s agreement to receive a prescription—even if that consent is not legally required—by documenting which aspects of the treatment recommendation the person *does* understand and to what extent they *do* agree to treatment. Use of psychiatric advance directives (PADs) or drawing in family, peers, or other support persons can also help. Also, once a person eventually *does* exhibit restored capacity, the prescriber will often repeat the medication consent procedures.

Source: W&I Code section 5977.1, subdivision (d)(1)(3)

CARE Act Roles and Capacity/Informed Consent



[Slide Image Description: This slide shows colorful boxes listing the roles included in the CARE Act process.]

Every role in the CARE process can and should strive to ensure the respondent has all the necessary information and support to give informed consent and to support the respondent in getting the necessary services to remain stable and engaged.

Consider the individuals and organizations in Mary's journey through the CARE process.

- **County BH:** County BH staff use their expertise working with individuals with mental illness to explain or present the services they can offer to Mary in an accessible and non-threatening manner.
- **Volunteer Supporter:** Throughout the CARE process, the goal of the supporter will be to help Mary process the information and ensure their preferences are reflected. They are to:
 - Work with the client on how to maintain autonomy and decision-making authority over their own life.
 - Work with the client on communicating their own preferences for the plan.

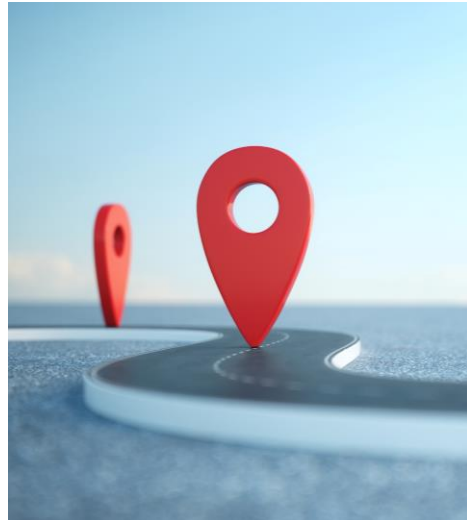
- **Counsel:** Can meet with Mary outside of court to discuss and explain the CARE process and services. In court, counsel ensures Mary’s voice is heard. If Mary expresses wishes and preferences, counsel will ensure they become part of the record.
- **Court:** The court’s role is unique because it is defined by neutrality – the court does not represent either the respondent or the behavioral health agency but is charged with the duty to protect the interests of all parties. For Mary, the judge can explain the CARE process and respond to her questions. The short-term goal of CARE is to engage the respondent in voluntary participation in the treatment agreement. The court can encourage Mary by direct communication (e.g., using strong words of encouragement and complements). Observing the collaborative court model, the court can also negotiate with all the parties to reach an agreement. Keep in mind the judge’s role can additionally have a direct impact on the respondent’s willingness to voluntarily participate in the CARE process (i.e., the black robe effect).

For more information on legal roles, see the [Legal Roles in the CARE Act](#) brief. For more information, visit the [Supporter Role in the CARE Act](#) brief and [The Supporter Role in the CARE Act](#) training materials. See the [Volunteer Supporter Toolkit](#) for additional resources and information.

Meeting Individuals Where They Are

Consider **supportive measures** to augment an individual's capacity to voluntarily participate throughout the process:

- » Simplify information.
- » Repeat explanations.
- » Use visual aids.
- » Create a supportive environment.
- » Involve support systems.
- » Use supported decision-making.



For guidance on plain language principles to make your communications more accessible, see the Public Health Communications Collaborative's [Plain Language for Public Health](#) guide. For strategies on creating a supportive environment, see [Incorporating Trauma-Informed Care into the CARE Process for Behavioral Health Agencies](#). For more information on supported decision-making, see the [Supported Decision-Making & The CARE Act](#) training.

[Slide Image Description: This slide has a list of supportive measures and has an image depicting two locations on a road.]

