
[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.]

Welcome to our presentation on the first CARE Act Annual Report. My name is Lauren Niles, and I am a Principal at Health Management Associates on the CARE Act Data Team, supporting DHCS to develop this report and data collection and reporting efforts.

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.

## Agenda

- Annual Report Findings (Q3 2023-Q1 2024 data)
- CARE Act Legislative Updates
- Data Collection and Reporting Resource Review

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[Slide Image Description: This cover slide shares the agenda, and includes an image of a three-dimensional pie chart.]

Our agenda for today includes:

1. An overview of findings from the first CARE Act Annual Report, which covers the first nine months of CARE implementation (Q3 2023-Q1 2024 data).
2. An overview of updates to CARE Act legislation that have impacted data and collecting reporting requirements.
3. And a reminder about data collection and reporting resources available to counties and other stakeholders.


[Slide Image Description: This slide introduces the section of the presentation dedicated to the Annual Report Findings from Quarter 3 of 2023 to Quarter 1 of 2024. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

Let’s first take a look at the Annual Report findings.

## CARE Act Annual Report & Implementation Update

The July 2025 CARE Act Annual Report released data about the first 9 months of implementation, including key takeaways and opportunities to leverage findings.

Accompanying CalHHS Implementation Update.


For more information, see CARE Act Annual Report & CARE Act Implementation Update – July 2025.

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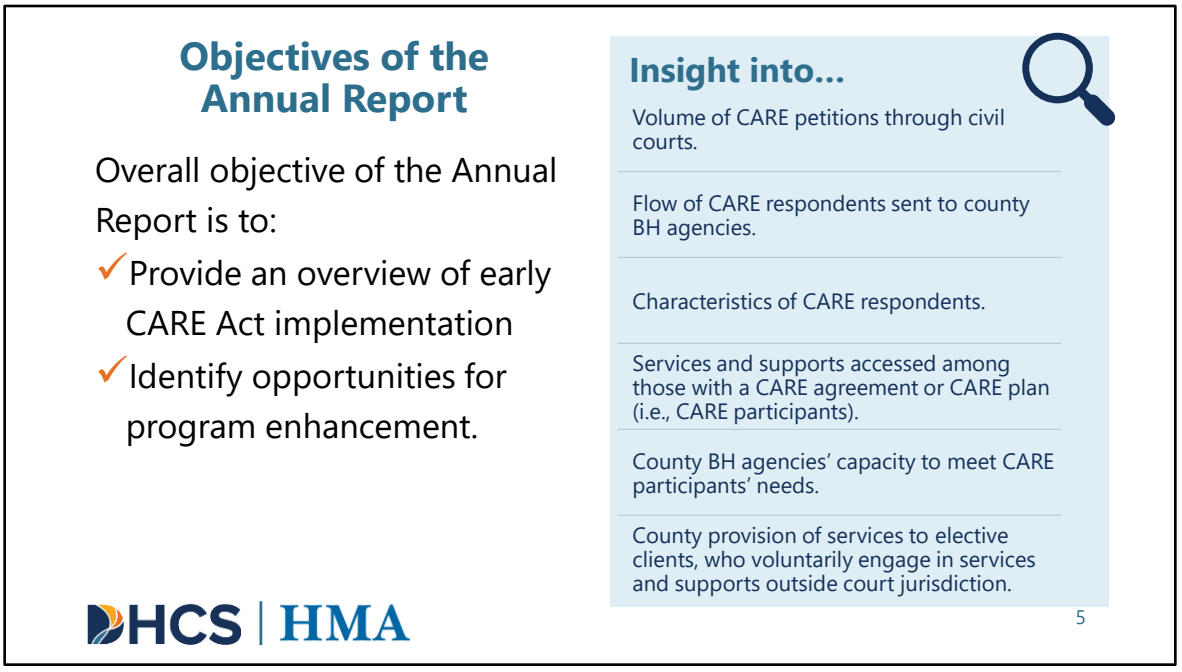
(Slide Image Description: This slide includes an screenshot of CalHHS's CARE Act Implementation Update for July 2025, a screenshot of the cover of the Community Assistance, Recovery, and Empowerment (CARE) Act Annual Report for July 2025, and a QR code.]

The Department of Health Care Services (DHCS) is required to develop an Annual Report to examine the scope of CARE Act impact and monitor the performance of CARE Act implementation. This report is distinct from the 3- and 5-year independent evaluation of CARE.

The first CARE Act Annual Report, which is now available on the DHCS website (and can be accessed using this QR code here) includes findings from the first 9 months of implementation, including key takeaways and opportunities to leverage those findings. The report is accompanied by an **Implementation Update** and **new videos** from the California Health and Human Services Agency that go into more details about how CARE is making a difference across the state and are meant to be used as companion resources to the Annual Report.

For more information, see CARE Act Annual Report & CARE Act Implementation Update – July 2025.

https://care-act.org/resource/care-act-annual-report-july-2025-care-act-implementation-update-july-2025/

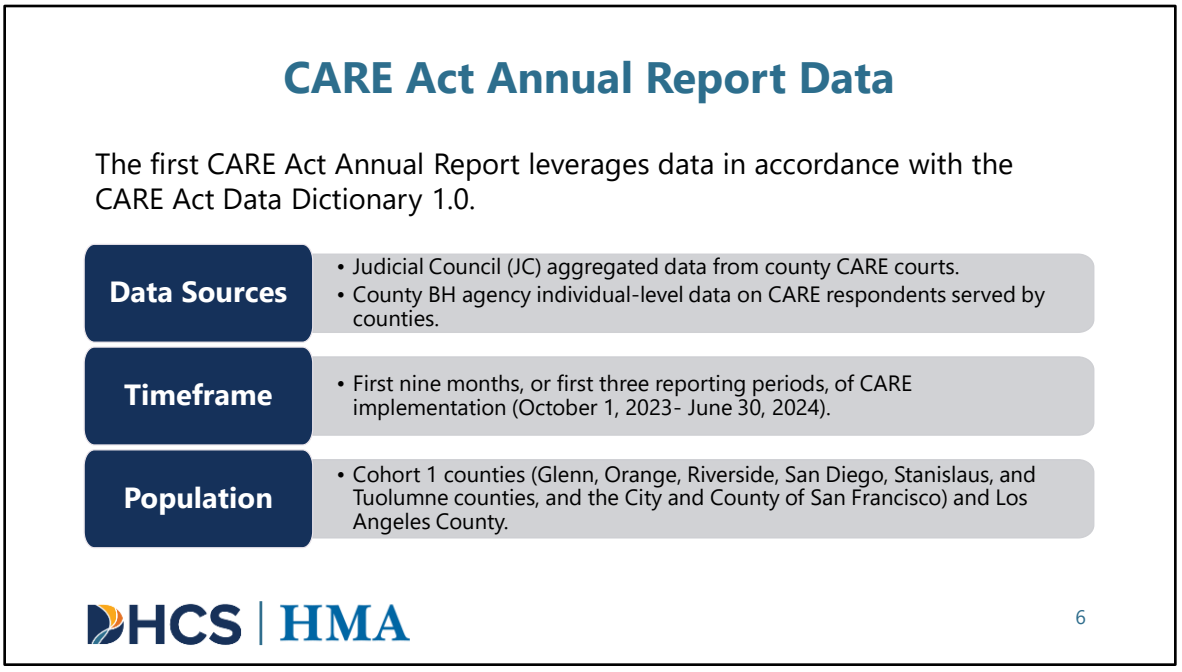



[Slide Image Description: This slide shows the overall objectives of the Annual Report, and along with six areas into which it provides insight and a picture of a magnifying glass over a light blue background.]

The overall objective of this report is to provide an overview of early CARE Act implementation by the courts and county BH agencies and identify potential areas for program enhancement.

Specifically, this report provides insight into:

- Volume of CARE petitions through courts.
- Volume of CARE respondents that are sent to county BH agencies from the courts.
- Characteristics of CARE respondents.
- Services and supports accessed among those with a CARE agreement or plan (i.e., CARE participants).
- County BH agencies' capacity to meet CARE participants' needs.
- County provision of services to elective clients, who voluntarily engage in services and supports outside court jurisdiction.




