# CARE Act

## Community Assistance, Recovery, and Empowerment Act

## Psychiatric Advance Directives & the CARE Process

The Community Assistance, Recovery, and Empowerment (CARE) Act process outlined in **California Welfare and Institutions Code (W&I Code) sections 5970 – 5987** is a civil court process that offers multiple pathways to treatment for **eligible adults**.

> For more information, see the **PADs in the CARE Act** training.

Psychiatric Advance Directives (PADs) allow individuals to document mental health treatment preferences through completion of a document before a mental health crisis event. Though the CARE Act speaks to PADs in graduation planning, PADs can also support person-centered care throughout the CARE process—from early engagement to a period of lost capacity. This toolkit includes guidance for incorporating PADs into the CARE process.



DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES HMA

## Background on PADs

A PAD is a document that allows individuals to outline their preferences for mental health treatment in anticipation of a time when they may lack the capacity to make informed decisions. A PAD offers a way to maintain autonomy and strengthen collaboration with providers. This proactive planning helps to ensure that care aligns with the person's preferences and helps to reduce uncertainty and conflict for providers and support persons in the case of a mental health crisis event.

A PAD can be beneficial for anyone who lives with a mental health condition which may, at times, impact their ability to make informed treatment decisions. A PAD can be especially valuable for individuals living with serious mental disorder, as these conditions may include episodes of psychosis, disorganized thinking, or impaired decision-making that can make it difficult to communicate treatment preferences in the moment. A "serious mental disorder" refers to a condition that is both severe in degree and persistent in nature, significantly affecting a person's behavior and ability to carry out essential daily tasks.

PADs empower individuals to retain autonomy by specifying treatment preferences to be used in the case of a mental health crisis event. PADs should be reviewed and updated regularly, including after any acute episodes or when a person wishes to add to or alter their treatment preferences. It's important to make sure that both formal and informal supports have updated copies of the person's PAD so that their up-to-date care preferences are known and accessible. While it may be challenging to ensure everyone receives the latest version, efforts should be made to track who has received copies, perhaps by keeping a distribution list.

A person can complete a PAD on their own or with help from a friend, family member, attorney, case worker, person with lived experience/peer, counselor, or other individuals. Ideally, the person helping would have familiarity or training regarding PADS, but this is not required.

Not only should PADs be used during a mental health crisis event to direct care, PADs can also be a blueprint for trauma-informed, person-centered care and can:

- Inform a **supported decisionmaking** (SDM) approach, allowing CARE participants to articulate preferences with assistance from trusted support persons.
- Inform crisis prevention plans, daily treatment plans, and crisis event responses.

- Outline treatment options that are known to be effective for an individual and which options should be avoided according to personal history and preferences (e.g., a medication from which the individual has experienced negative side effects).
- Reflect cultural values and include individual history considerations.
- Name a trusted support person as a proxy decision-maker in the case of a mental health crisis event when a person loses capacity.

The role of the county behavioral health (BH) team should be focused on ensuring the CARE participant's preferences are captured and honored. Legal counsel can help a CARE participant ensure their PAD meets legal requirements.

In California, the general provisions for an Advance Health Care Directive (AHCD) are found in **Probate Code sections 4670 – 4698**. California's AHCD law recognizes a PAD as a legal document created voluntarily by individuals who have the capacity to make medical decisions. California directs PADs to include the same legal requirements as other AHCDs, but there is no required form.

CARE participants may choose to take additional steps, such as embedding their PAD in an AHCD and registering it with the state if they would like to increase accessibility for healthcare providers.

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Studies show that PADs significantly improve outcomes for individuals with serious mental illness (SMI), including:

- Enhanced autonomy and empowerment.
- Improved treatment adherence.
- Reduction in coercive interventions.
- Better crisis event management.
- Increased engagement and trust.

Evidence is outlined in the Substance Abuse and Mental Health Services Administration's (SAMHSA) **Practical Guide to Psychiatric Advance Directives** and the **Psychiatric Advance Directives: Origins, Benefits, Challenges, and Future Directions** article.

