Community Assistance, Recovery and Empowerment (CARE) Act

California Health & Human Services Agency

Person Centered. Equity Focused. Data Driven.

CARE Act Working Group Meeting
May 13, 2026

California Health & Human Services Agency

Person Centered. Equity Focused. Data Driven.

Welcome and Opening Remarks

Agenda

1. Welcome and Opening Remarks
2. CARE Act Implementation Updates
3. Featured Topic: Families and Peers
4. CARE Act Data: Reporting and Evaluation Update
5. Lunch
6. Fresno County CARE Act Implementation Update
7. San Bernardino CARE Act Implementation Update
8. Working Group Discussion of 2026 Priorities
9. Closing Thoughts
10. Public Comment

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Working Group Members

Amber Irvine

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Nichole Zaragoza-Smith

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Sarah Davis

Hon. Scott Herin

Stephanie Regular

Stephanie Welch

Susan Holt

Tim Lutz

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Virtual Meeting Guidelines

- Meeting is being recorded
- American Sign Language interpretation in pinned video
- Live captioning link provided in chat

Working Group Members

- Mute/Unmute works for members and policy partners.
- Stay ON MUTE when not speaking and use the “raise hand feature” if you have a question or comment.
- Please turn on your camera as you are comfortable

MEMBERS OF THE PUBLIC will be invited to participate during public comment period

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Working Group Overview – Operations

- The Working Group will meet quarterly during the implementation of the CARE Act through December 31, 2026.
- Working Group meetings will be a mix of in person and virtual, with in person meetings held primarily in Sacramento, but at times possibly in other locations throughout California.
- Working group members are expected to attend 75% of meetings each year, with the option of sending a delegate for the remainder.
- All meetings of the Working Group shall be open to the public and subject to Bagley-Keene Open Meeting Act requirements.

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Working Group Agreements

- Be present and curious.
- Respect each other's expertise and time and participate fully.
- Encourage different opinions and be respectful of disagreements.
- Be accountable to your fellow group members and practice patience and persistence – we can't solve everything in a single conversation or meeting, but we need to remain solution focused.
- Assume Positive Intent: Trust that people are doing the best they can.

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Recap of February Meeting

1. San Diego Implementation Update
2. CARE Act Communication Strategies
3. Potential Framework from Psychiatry Subject Matter Experts on CARE Agreements/Plans
4. Looking Ahead: 2026 CARE Act Annual Report

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CARE Act Implementation Updates

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health
California Health and Human Services Agency

The Latest CARE Act Data (March 2026)

- 4,409 petitions
- 1,097 agreements
- 41 plans
- 4,887 diversions / redirections

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February Site Visits

- **February 23 in San Bernardino**
  - Tour of mobile court unit
  - Discussion of implementation successes and opportunities
  - Tour of service rich housing site for CARE respondents and others
- **February 24 in Riverside**
  - Sec. Johnson and Dep. Sec. Welch meeting with City of Riverside Mayor
  - Roundtable with leaders. See Press Release
  - Sec. Johnson and Dep. Sec. Welch meeting with BH leadership

More Site Visits!

Ventura (March 18)

- County Leadership meeting
- Court visit
- Tour of jail health unit
- Discussion with jail mental health deputies to support petitions

Orange County (Apr 24)

- County Leadership meeting
- Meeting with City of Irvine Police Department and Irvine Community Alternative Response and Engagement (I-CARE) Team
- Meeting with NAMI OC and Community Members

Santa Clara (May 6)

- Discussion of BH continuum and CARE
- Self-help center visit
- Court visit and meeting with judge, county counsel, public defenders and staff
- County Leadership meeting

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Monterey Site Visit Highlights (May 7)

- Discussion of county history of BH continuum and CARE implementation
- Visit to BHBH site with CARE respondents and other residents
- Discussion of CARE legal and policy challenges and opportunities

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Additional Data Collection for CARE

Behavioral Health Services Act (BHSA) Integrated Plan CARE Act Questions

1. Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.
2. Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.
3. Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

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CARE Court Improvement and Coordination Unit (ICU) Activities