[Slide Image Description: This slide provides information on the data sources, timeframe, and population for the CARE Act Annual Report Data, in dark blue and light grey boxes.]

Importantly, the data that is leveraged for this first Annual Report corresponds with the data points specified in the CARE Act Data Dictionary 1.0 reported for the period covering October 1, 2023 through June 30 2024, or the first nine months of CARE implementation.

Data is from two sources:

1. Aggregate data reported on CARE petitions and hearings from the Judicial Council.
2. Individual level data on CARE respondents served by county BH agencies.

Timeframe: The timeframe for data in this report is the first nine months, or first three reporting periods, of CARE implementation (October 1, 2023- June 30, 2024).

Population: Counties reporting data during this period of time included the seven Cohort I counties that implemented starting in October of 2023 (Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne counties, and the City and County of San Francisco) and Los Angeles county, who began implementing starting in December of 2023.

## Volume of CARE Petitions Through Courts

**556 CARE petitions were filed over the first nine months of CARE implementation.**

- 101 (18%) resulted in an approved CARE agreement or ordered CARE plan.
- 217 (39%) were dismissed by the courts, including 15 petitions that resulted in elective clients.

**782 total hearings were held, including 403 initial CARE appearances.**

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[Slide Image Description: This slide contains an image of a woman and a man looking over documents, and contains information about CARE petitions filed, separated by orange divider lines.]

Starting first with data reported from the Judicial Council, which is the volume of CARE petitions through courts.

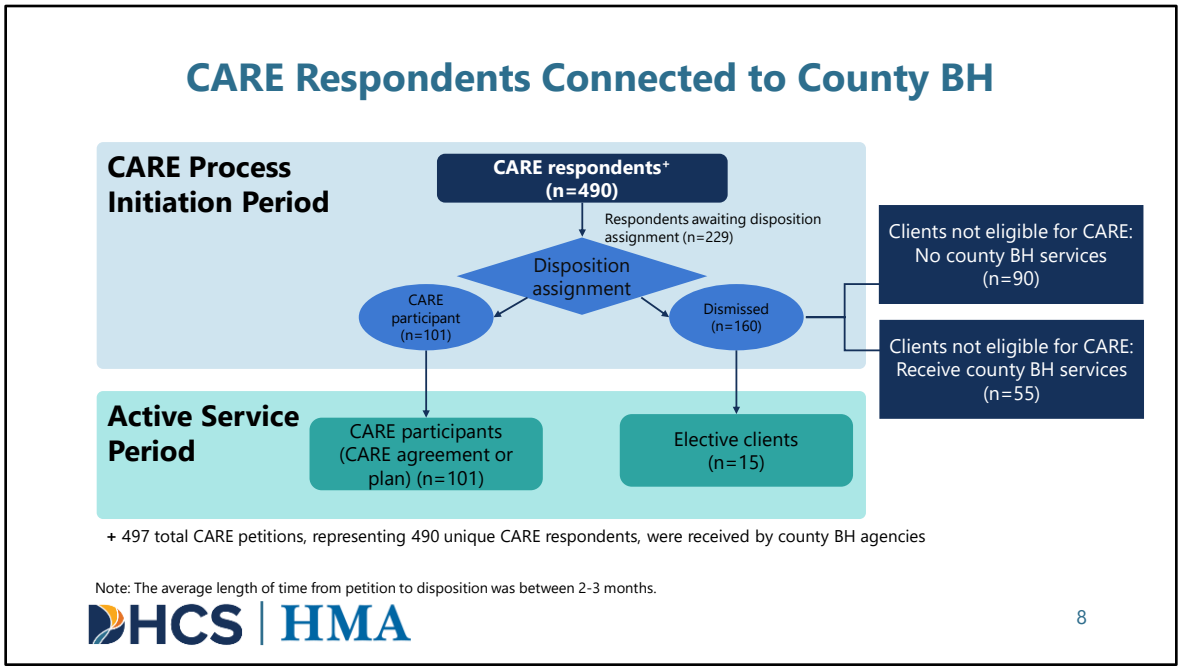
556 CARE petitions were filed during the first nine months of CARE implementation and were received by the courts as of June 30, 2024.

- Of the filed CARE petitions, 101 (18%) resulted in an approved CARE agreement or ordered CARE plan.
- 217 (39%) were dismissed.

Of note, for this first Annual Report, we had to combine CARE agreements and CARE plans to ensure we met data privacy requirements. In future Annual Reports, we will attempt to present them separately.

The remainder of filed CARE petitions were still in the court review process at the time of this report development and pending disposition assignment.

Additionally, 782 total CARE hearings were held during this time, including 403 initial appearances.




[Slide Image Description: This slide contains a diagram showing the paths CARE respondents can take through the CARE process initiation and active service periods. CARE respondents receive a disposition assignment, at which point they either become a CARE participant and enter the active service period with a CARE agreement or plan, or are dismissed, at which point they either become elective clients and enter the active service period, are not eligible for CARE but receive county BH services, or are not eligible for CARE and do not receive county BH services.]

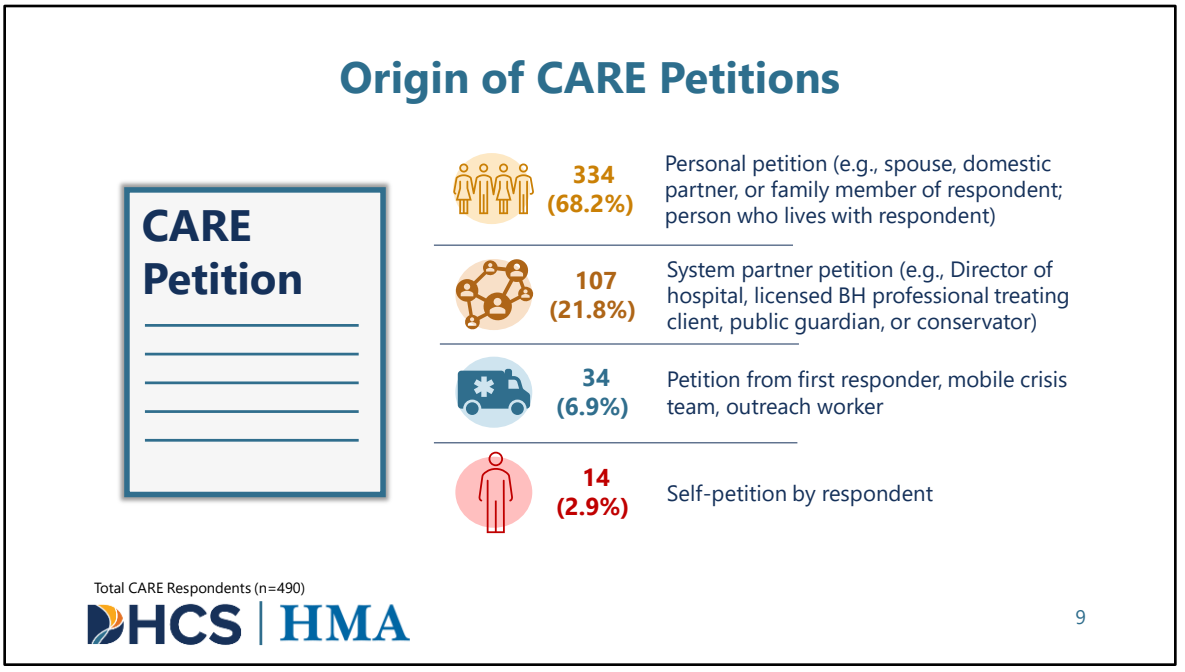
We think it is important to spend a moment orienting folks to how petitions flow from courts to county BH, including disposition assignment by courts and county action.

- Of the total 556 petitions submitted to the courts that we spoke about on the previous slide, 497 CARE petitions were received by county BH agencies during the first nine months of CARE Act implementation (representing 490 unique CARE respondents).
    - Why we see this discrepancy between total petitions at the court level and the county level is because courts can dismiss a petition for not meeting eligibility criteria for CARE proceedings (i.e., a prima facie showing) prior to county BH agency involvement. County BH agencies are only aware of and

able to track CARE petitions they file themselves or those they are ordered to investigate by the courts.
    - Once a county receives a petition from the court, they are required to report monthly on the petitioned individual during their CARE initiation period and active service period. If a respondent is dismissed and found to not be eligible for CARE, counties are no longer required to report on them.