For more information about the background of PADs, demonstrations of effectiveness, and how they can be used, see **PADs in the CARE Act** training.

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The **National Resource Center on PADs** has a state-based repository with links to forms and other state-specific resources. California's advance directive forms can be viewed **here**.

# Implementing PADs in CARE: What, When, Who, and How

CARE teams have a valuable opportunity to work with individuals to create PADs while they are participating in the CARE process. These PADs can continue to support the individual during and after they leave CARE by helping inform providers regarding the client's preferred services, supports, and interventions.

Conversations regarding PADs should be integrated thoughtfully throughout the CARE process, from initial engagement to ongoing treatment to graduation planning. In the **PADs in the CARE Act** training, additional prompts and guidance help teams identify components that could be included, when and how to support PAD development, who should be involved (especially peers), and how to help keep PADs accessible and up to date.

The following section outlines key considerations for creating, sharing, and maintaining PADs.

## What are components that can be included in a PAD?

A PAD is a deeply personal document, and its contents should reflect the unique values, needs, and priorities of the individual creating it. While there are common categories that many people choose to include, there is no one-size-fits-all approach. The examples below illustrate the kinds of information that can be incorporated into a PAD, but ultimately, it should be tailored to include the specifics that matter most to the person.

SAMHSA offers a sample PAD template—including a pocket-sized version—that's a useful starting point.

See **SAMHSA's A Practical Guide to PADs**.

Below are specific examples of what could be included in a PAD to help inform an individual's care as is appropriate and available:

- **Current conditions,** including any mental health, physical health, or substance use disorder diagnoses that may be present.
- **Statutory requirements,** including date of execution, signature or notarization, and witnesses.

- **Treatment preferences,** including accessibility needs, effective and ineffective medications, preferred hospitals and providers, current medical conditions, and effective **psychosocial interventions**.
- **Crisis event response strategies,** including communication preferences (e.g., eye contact, stance, name usage, language preferences) and interaction styles with law enforcement or emergency personnel.
- **Personal needs**, including instructions for managing responsibilities such as child or pet care, financial obligations, and living arrangements.
- **Designated decision-makers,** including a health care agent or proxy. The agent is a trusted person chosen by the individual to make mental health care decisions on their behalf if they are unable to do so. The agent role is formally established through the completion of **power of attorney** legal forms, which grants the agent legal authority to act according to the preferences documented if the individual is deemed incapacitated by a medical professional.
- **Release of information** to authorize sharing information with specified individuals and organizations.

## When can a PAD be created and revisited?

While PADs are referenced in the CARE Act specifically as part of the Graduation Plan, they can be developed at any time and revisited regularly throughout the CARE process.

They can be introduced:

- During voluntary engagement with county BH agencies.
- While developing CARE agreements or CARE plans.
- At status review hearings.
- As part of ongoing treatment and care planning.

This flexible, ongoing approach ensures PADs remain relevant and effective in supporting person-centered care and crisis planning. Importantly, if an individual has capacity, even in a mental

PADs are living documents. They should be:

- **Introduced early**: Ideally during initial engagement or while developing CARE agreements or CARE plans.
- **Revisited often**: Especially during status reviews or treatment updates.
- **Updated anytime**: Whenever preferences change or new insights emerge.

health crisis event, they retain the right to change their mind or override their PAD. This respects the individual's autonomy and reinforces the principle that PADs are tools to support, not replace, self-determined decision-making whenever possible.

## When does a PAD become activated?

A PAD can be referenced at any time to support person-centered care, especially in the early stages of a mental health crisis event to help guide de-escalation and reduce the likelihood of a more coercive intervention (such as an arrest or hospitalization). To support timely use, county BH staff should try to locate the PAD early in a mental health crisis event by checking the Electronic Health Record (EHR), asking the individual where it's stored (e.g., paper, phone, or email), or contacting care team members or the person's support network. The responsibility for asking about PADs should be clearly outlined in the agency's policies and procedures.