Site Visits & Implementation Support

Training & Technical Assistance for Petitioners

Strategic Communication Support

Resource Coordination & Funding Access

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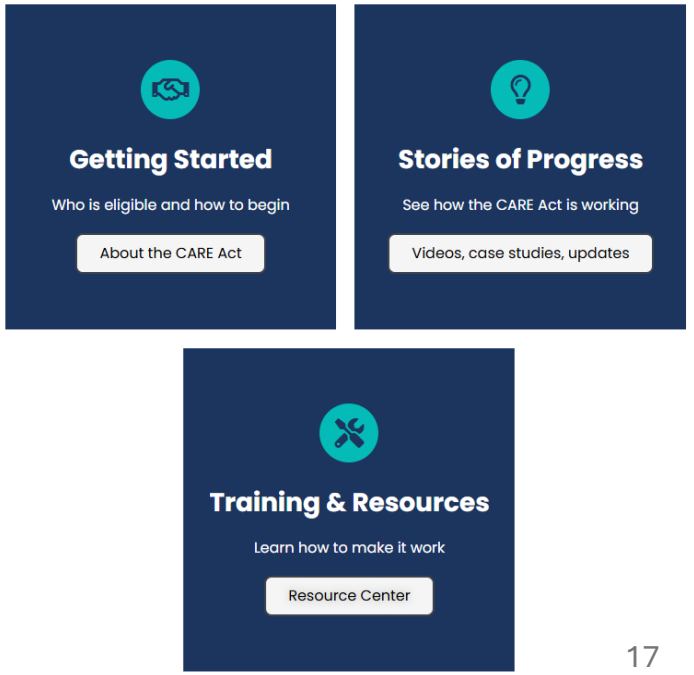
Communications Updates

- CalHHS CARE Act website traffic rose to **32,000 visitors** during April.
- CalHHS continues posting weekly videos and quotes from CARE stakeholders across the state, with 30 new videos posted to YouTube this year. Please re-share our CARE content!
- To bolster awareness of CARE, we're continuing to gather CARE stories of progress. Particularly strong stories:
  - Reflect progress, including non-linear or imperfect progress
  - Clarify the impact of CARE on petitioners and families
  - Show the coordinated services activated through CARE
- We're looking for stories from lived experience, including petitioners, and their families. To submit a story, reach out to Neimand Collaborative at any time at sarah@ncollaborative.com.



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Featured Topic: Families and Peers

Keris Jän Myrick, CARE Act Working Group Member

FOCUS GROUP BACKGROUND

- Initial meeting held 4/27. Planning in progress for future meetings.
- This group was convened to expand the prior provider-focused discussion on establishing a standard of care.
- Assembled with the intent of centering the perspectives of people with lived experience and first-hand family experience in CARE.
  - Goal: Elevate peer and family perspectives to inform collaborative, creative solutions that strengthen and improve the CARE process.
  - Focused on implementation guidance, not policy recommendations.

PRIORITY TOPICS

With CARE as we know it today:

- How can peers and family members be better integrated and optimally engaged in the CARE process?

- How can supports for family members be strengthened?

- How can the voluntary supporter role be more effectively implemented? What are the benefits and challenges of the range of individuals who may serve in this role?

OVERARCHING DISCUSSION THEMES

- Participants emphasized the importance of recognizing the needs of both:
  - People receiving care, and
  - People providing care, especially family members and other loved ones.

- Participants highlighted the need to move beyond a purely clinical frame and beyond traditional county systems, toward a broader recovery-oriented approach.
  - Must integrate meaning, belonging, trusted relationships, broad social networks, and community-based supports.
  - Must think creatively about resources that can be leveraged to support the needs of participants and families, taking a cross-system approach (e.g. IHSS)

ROLE OF PEER SUPPORT IN THE CARE PROCESS

Key takeaways from initial discussion:

- Peer support is invaluable for both respondents and family members alike.
- Peers working with the CARE population need the right experience, preparation, and fit.
- Expanding peer support in court settings is a priority, which requires appropriate training.
- TA is needed to expand capacity of county systems to hire and supervise peer staff.
- Peer-run organizations have a role to play in delivering peer services in CARE.

NEEDS OF FAMILY MEMBERS IN CARE

Key takeaways from initial discussion:

- Families often carry substantial responsibility for supporting loved ones in CARE, especially outside of standard business hours.