We have been talking about the specific moment in the CARE Act related to assessing decisional capacity to give informed consent. Taking a step back, consider ways to support the CARE respondent's ability to consent throughout the CARE process. Even when they may be actively experiencing symptoms, you can use these supportive measures to gain consent and encourage voluntary participation:

- **Simplify information:** Present information in a clear, simple, and straightforward manner, avoiding legal and clinical jargon. For guidance on plain language principles to make your communications more accessible, see the Public Health Communications Collaborative's [Plain Language for Public Health](#) guide.
- **Repeat explanations:** Be prepared to explain information multiple times and check for understanding throughout the discussion. Avoid showing impatience or rushing the conversation.
- **Use visual aids:** Use visual aids and written materials in addition to verbal explanations.
- **Create a supportive environment:** Create a calm and supportive environment to reduce anxiety and distractions. Consider asking the individual what helps keep them

calm (e.g., music, art, nature, animals). For strategies on creating a supportive environment, see [Incorporating Trauma-Informed Care into the CARE Process for Behavioral Health Agencies](#).

- **Involve support systems:** Include family members, peers, or other natural supports in the consent process, if appropriate, to help explain information and support decision-making.
- **Use supported decision-making:** Implement supported decision-making strategies that help individuals make decisions without undermining their autonomy. For more information on supported decision-making, see the [Supported Decision-Making & The CARE Act](#) training.

By addressing these challenges with tailored approaches, health care providers can better support individuals with schizophrenia spectrum or other psychotic disorders in making informed decisions about their care.

For guidance on plain language principles to make your communications more accessible, see the Public Health Communications Collaborative's [Plain Language for Public Health](#) guide. For strategies on creating a supportive environment, see [Incorporating Trauma-Informed Care into the CARE Process for Behavioral Health Agencies](#). For more information on supported decision-making, see the [Supported Decision-Making & The CARE Act](#) training.

Supported Decision-Making (SDM)

Supports and services that help an adult with a disability make his or her own decisions by using friends, family members, professionals, and other people they trust to:

- » Help understand the issues and choices, ask questions.
- » Receive explanations in language they understand.
- » Communicate their own decisions to others.

SDM & the CARE Act

The goal is to support self-determination to the greatest extent possible.

SDM is a decision-making model for the CARE Act participant and supporter.



For more information, visit the Supported Decision-Making trainings [for supporters](#) and [for implementation teams](#), as well as read "[The Right to Make Choices](#)"; [The National Resource Center for Supported Decision-Making](#) and the [Human Rights Brief](#).

[Slide Image Description: This slide shows the definition of supported decision-making and an image of holding hands.]

We have mentioned supported decision-making (SDM) a couple times. We have a separate training on what it is and how you can use SDM in the CARE Act. As an overview, SDM is a paradigm shift. Instead of assuming people with disabilities lack the capacity to make decisions, SDM asks what supports and services would enable individuals to make their own decisions. SDM means decisions are not made for the person, they are made by the person.

Supports and services that help an adult with a disability make his or her own decisions by using friends, family members, professionals, and other people they trust to:

- Help understand the issues and choices, ask questions.
- Receive explanations in language they understand.
- Communicate their own decisions to others.

The CARE Act references that SDM is a fundamental tool for advancing California values. This is a decision-making framework. It is a tool that will not always work perfectly, and there are a few black and white issues where SDM would not apply. An

individual may be untreated and unstable but still able to accept your support in helping them make their own decisions.

For more information, visit the Supported Decision-Making trainings [for supporters](#) and [for implementation teams](#), as well as read ["The Right to Make Choices:" The National Resource Center for Supported Decision-Making](#) and the [Human Rights Brief](#).