- Over this first nine months of implementation, the average time from petition to disposition was 2.5 months or about 76 days.
- Of the 490 unique CARE respondents that flowed to county BH agencies, 160 were dismissed by the CARE court. Among the 160 dismissed:
    - 15 became elective clients.
    - 55 were found to be ineligible for CARE but received county BH services.
    - 90 were found to be ineligible for CARE and did not receive any county services.
- An additional 101 CARE respondents were found to meet CARE eligibility requirements and had a CARE plan ordered or CARE agreement approved by the court. These respondents are now called CARE participants and move into their active service period, where they are tracked for a minimum of 12 months, followed by another 12 months of a follow-up period. This is the same for elective clients, who were dismissed from the courts but are receiving county services and supports and were found to be CARE eligible.
- At the end of June 30, 2024, petitions for 229 respondents remained under evaluation and did not yet have a disposition assigned

- Of note, the July 2025 CalHHS Implementation Update brief, released simultaneously with this Annual Report, provides more detail on how counties are “diverting” many from CARE directly into county BH services. Although a different time period, the brief notes that through December 31, 2024, counties reported 1,358 total diversions– individuals connected to counties due to CARE outreach who were directly engaged in services and “diverted” from CARE.

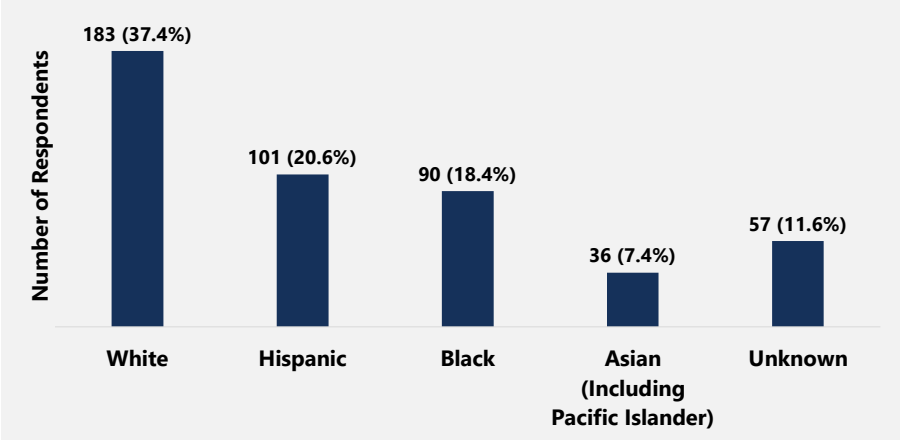



[Slide Image Description: This slide contains an image of a CARE Petition, as well as an image of 4 individuals representing those who file personal petitions, an image of a social network of individuals connected to one another representative of system partner petitions, an image of an ambulance representative of petitions from first responders/mobile crisis teams/outreach workers, and an image of a single individual representative of a self-petition by a respondent.]

CARE petitions can be filed by a range of individuals. The Annual Report breaks down the petitioner types for these first nine months:

- 334 (68.2%) were petitioned by what we call a "personal petitioner" (e.g., spouse, domestic partner, or family member of respondent; person who lives with respondent).
- 107 (21.8%) were petitioned by a system partner (e.g., hospital directors, licensed BH professionals, public guardians, conservators)
- 34 (6.9%) were filed by a mobile crisis team, outreach worker, or first responder.
- 14 (2.9%) were filed by the respondent themselves.

## CARE Respondents: Race




Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024; Prepared by the California Department of Health Care Services. Note: Respondents may identify as more than one race and may be included in more than one category. The sum of respondents by race will not equal the total number of respondents.

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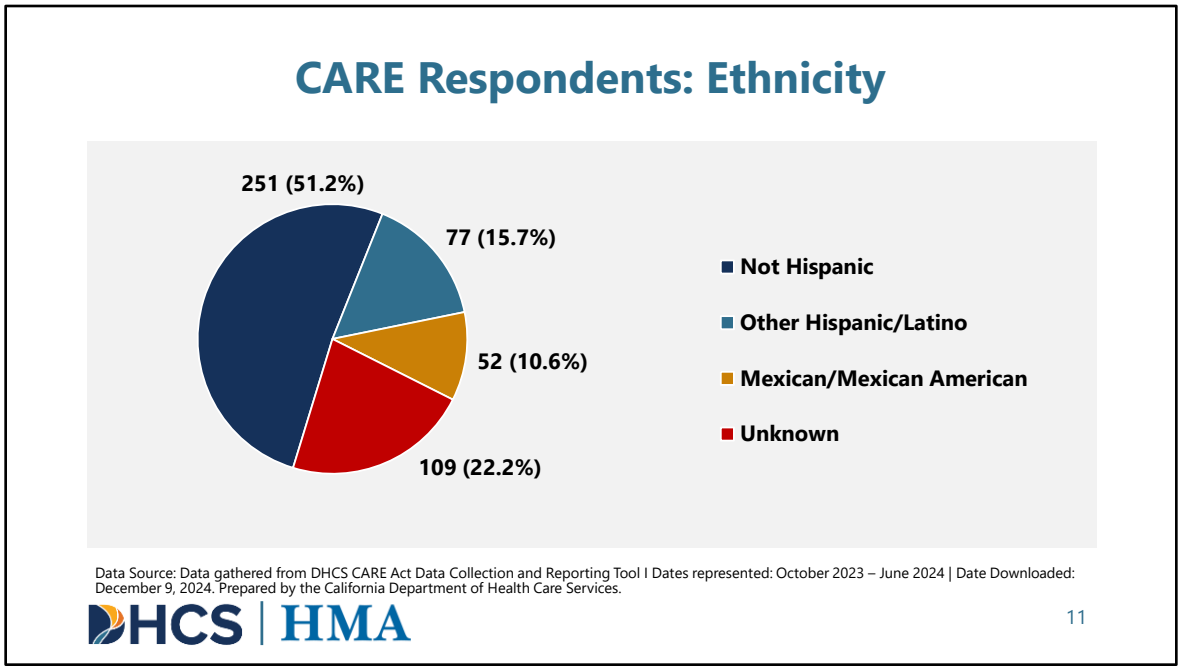
[Slide Image Description: This slide contains a bar chart showing the number of CARE respondents belonging to each of 5 racial groups and the percentage out of the whole each group accounts for.]

With regard to the racial makeup of CARE respondents, over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian. Of note, for this data point, respondents could be identified as more than one race and show up in more than one race category

Here is the racial makeup of CARE respondents:

- White: 183 (37.4%)
- Hispanic: 101 (20.6%)
- Black: 90 (18.4%)
- Asian (Including Pacific Islander): 36 (7.4%)
- Unknown: 57 (11.6%)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024; Prepared by the California Department of Health Care Services. Note: Respondents may idenitfy as more than one race and may be included in more than one category. The sum of respondents by race will not equal the total number of respondents.