- Families and other loved ones need:
  - Better access to 24/7 support
  - Peer support structures
  - Connection to community-based networks and resources that can reduce reliance on formal systems alone

STRENGTHENING THE VOLUNTARY SUPPORTER ROLE

Key takeaways from initial discussion:

- More education is needed around what the supporter role (and supported decision-making) is and is not.
- Additional training is needed for supporters, including resource lists and practical guidance on engagement strategies.
- Identifying a supporter should begin with understanding a participant's existing support network from their own perspective.
  - In some cases, non-family supporters may be a better fit for their needs

POTENTIAL TA TOPICS FOR COUNTIES

- Guidance on recruiting, interviewing, and supervising peer staff
- Clarifying the skills and competencies needed for peer roles in CARE
- Consideration of what additional preparation peers need to operate effectively in court-based environments
- Connecting respondents and families to community-based resources in addition to clinical care and housing, and guidance on including these resources in CARE agreements/plans
- Broadening understandings of recovery, engagement, and support networks

NEXT STEPS

- Continue convening peer/family focus groups prior to the August Working Group meeting with the goal of developing concrete recommendations for the Working Group
  - Co-facilitation planned for subsequent meetings

- Integrate peer/family perspective with provider clinical standard of care recommendations

Q&A

CARE Act Data: Reporting and Evaluation Update

Health Management Associates

RAND

2026 CARE ACT ANNUAL REPORT

CARE Act Working Group

May 13, 2026

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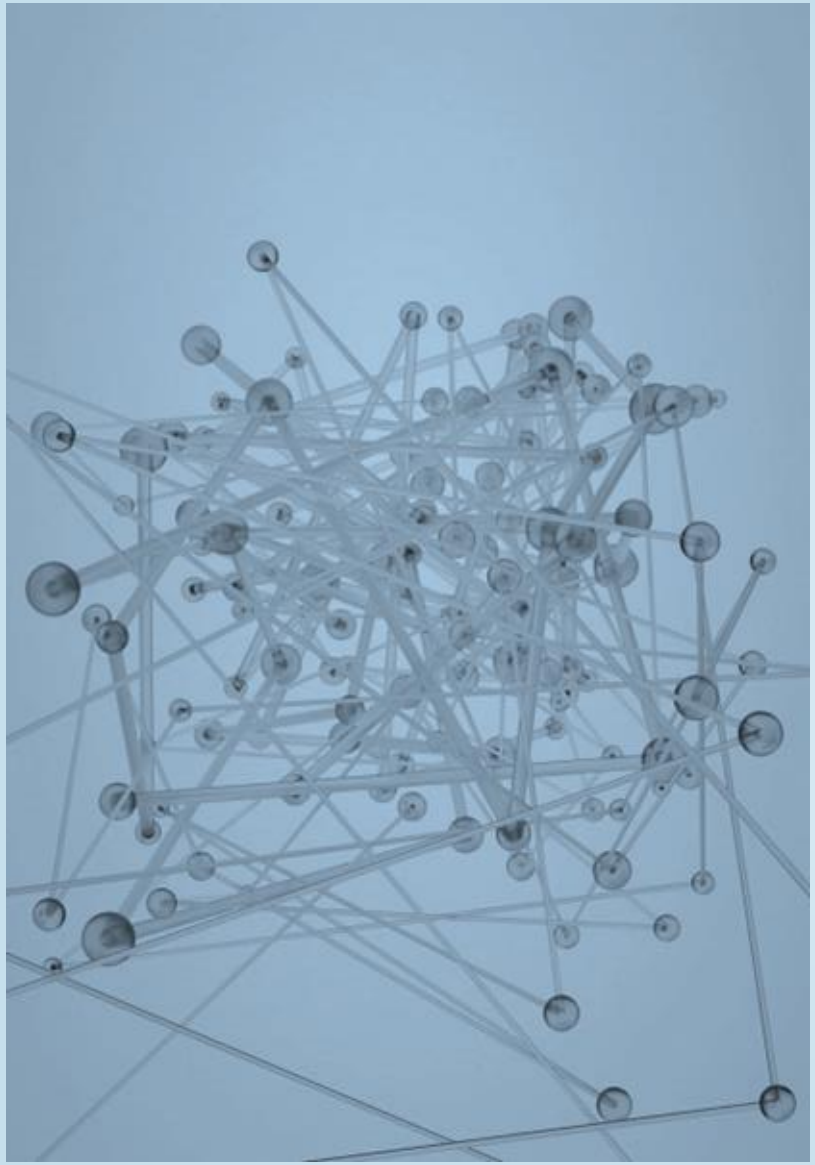
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