The instructions in a PAD are "activated" when a qualified mental health professional determines that the person lacks the capacity to make informed decisions. Generally, this means they are unable to understand relevant information, weigh risks and benefits, or communicate a clear and consistent choice. During this time, the PAD serves as the source of truth of decision-making for the care team, outlining treatment preferences, crisis event strategies, and the role of any designated decision-makers.

Providers are expected to follow a PAD's guidance when it is in effect to the extent possible. The PAD should be adhered to as any AHCD. Providers may not be able to follow a PAD if the requested treatment is unavailable, unsafe, prohibited by law, or conflicts with standards of care. In emergencies, a provider may need to deviate from PAD instructions to prevent serious harm. In this case, the provider should document the reason, how it aligns with the person's best interests, and how they plan to return to the PAD's guidance when possible. If providers have questions about PADs' applicability or enforceability they should consult with their legal counsel.

> For more information on capacity and informed consent in CARE, see **the Capacity & Informed Consent in the CARE Process** training.

## Who should help create a PAD and have access?

The CARE participant should lead the development and use of their PAD, with others offering guided support. Their preferences and lived experience must guide the PAD development process. The individual may choose to develop a PAD on their own, but

many people find that the process is more effective when they have someone to help with its creation.

The person may choose from a number of individuals to support the development of a PAD, including peer specialists, case managers, counselors, trained facilitators, family members, faith leaders, or a CARE volunteer supporter. The individuals involved should understand mental health treatment, be able to help navigate preferences, and respect the client's autonomy and cultural background. Importantly, they are to help the person document their *own* preference, not to influence them.

PADs should be shared with parties identified by the CARE participant, including local first responders, preferred hospitals or medical systems, county BH agencies (including peer support specialists), family members, mental health proxies or agents, and legal counsel. Even if a person's PAD is in an agency's EHR, it may be beneficial to keep a copy of the PAD with the person, whether on paper or on their phone or email. This helps promote quick access if a mental health crisis event occurs.

## The Facilitator

A facilitator supports the client in creating their PAD without making treatment decisions. All facilitators must remain neutral and be focused on the person's own choices and preferences, avoiding their own bias. It's ideal for facilitators to have special training in PAD completion. Their role includes:

- Explaining the PAD's structure, purpose, and benefits.
- Guiding the client through PAD completion.
- Supporting reflection on past treatment experiences.
- Helping identify value-aligned supports.
- Ensuring the PAD meets legal and crisis-use requirements.

Using **trauma-informed, person-centered approaches**, facilitators create a safe space where the client's voice leads.

Consider the following potential facilitators:

- **Peer Support Specialists:** Peers bring invaluable insight and empathy to PAD development through their lived experience. They help clients feel seen and supported, offering guidance that is grounded in shared understanding. Peers can facilitate or support the PAD development process in collaboration with the client, and may emphasize the use of the **Wellness Recovery Action Plan** that the client may have developed to inform the content of the PAD. County BH

agencies can consider partnering with peer support organizations to ensure this valuable support is available to CARE participants.

- **Mental and Physical Health Providers:** Health providers—such as clinicians, therapists, psychiatrists, and case managers—can help clients turn past treatment experiences into clear, actionable preferences, while centering the client's voice. These conversations should be approached with humility and sensitivity, especially when revisiting times when the client's autonomy or dignity may have been compromised. Providers must also work intentionally to disrupt traditional power imbalances, fostering a collaborative dynamic where the client's expertise in their own life is fully respected. Note that while healthcare providers can assist with the creation of the PAD, they can't be a witness.