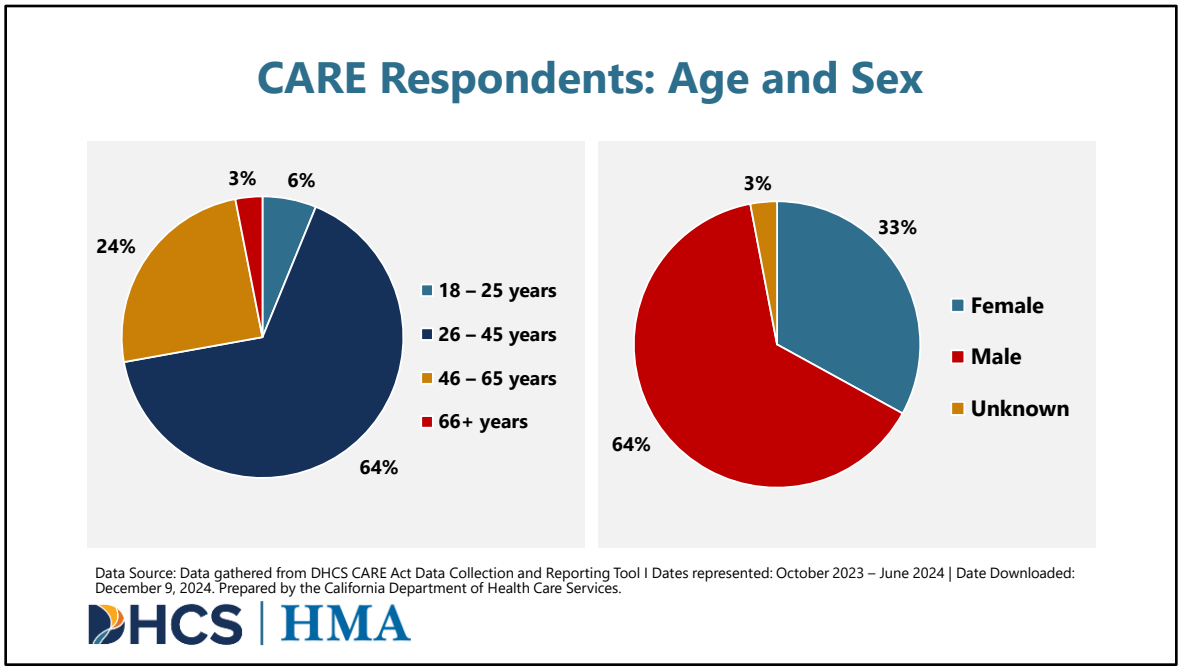



[Slide Image Description: This slide contains a pie chart showing the number of CARE respondents belonging to each of 4 ethnic groups and the percentage of each out of the whole.]

Here is the breakdown of CARE respondent ethnicity:

- Not Hispanic: 251 (51.2%)
- Other Hispanic/Latino: 77 (15.7%)
- Mexican/Mexican American: 52 (10.6%)
- Unknown: 109 (22.2%)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.




[Slide Image Description: This slide contains two pie charts, one showing the percentage of CARE respondents broken down by age range, the other broken down by sex.]

The majority of CARE respondents were between the ages of 26 – 45 years (about two thirds), followed by 46-65 years (about a quarter).

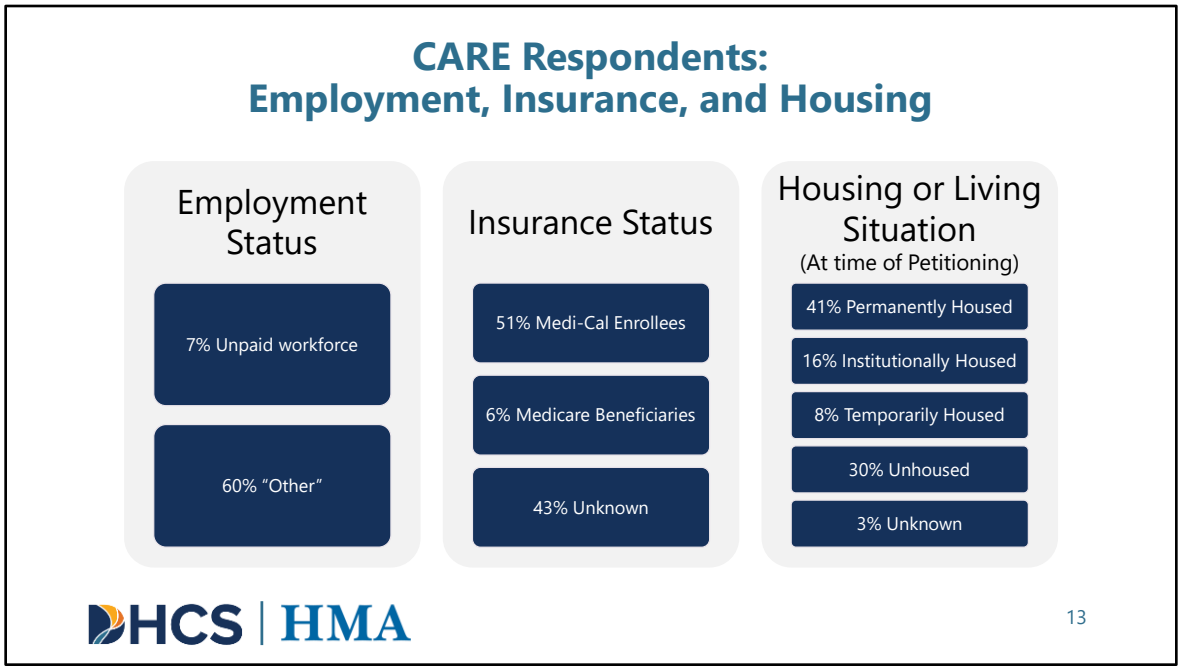
Here's the breakdown of ages:

- 18 – 25 years: 6% (27)
- 26 – 45 years: 64% (313)
- 46 – 65 years: 24% (117)
- 66+ years: 3% (15)

The majority of CARE respondents were male (around two thirds).

- Female: 33% (160)
- Male: 64% (314)
- Unknown: 3% (16)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.




[Slide Image Description: This slide contains information related to the employment status, insurance status, and housing or living situation at the time of petitioning for CARE respondents, within dark blue boxes.]

- Employment Status
  - Of the 490 unique CARE respondents, 7 percent were reported to be in the unpaid workforce (e.g., student, retired, looking for work). T
  - he largest proportion of CARE respondents' employment status was in the "other" response category (60 percent), with the most common descriptors noting the respondent was unemployed, not seeking work, or unable to work due to a disability.
- Insurance Status
  - Regarding health care coverage, about half of CARE respondents reported being Medi-Cal enrollees (51 percent) and a small proportion reported being Medicare enrollees (6 percent) at the time of petitioning.
  - A large proportion of CARE respondents had unknown health care coverage (43 percent).
- Housing or Living Situation (At time of Petitioning)
  - 65 percent of respondents were housed (permanent, institutional, or

temporary). Most respondents were reported to be in permanent housing (41 percent) rather than institutional (16 percent) or temporary housing (8 percent).

    - Institutional housing includes foster care, hospital, substance use disorder facility, long term care facility, nursing home, jail, or prison.
    - Temporary housing includes residential project, hotel/motel, staying with or living with friends or family temporarily, host home, or transitional housing.
- 30 percent were unhoused at the time of petitioning.
- 3 percent had an unknown housing or living situation.

## Time to First Disposition Assignment

Of the 261 CARE respondents with a petition disposition, the average number of days from petition to first disposition was 75.6 calendar days, or approximately 2.5 months (range: 8 – 253 days). 85 percent of respondents took 31 or more days to have a petition disposition assigned.

| Respondent Group | Time from CARE Petition to First Disposition Assignment (in Calendar Days) | | | |
|---|---|---|---|---|
| | Mean | Min | Max | Std. Dev. |
| **All CARE Respondents with Assigned Disposition (n=261)** | **75.6** | **8** | **253** | **43.9** |
| CARE participants (CARE agreements and CARE plans) (n=101) | 79.3 | 8 | 253 | 47.3 |
| Dismissed (including elective clients) (n=160) | 73.2 | 16 | 235 | 41.5 |

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024.

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[Slide Image Description: This slide contains a table showing the time from CARE petition to first disposition assignment in calendar days for various respondent groups.]

To get a sense of how long petitioned individuals were remaining in the court process prior to first disposition assignment, we examined the average time from petitioning to first disposition.

- The average number of days from petition to first disposition assignment by the court was 75.6 calendar days, or approximately 2.5 months, with a wide range: 8 – 253 days. Individuals with a CARE agreement or plan took slightly longer (on average about 6 days) than dismissed clients to receive their first disposition.
- Of the 261 CARE respondents with a petition disposition, 223 (85 percent) took 31 or more days to have a petition disposition assigned.

During a respondent's CARE Process Initiation Period, a range of activities can occur simultaneously, such as outreach and engagement, service and support delivery, county investigation and information gathering for the purposes of court disposition assignment, and trust building with the respondent. Future Annual Reports will include the information about the extent of county BH outreach and engagement efforts, as well as services and supports provided during the CARE Process Initiation Period, per

Senate Bill 1400 signed into law in September of 2024.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I
Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024.