Psychiatric Advance Directive (PAD)

The image shows a training resource page for Psychiatric Advance Directive (PAD). The page includes a title, a publication date of 08/28/2023, and a link for training slides and video. It lists topics such as Behavioral Health, CARE Act Process, Case Worker / Case Manager, Counsel/Courts, Equitable & Person Centered Care, Serious Mental Illness & Evidenced-based Care. There are two callout boxes: 'Background & Purpose' and 'PADs in Practice'.

Psychiatric Advance Directive

Published: 08/28/2023
Training Slides & Video

Psychiatric Advance Directive on 8/28/23

Topics:

- Behavioral Health, CARE Act Process, Case Worker / Case Manager, Counsel/Courts, Equitable & Person Centered Care, Serious Mental Illness & Evidenced-based Care

Resource Details

Background & Purpose

- Background, purpose, and evidence of PADs.
- The PAD as a blueprint for person-centered care.
- Activating and changing a PAD.
- Update on Mental Health Services Act Multi-county Innovations Project.

PADs in Practice

- PADs in the CARE process.
- When, who, how, and what of PADs.
- Example PADs.

For more information, see the [Psychiatric Advance Directives training](#) on the CARE Act Resource Center.

[Slide Image Description: This slides shows an image of the Psychiatric Advance Directive (PAD) training resource with a detailed description of the background, purpose, and use of PADs.]

A PAD is a tool to document someone’s preferences when they may not be able to express them due to psychiatric crisis.

PADs offer an effective way of helping a CARE respondent to feel more in control of their care, even during times when their condition makes it difficult for them to advocate for themselves.

When used to empower an individual, a PAD can be a good way for a person to communicate who to contact in times of psychiatric crisis; carry forward medication preferences in times of crisis; or even what to do to care for a pet or other personal need. It can also be used to inform treatment preferences before a crisis even occurs.

Although not a required step in the CARE Act process, counsel can help a respondent document their preferences in a PAD. This information can be part of an advance health directive, which can be registered with the state. Respondent’s counsel can assist with

documenting preferences, and the courts can encourage the respondent and their counsel to consider this step.

For more information on PADs, see the [Psychiatric Advance Directives training on the CARE Act Resource Center](#).

Ideas in Action

» How might you support Mary's decision-making in light of her need for treatment?

- Ensuring Mary has access to information and materials that support her understanding.
- Consider bringing in other individuals from Mary's care team to assist in decision-making.
- Identify existing advance health directives.



[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 and an icon of Mary.]

How might you support Mary's decision-making in light of her need for treatment?

- Ensuring that Mary has access to information and materials that support her understanding and health literacy. Often this is done by taking plenty of time to provide basic information and answer questions.
- We learned from the description of Mary that her sister is involved and concerned about Mary's welfare. With Mary's consent, we could reach out to Mary's sister to help support Mary in her decision-making process.
- Consider drawing in other persons from Mary's care team to assist in decision-making – such as a trusted therapist, case manager, peer support, or volunteer supporter.
- We also could inquire as to the presence of any mental health advance directives.

Objectives

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

- › Describe the concepts of capacity and informed consent in the context of the CARE Act.
- › Define the factors that ensure informed consent.
- › List strategies to support the respondent to give informed consent.

[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 concepts of capacity and informed consent in the context of the CARE Act.
- Define the factors that ensure informed consent.
- List strategies to support the respondent to give informed consent.

Next Steps

- » Visit [CARE-Act.org](https://www.care-act.org) for resources (including recordings of past trainings) and to submit questions/TA requests.

- » View the other relevant trainings.
 - Supported Decision-Making trainings [for supporters](#) and [for implementation teams](#).
 - [Psychiatric Advance Directives](#).



[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.

View the other relevant trainings.

- Supported Decision-Making trainings [for supporters](#) and [for implementation teams](#).
- [Psychiatric Advance Directives](#).

Questions?

[CARE-Act.org](https://www.care-act.org) | [info@CARE-Act.org](mailto:info@care-act.org)

[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](https://www.care-act.org), and our email address is [info@CARE-Act.org](mailto:info@care-act.org).