### Family Members and Trusted Supports

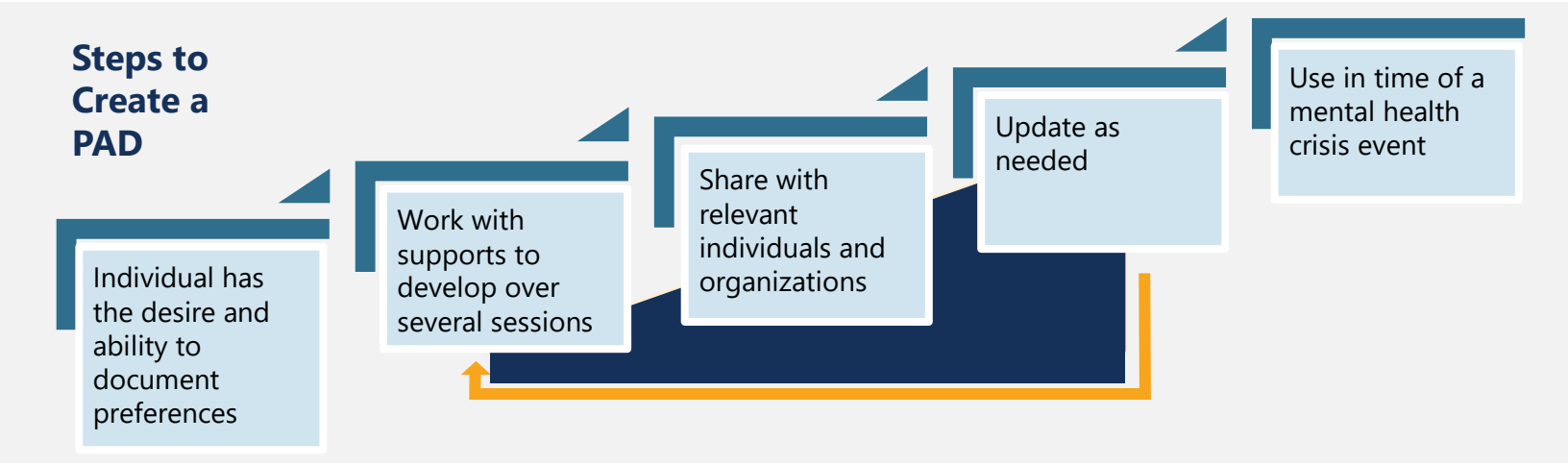
Family members and trusted support persons can offer meaningful support in the PAD process, but their involvement must be guided by the individual's direction. Their role is to listen, not lead, and remain neutral, setting aside their own preferences to ensure the PAD reflects the individual's voice and choices.

To manage potential conflicts of interest, it may be helpful for the individual to gather input from family members outside of PAD development sessions. This allows them to gather insights without influencing the tone or content of the sessions themselves.

## How to Approach PAD Development

Effective PAD development requires:

- **Education**: Explain the PAD's purpose and benefits in accessible language. Opportunities for education may include training in individual or group settings and can be spearheaded by county BH agencies.
- **Cultural Sensitivity**: Ensure PADs reflect the client's language, culture, and spiritual practices.
- **Supported Decisionmaking (SDM)**: Use SDM to maximize client autonomy.
- **Trauma-Informed Care**: Recognize that past treatment experiences may be triggering.
- **Intentional Facilitation**: Dedicate time and support to PAD creation, including psychoeducation and paperwork assistance.




## System Barriers and California Solutions

Challenges to PAD adoption include limited access to the PAD document, lack of awareness and education regarding the legal weight of a PAD, systemic fragmentation, lack of trained facilitators, and a lack of recovery-focused templates. To address these barriers, the **PADs Mental Health Services Act (MHSA) Multi-County PADs Innovations Project**) aims to develop best practices and scalable tools. This project is led by several counties and supported (but not directed) by the Commission for Behavioral Health (CBH). They are partnering with RAND and the Burton Blatt Institute to assess usability, adoption, and impact on crisis response systems.

Key goals include:

- **Digital Template**: Merging multiple PAD models into a universal, digital template integrated into an interactive app.
- **Peer Involvement**: Engaging individuals with lived experience in every phase, from design to facilitation.
- **Facilitator Training**: Creating a train-the-trainer curriculum to support PAD development statewide.
- **Technology Development**: Building a multilingual, mobile-accessible platform that allows PADs to travel with individuals across counties.
- **Legislative Advocacy**: Advancing policies to formally recognize PADs and ensure legal clarity around consent, privacy, and access.