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Table showing "Mean Time from CARE Petition to Disposition Assignment"
The header row contains the column titles: "Respondent Group" and "Time from CARE Petition to Disposition Assignment (in Calendar Days)". This header has four sub-headings titled "Mean", "Min", "Max", "Std Dev". The data rows list the following data:
All CARE respondents with Assigned Disposition (n=261): 75.6; 8; 253; 43.9
- CARE participants (CARE agreements and plans (n=101): 79.3; 8; 253; 47.3
- Dismissed (including elective clients) (n=160): 73.2; 16; 235; 41.5


[Slide Image Description: This slide introduces the presentation chapter on CARE services and supports accessed over first nine months, over a dark blue background with the logos of the Department of Health Care Services and Health Management Associates.]

In this next section, we will present data on the types of services and supports accessed by CARE participants. For this report, “access” is defined as a CARE participant being enrolled in or having documented receipt of a service or support at some point during their Active Service Period.

This first Annual Report focuses on point-in-time access due to the short span of time that CARE participants spent in Active Service Period (3 months on average), which limits the ability to observe trends in service and support utilization and engagement. Future Annual Reports will expand upon this initial analysis.

## Access to Specialized Programs

Over three quarters (76%) accessed a specialized program for individuals with serious mental disorders (e.g., Assertive Community Treatment or Full-Service Partnership).

| Program | CARE Participants (CARE Agreements + Plans) (n=101) with Specialized Program Access n(%) |
|---|---|
| **Specialized Program - Any** | **76 (76.2%)** |
| (Assertive Community Treatment (ACT))+ | 48 (47.8%) |
| (Full-Service Partnership (FSP) ) | 31 (30.0%) |

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

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[Slide Image Description: This slide contains an image of a group of individuals made out of paper holding hands in a circle, beside a table showing the CARE Participants with specialized program access in the Assertive Community Treatment and Full-Service Partnership programs.]

Three quarters of CARE participants (76 percent) were reported to be enrolled in a specialized program at some point during their Active Service Period.

- The most accessed specialized program was Assertive Community Treatment (ACT), with nearly half of all CARE participants (48 percent) enrolled in ACT at some point during their Active Service Period.
- The second most accessed specialized program was Full-Service Partnership (FSP), with nearly third (31 percent) of CARE participants enrolled in an FSP program during the Active Service Period.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

## Service and Support Access

Most received mental health treatment services (93%) and stabilizing medications (72%); of those who received medications, 40% received a long-acting injectable.

| Service or Support Category | CARE Participants (CARE Agreements + Plans) (n=101) with Service or Support n(%) |
|---|---|
| Any Mental Health Treatment Service | 94 (93.1%) |
| Stabilizing Medication at Any Time | 73 (72.3%) |
| Any Social Service or Support | 61 (60.4%) |
| Any CalAIM Community Support | 16 (15.8%) |

* Values are not shown to protect the confidentiality of the individuals summarized in the data. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

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[Slide Image Description: This slide contains an image of a man and a woman selecting groceries at a grocery store, beside a table showing the number and percentage of CARE participants with service or support per service or support category.]

Most received mental health treatment services (93%) and stabilizing medications (72%); of those who received medications, 40% received a long-acting injectable.

Let's take a closer look at these services and supports.

- The most common service type accessed was mental health (MH) treatment services, with 93 percent of CARE participants receiving at least one MH treatment service during their Active Service Period. The top two most accessed MH services were targeted case management and medication support. The majority of participants also received stabilizing medications (72 percent) and social services and supports (60 percent).

- The least commonly received service type provided was substance use disorder treatment services.

- 16 percent of CARE participants accessed a California Advancing and Innovating Medi-Cal (CalAIM) community support. These supports are a set of services designed to address the social determinants of health and improve well being of individuals with complex needs. The most frequently provided CalAIM supports provided were housing tenancy and sustaining services and housing transition navigation services.

* Values are not shown to protect the confidentiality of the individuals summarized in the data. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

## Housing Supports

Fifteen percent of CARE participants received a CalAIM housing service or support, and 31 percent received a county, state or federally funded housing service or support.

| Housing Service or Support Category | Total CARE Participants (CARE Agreements + Plans) (n=101) with Support n(%) |
|---|---|
| Any CalAIM Housing Support | 15 (14.8%) |
| Any County, State, or Federally Funded Housing Support (Not CalAIM) | 31 (30.7%) |

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

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[Slide Image Description: This slide contains an image of a paper cut-out of a house being held by a person's hand, beside a table showing the number and percentage of total CARE participants with support by housing service or support category.]

Because engagement in evidence-based treatment is difficult when an individual is unhoused or unstably housed, a critical feature of the CARE Act is to promote access to a diverse range of housing services and supports

We observed that 15% of CARE participants received a CalAIM housing service or support, and 31% received a housing service or support funded through county, state, and federal programs at some point during their Active Service Period (e.g., The No Place Like Home Program, California Housing Accelerator, The Multifamily Housing Program).

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

## Receipt of Key Recovery-Supporting Services

63 percent of CARE participants received all three critical services—stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports—while 28 percent received two of the three, most often a combination of housing supports and psychosocial treatment.

| Three Recovery-Supporting Services | Total CARE Participants (CARE Agreements + Plans) (n=101) with Service or Support n(%) |
|---|---|
| All Three Components | 64 (63.4%) |
| Two of Three Components | 28 (27.7%) |
| One of Three Components | * |
| No Components | * |

*Values are not shown to protect the confidentiality of the individuals summarized in the data.

**Note**: a CARE participant was counted as having housing supports if they (a) accessed a housing support program (e.g., No Place Like Home, California Housing Accelerator); (b) received a CalAIM community housing support service (i.e., Housing Deposits); or (c) were housed in permanent, temporary, or institutional housing.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

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[Slide Image Description: This slide contains an image of a woman with her arms around another woman offering support, beside a table showing the number and percentage of total CARE participants with service or support per the three recovery-supporting services.]

Collectively, three evidence-based components of care form the recovery-supporting services that are tracked as a measure of CARE Act success: **stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports**.

- 63 percent of CARE participants received all three key services and supports during their Active Service Period, and 28 percent received two of the three key services and supports.
- Of the participants that received two of the three services and supports, the most commonly observed combination was housing supports and psychosocial and community-based treatment.
- For the purposes of this analysis, a CARE participant was counted as having housing supports if they (a) accessed a housing support program (e.g., No Place Like Home, California Housing Accelerator); (b) received a CalAIM community housing support

service (i.e., Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, or ShortTerm Post-Hospitalization Housing); or (c) were housed in permanent, temporary, or institutional housing.

Note that values are not shown to protect the confidentiality of the individuals summarized in the data, including the number of CARE participants receiving either one component or no components.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I
Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024.
Prepared by the California Department of Health Care Services.


## Unmet Needs Impacting Community Stability

### Housing Challenges

- **28% were unhoused** for at least part of the active service period.
- **12% were temporarily housed.**
- **20% spent a majority of a month in institutional settings** (e.g., jail, prison, psychiatric facility, hospital, long-term or nursing home care facility)

### Other Indicators of Unmet Needs*

- **25%** had criminal justice involvement.
- **21%** visited an emergency department.
- **20%** had inpatient hospitalizations.
- **20%** experienced LPS holds.

* About **15%** of data on these events was reported as "unknown," suggesting that these challenges may be even more widespread.

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[Slide Image Description: This slide contains an image of a first responder and an ambulance, beside some information regarding unmet needs impacting community stability.]

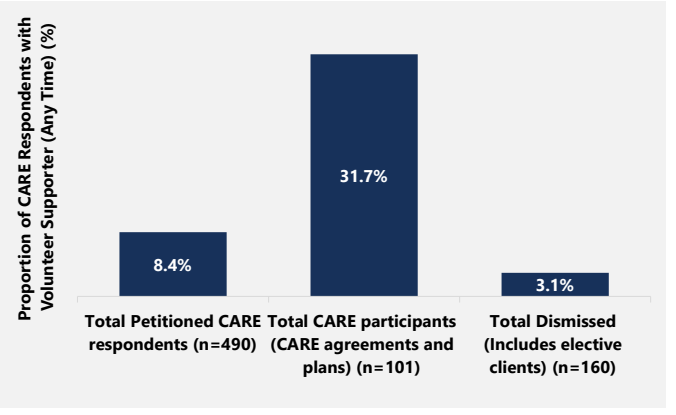
This slide summarizes the number and proportion of CARE participants who had an event that may signal a need that was not addressed within a community-based setting at some point during their Active Service Period.

- Housing Challenges
    - The most common unmet need for CARE participants was securing and maintaining permanent housing. At some point during their Active Service Period, 28 percent were unhoused, 12 percent were temporarily housed, and 20 percent were institutionally housed (e.g., jail, prison, psychiatric facility, hospital, long-term or nursing home care facility) for, at minimum, the majority of a month.
- Other Indicators of Unmet Meets
    - At some point during their Active Service Period:
        - One quarter of CARE participants had criminal justice involvement.
        - One fifth had an emergency department visit.
        - One fifth had an inpatient hospitalization.
        - One fifth had an LPS hold.
    - About 15% of data on these events was reported as "unknown," suggesting that these challenges may be even more widespread.

## Adoption of PADs and Volunteer Supporters

Psychiatric advance directives (PADs) and volunteer supporters are considered key features of person-centered care for CARE participants.

- No PADs were reported for any CARE participant.
- A third of participants had a volunteer supporter.




Values for Total dismissed petitions are not shown to protect confidentiality of individuals. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services

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[Slide Image Description: This slide contains a bar chart showing the proportion of CARE respondents with volunteer support in the categories of total petitioned CARE respondents, total CARE participants, and total dismissed.]

The CARE Act emphasizes two key features to support person-centered care for CARE participants: psychiatric advance directives (PADs) and volunteer supporters.

- PADs
    - Specific to the CARE Act, PADs can be a useful tool to ensure services are delivered to an individual in alignment with their preferences throughout CARE court and beyond.
    - At the time of this report, no PADs had yet been established for any CARE participant.
- Volunteer Supporters
    - A volunteer supporter is an adult chosen by the CARE respondent to provide support throughout the CARE process. Their role is to promote the respondent's preferences, choices, and autonomy. The volunteer supporter helps the respondent understand, make, and communicate decisions and

express preferences during CARE proceedings. This person can be any adult selected by the respondent—such as a family member, friend, homeless outreach worker, or even a peer or peer support specialist.

- As shown in the chart on this slide, approximately one-third of CARE participants (32%) and 8% of CARE respondents elected to have a volunteer supporter. Among those, about 80% were family members.
- Note that this data refers exclusively to the volunteer supporter role. This is separate from peer involvement in treatment teams or outreach teams which many counties have incorporated into their CARE work.

## Elective Clients

During the first nine months, 15 petitioned CARE-eligible clients were diverted to receive county services and supports outside court jurisdiction, referred to as "elective clients."

Elective clients received fewer services overall than CARE participants, but also had more data quality issues (e.g., missingness) – likely reflecting inherent challenges with tracking individuals outside the court jurisdiction.

Half the elective clients were enrolled in ACT, but none were engaged in FSP, Early Psychosis Intervention, or Forensic ACT (FACT) services.

Few received all three services and supports foundational to recovery (i.e., stabilizing medications, comprehensive BH services, housing supports).

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[Slide Image Description: This slide contains information about elective clients over a light blue background, along with an image of a man in a white shirt within a hexagon frame representative of an elective client.]

During the first nine months of CARE Act implementation, 15 petitioned CARE-eligible clients were diverted to receive county services and supports outside court jurisdiction, referred to as "elective clients."

- Elective clients received fewer services overall than CARE participants, but also had more data quality issues (e.g., missingness) – likely reflecting inherent challenges with tracking individuals outside the court jurisdiction. Overall, we found elective clients received fewer services than CARE participants, with only MH and SUD services being accessed by this group.
- Half of elective clients were enrolled in ACT, but none were engaged in FSP, Early Psychosis Intervention, or Forensic ACT (FACT) services.
- With regard to the **three evidence-based services and supports that provide critical foundations for recovery** (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports), very few elective clients received all three services and supports foundational to recovery.

## Data Limitations: Inconsistencies Between County BH and Court Data

- Discrepancies in County BH and JC reported counts of CARE plans ordered and CARE agreements approved.
- County BH agencies have been encouraged to work with their CARE courts to identify opportunities to improve coordination and alignment of submitted data.

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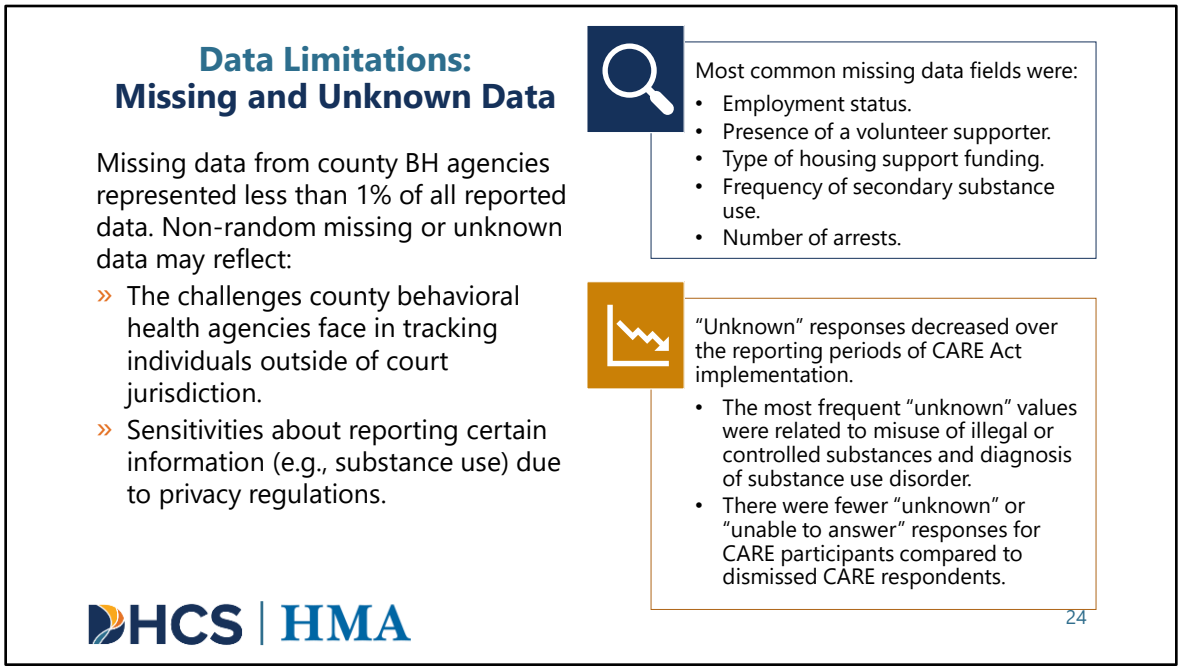
[Slide Image Description: This slide contains an abstract image composed of numerous circular shapes featured in varying degrees of focus, representative of data points.]

There are some data limitations to note, specifically inconsistencies between county BH and court data.

- Discrepancies in county BH and JC reported counts of CARE plans ordered and CARE agreements approved.
- County BH agencies have been encouraged to work with their CARE courts to identify opportunities to improve coordination and alignment of submitted data.




[Slide Image Description: This slide contains an image of a magnifying glass by a text box about the most common missing data fields, and an image of a downward-sloping line graph by a text box about 'unknown responses decreasing over the reporting periods of CARE Act implementation.]

Second, across the first nine months, we did observe missing or unknown data being reported by county BH agencies, less than 1% of all reported data.

- When we reviewed the missing or unknown responses, we found that missingness was not random; we saw higher missingness for elective clients and among certain data points.
- This could reflect :
    - The challenges county BH agencies face in tracking individuals outside of court jurisdiction.
    - Sensitivities about reporting certain information (e.g., substance use) due to privacy regulations.