Significant progress has been made on these goals including the creation of a digital template, facilitator training, and a digital PADs registry. These resources are currently only available to counties participating in the PADs Mental Health Services Act (MHSA)

Multi-County PADs Innovations Project. Counties can learn more and inquire about participation by visiting **www.padsca.org**.

# Resources to Better Understand PADs

## California State Resources

- **California Association of Local Behavioral Health Boards and Commissions – PADs**
- **California Secretary of State Advance Health Care Directive Registry**
- **Disability Rights California**
- **National Resource Center on PADs – California Forms**
- **Painted Brain**
- **Painted Brain on Supported Decision Making – Part 1**
- **Painted Brain on Supported Decision Making – Part 2**
- **PAD MHSA Multi-County Innovations Project**
- **Multi-County PADs Innovation Project Annual Report, Fiscal Years 2021-22 through 2022-23**
- **Multi-County PADs Innovation Project Annual Report, Fiscal Years 2022-23 through 2023-24**

## National Resources

- **National Resource Center on PADs**
- **SAMHSA Practical Guide to PADs**
- **Copeland Center for Wellness and Recovery – PADs**
- **National Alliance on Mental Illness - PADs**
- **Bazelon Center for Mental Health Law – Advance Directives**
- **Mental Health America – PADs**
- **SAMHSA PADs to Promote Community Living Webinar**
- **SAMHSA Extended Webinar on PADs Part Two**
- **Washington State Health Care Authority – Mental Health Advance Directives**

# COUNTY APPROACHES TO PADS IN THE CARE PROCESS

A Psychiatric Advance Directive (PAD) is a legal document that allows individuals to outline their preferences for mental health treatment in anticipation of a time when they may lack the capacity to make informed decisions.

This section highlights how counties across California are implementing PADs within the CARE Act process. The following county case studies highlight how different county CARE teams across California are integrating PADs into their local processes. Each example reflects unique strategies for promoting self-determination, continuity of care, and person-centered planning.

## San Diego County – Using PADs Throughout CARE

San Diego Behavioral Health Services (BHS) incorporates PADs as part of graduation planning and also encourages their use throughout CARE participation. Their clinicians initiate PAD discussions during regular status reviews, typically starting around the 6-month mark. PADs are completed when clinically appropriate and included in the graduation plan. Staff have received training using the **PADs in the CARE Act** training. PADs are shared with post-CARE service providers to help ensure continuity of care after transition. This approach helps ensure that treatment preferences are honored beyond the CARE process and that transitions are supported by informed service providers.

## Los Angeles County – Tools for Self-Determination

The Los Angeles County Department of Mental Health (DMH) integrates PADs into the consent for services process and revisits during exit planning. During an individual's intake into services with the county, DMH provides education on PADs, including their purpose, legal standing, and how to complete and share them. PADs are treated as tools for self-determination and are included in graduation planning, when appropriate. This education-first approach helps ensure that individuals understand their rights and options from the outset of CARE participation.

## Riverside County – Integrating PADs into Behavioral Health

In the Riverside University Health System, behavioral health staff support individuals in completing PADs with the help of peers and therapists. They recognize a need for standardized communication about PADs and education for emergency responders so that they can be better used in mental health crisis events. The county recognizes that

while PADs are being used, consistent protocols and broader system awareness are needed to fully realize their potential.

## Orange County – Collaborative Planning and Digital Pilot

Orange County Behavioral Health Services (BHS) has begun piloting a digital PAD app and includes PADs in graduation planning. The county emphasizes collaborative planning with public defenders and behavioral health teams. PADs are completed in both digital and print formats and are shared with ongoing service providers to support post-CARE transitions. The digital pilot aims to make PADs more accessible, portable, and user-controlled, with the goal of improving continuity and responsiveness across care settings.