- The most common missing data fields were:
    - Employment status
    - Presence of a volunteer supporter

    - Type of housing support funding
    - Frequency of secondary substance use
    - Number of arrests
- "Unknown" responses decreased over the reporting periods of CARE Act implementation.
    - The most frequent "unknown" values were related to misuse of illegal or controlled substances and diagnosis of substance use disorder.
    - There were fewer "unknown" or "unable to answer" responses for CARE participants compared to dismissed CARE respondents.


[Slide Image Description: This slide introduces the next section of the presentation, “key takeaways and opportunities: lessons from the first nine months”, over a dark blue background.]

Now that we’ve taken a look at the data in the Annual Report, let’s discuss some key takeaways and opportunities to leverage findings.

Key Takeaways

**The majority of CARE respondents engaged were males, between ages 26-45, and indicated English as their preferred language. Over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian.**

**Opportunities to Leverage Findings**

- Increase awareness of CARE Act among system partners and potential petitioners.
- Expanding outreach and engagement efforts (and data collection) in CARE Act implementation, ensuring equitable access for eligible individuals who may be difficult to reach.

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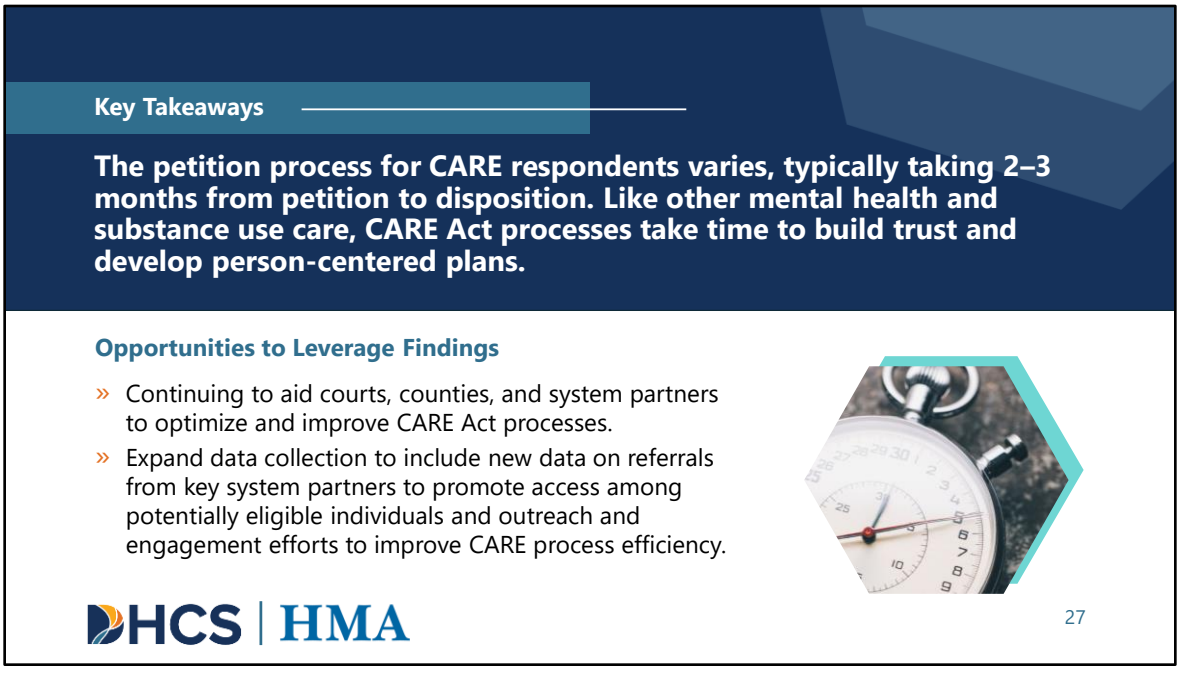
[Slide Image Description: This slide features a short paragraph on a key takeaway from the first 9 months of CARE Act implementation, over a dark blue background, beneath which is an image of a person holding someone else's hand.]

The majority of CARE respondents engaged were males, between ages 26-45, and indicated English as their preferred language. Over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian.

These findings suggest a need to expand efforts to raise awareness about the CARE Act, especially for particular populations. Efforts should focus on the public, as well as those involved in CARE Act implementation, and be aligned with ensuring equitable access to CARE for potentially eligible individuals.

Specific opportunities, most of which are already underway, include:

- Expanding efforts to raise awareness about the CARE Act, especially among system partners and other potential petitioners who may be well-positioned to refer and connect individuals to CARE.
- Expanding outreach and engagement efforts in CARE Act implementation, ensuring equitable access for eligible individuals who may be difficult to reach (e.g., limited English proficiency, individuals experiencing homelessness, non-citizens, and those not enrolled in Medi-Cal).




[Slide Image Description: This slide features a short paragraph on a key takeaway from the first 9 months of CARE Act implementation, over a dark blue background, beneath which is an image of stopwatch.]

**The next takeaway is that CARE Act processes—like all MH and SUD care—may require time to build trust and develop person-centered plans needed for long-term recovery and stability.**

We found that the petition process for CARE respondents is not uniform, with the **time from petitioning to disposition assignment taking 2-3 months, on average; 85% of respondents taking more than 31 days to have a disposition assigned.**

**Opportunities to Leverage Findings:**

- Continuing to aid courts, counties, and system partners to optimize and improve CARE Act processes.
- Expand data collection to include new data on referrals from key system partners to promote access among potentially eligible individuals and outreach and engagement efforts to improve CARE process efficiency.

## Key Takeaways

**Ongoing housing services and supports are an area of high need, likely compounded by other unmet needs among CARE participants. The proportion of CARE participants with permanent housing increased over the first nine months of CARE implementation (from 46 percent to 56 percent).**

### Opportunities to Leverage Findings

- Prioritize housing services and connect participants to federal and state programs supporting housing needs.
- Promote awareness of programs that offer rental subsidies and housing supports, such as BH-CONNECT and Proposition 1.

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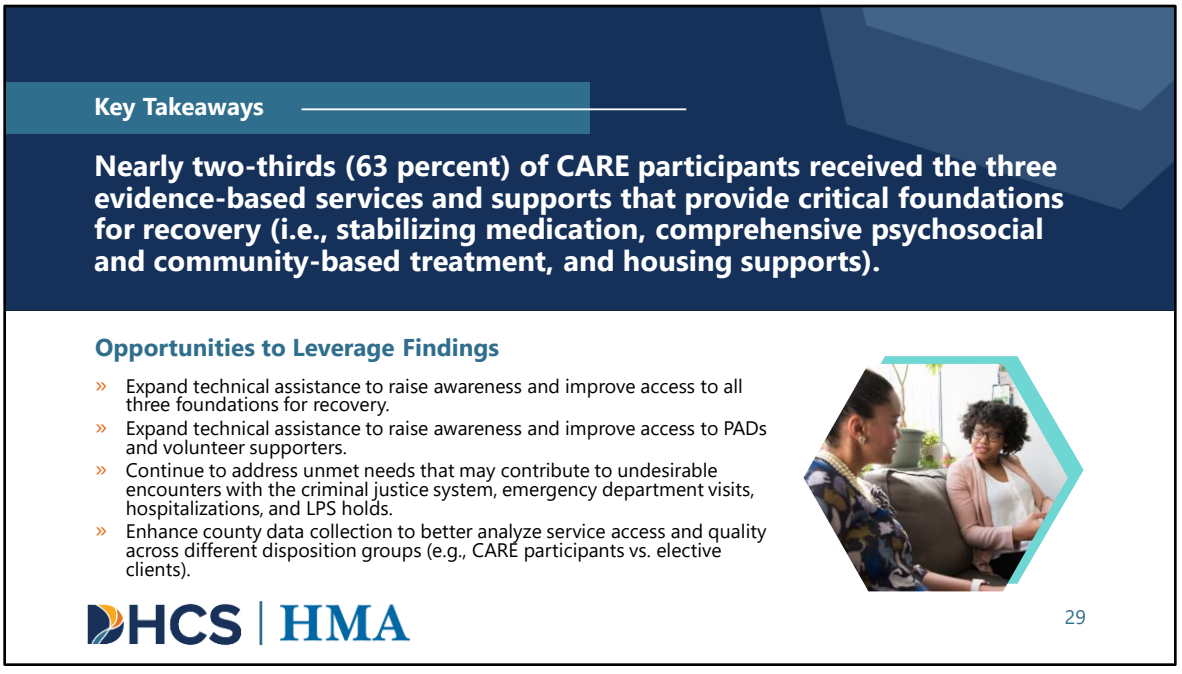
[Slide Image Description: This slide features a short paragraph on a key takeaway from the first 9 months of CARE Act implementation, over a dark blue background, beneath which is an image of a key inserted within a door lock.]

**The next takeaway is that ongoing housing services and supports are an area of need for the CARE population and are essential to helping individuals manage serious mental illness and make progress toward long-term recovery.**

Overall, the data from these first three quarters of implementation were promising in terms of CARE supporting housing, with the proportion of CARE participants with any housing, as well as permanent housing, increasing over time. However, there is still a sizable proportion of CARE participants who are unhoused or show instability in housing status.

**Opportunities to Leverage Findings:**

- Prioritize housing services and supports for CARE participants and ensure they have access to federal and state programs that support the housing needs of eligible individuals.
- Increase awareness of programs that prioritize CARE participants for permanent rental subsidies, housing services, and supports, (e.g., Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) and Proposition 1).




[Slide Image Description: This slide features a short paragraph on a key takeaway from the first 9 months of CARE Act implementation, over a dark blue background, beneath which is an image of a woman speaking with another woman, receiving support services.]

**The next key takeaway from the AR is that two-thirds of CARE participants received the three evidence-based services and supports that provide critical foundations for recovery (*i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports*).**

- We did note that, across all service and support types, elective clients were found to access services at lower rates than CARE participants and very few received the three foundations for recovery.
- This may suggest that CARE civil process and court oversight associated with a CARE plan or CARE agreement may enhance client access and engagement in services and improve county accountability in efforts to engage these individuals.
- We also noted that psychiatric advance directives and volunteer supporters were underutilized over the first nine months of CARE implementation. There were no

PADs established for any CARE participants and just one third of participants had an assigned volunteer supporter

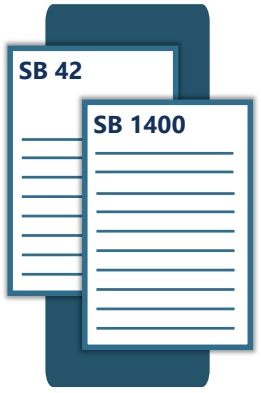
**Opportunities to Leverage Findings:**

- Expand TA efforts to promote awareness of best practices and improve access to all three foundations for recovery, as well as promote the use of PADs, and volunteer supporters.
- Continue to identify opportunities to reduce undesirable encounters with criminal justice, law enforcement, and acute care
- Expand county CARE Act data collection to include new data that will allow for more robust analysis of access to and quality of care among individuals petitioned to CARE who receive different dispositions (e.g., CARE participants vs. elective clients).


[Slide Image Description: This slide introduces the next section of this presentation over a dark blue background: “Policy in Action: CARE Act Legislative Updates”.]

We next want to discuss some recent updates to CARE Act legislation that have impacted the data collection and reporting processes

## Legislative Updates




» Senate Bill (SB) 42: Amended provisions of the CARE Act, including referrals by facilities to County BH, communication between courts, alternatives to conservatorship, changes to CARE procedures, as well as collaboration on system performance.
- Referral data from facilities to be included in the Annual CARE Act Report (SB 42 Brief here).

» Senate Bill (SB) 1400*: Amended provisions of the Penal Code related to CARE referrals of individuals deemed incompetent to stand trial. Additionally, it amends provisions to expand reporting requirements related to CARE inquires, referrals, and petitioned individuals (SB 1400 Brief here).

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[Slide Image Description: This slide contains an image representing two pieces of legislation: SB 42 and SB 1400.]

In particular, two legislative updates had implications for data collection and reporting: Senate bill 42 and 1400.

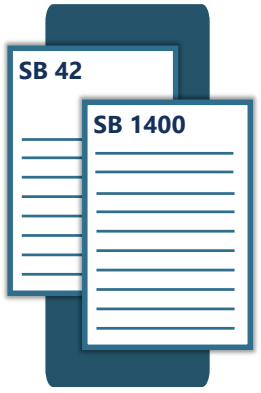
- Senate Bill (SB) 42: Amended provisions of the CARE Act, including referrals by facilities to County BH, communication between courts, alternatives to conservatorship, changes to CARE procedures, as well as collaboration on system performance.
    - Referral data from facilities to be included in the Annual CARE Act Report (SB 42 Brief here).

- Senate Bill (SB) 1400*: Amended provisions of the Penal Code related to CARE referrals of individuals deemed incompetent to stand trial. Additionally, it amends provisions to expand reporting requirements related to CARE inquires, referrals, and petitioned individuals (SB 1400 Brief here).

Two briefs on these legislative updates and their impacts are available on the CARE Act Resource Center.

https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB42
https://care-act.org/resource/senate-bill-42-amendments/
https://legiscan.com/CA/bill/SB1400/2023
https://care-act.org/resource/senate-bill-1400-amendments/

## Legislative Updates




- Per SB 1400, DHCS is required to include the additional data elements in its annual CARE Act report, beginning in 2026. These include:
  - Outreach and engagement to petitioned and referred individuals.
  - Services provided during early stages of the CARE process.
  - County recommendations and court actions.
  - System referrals and inquires made to County BH agencies.
- **Effective January 1, 2025**, counties are expected to report on the expanded data requirements.

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[Slide Image Description: This slide contains an image representing two pieces of legislation: SB 42 and SB 1400.]

Related to CARE Act data reporting, these bills require DHCS, beginning in 2026, to include additional data in its annual CARE Act report to be posted on the DHCS website.

County CARE Act data collection and reporting requirements have been expanded, effective January 1, 2025, to now include:

- Outreach and engagement efforts to both petitioned and referred individuals.
- Outcomes and patterns of service access among individuals petitioned to CARE during the time period prior to court disposition assignment.
- County recommendations and court actions related to eligibility of petitioned individuals.
- Referrals from key system partners to promote access among potentially eligible individuals.

These updates have already been incorporated into the DD 2.0 and counties have successfully reported quarter 1 2025 data in accordance with these new data points and requirements.


[Slide Image Description: This slide introduces the next section of this presentation over a dark blue background: “Data Collection and Reporting Resource Review”.]

Finally, we want to end by speaking to some of the resources we have made available to counties related to data collection and reporting


## Data Collection & Reporting TTA for Counties

- Redesigned Data Collection and Reporting Resources page:
  - Trainings, tools, and resources to support reporting and transition to Data Dictionary 2.0.
  - Supplemental Guide with general and scenario-based guidance.
- Ongoing bi-weekly data office hours, with special topics.
- Dedicated CARE Data email inbox. CAREdatateam@healthmanagement.com
- Novel training presentations, including a Q1 2025 Data Quality Summary upcoming in July 2025.

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[Slide Image Description: This slide contains a screenshot of the data collection & reporting resources page on the CARE Act resource center website.]

To support county data collection and reporting, HMA has developed various resources, including:

- Redesigned Data Collection and Reporting Resources page:
  - Trainings, tools, and resources to support reporting and transition to Data Dictionary 2.0.
  - Supplemental Guide with general and scenario-based guidance.
- Ongoing bi-weekly data office hours, with special topics.
- Dedicated CARE Data email inbox. CAREdatateam@healthmanagement.com
- Novel training presentations, including a Q1 2025 Data Quality Summary upcoming in July 2025.

https://care-act.org/library/data-collection-reporting-resources/
mailto:CAREdatateam@healthmanagement.com


[Slide Image Description: This slide includes a prompt for the audience to ask questions, and under a curvy blue line design contains the logos for the California Department of Health Care Services and Health Management Associates.]

Please reach out to info@CARE-Act.org with questions. Email CAREdatateam@healthmanagement.com for questions specific to data collection and reporting.

CARE-Act.org