HMA



Agenda

The Annual Report vs. Independent Evaluation

What's New in 2026 Annual Report

Questions and Answers

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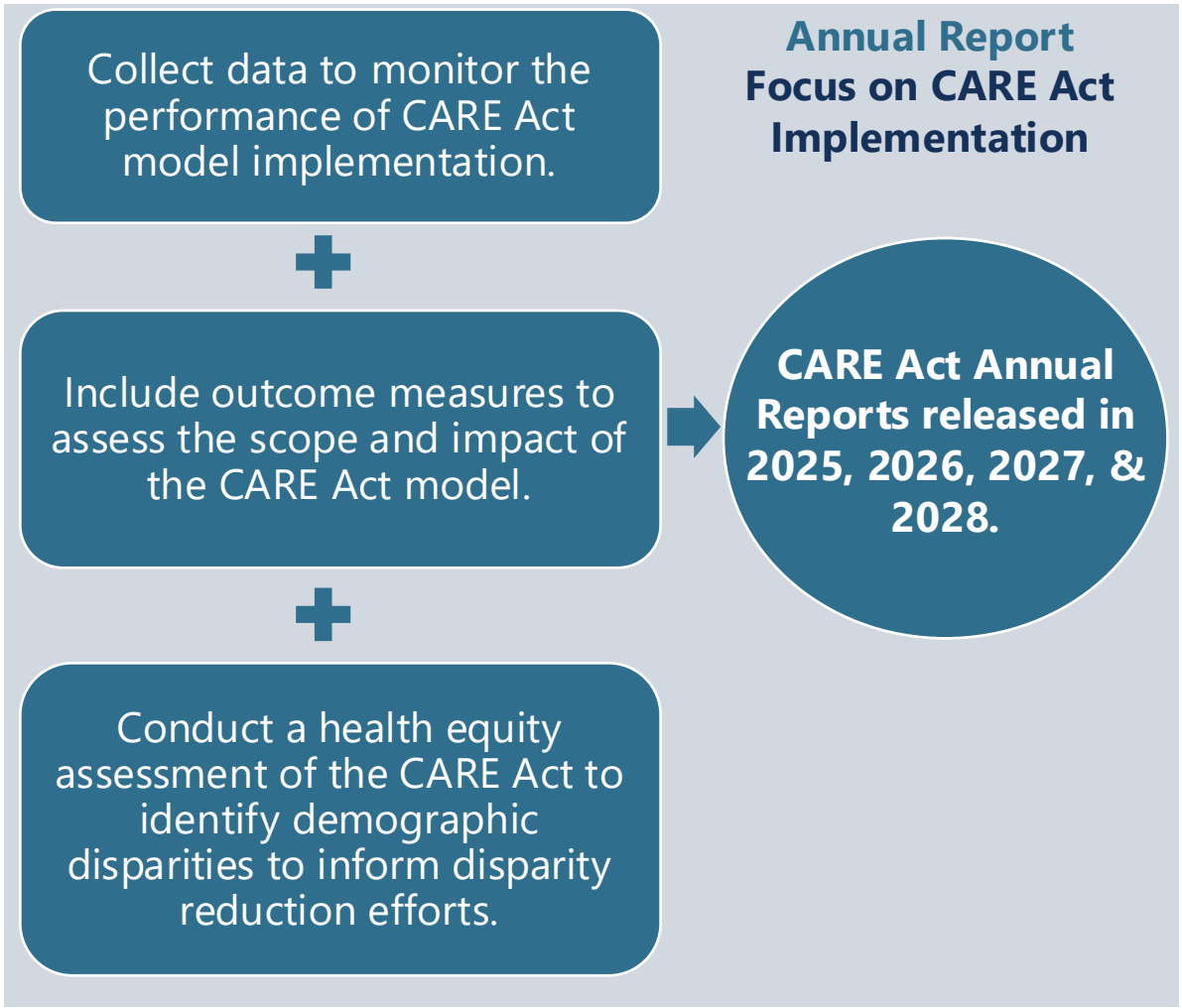
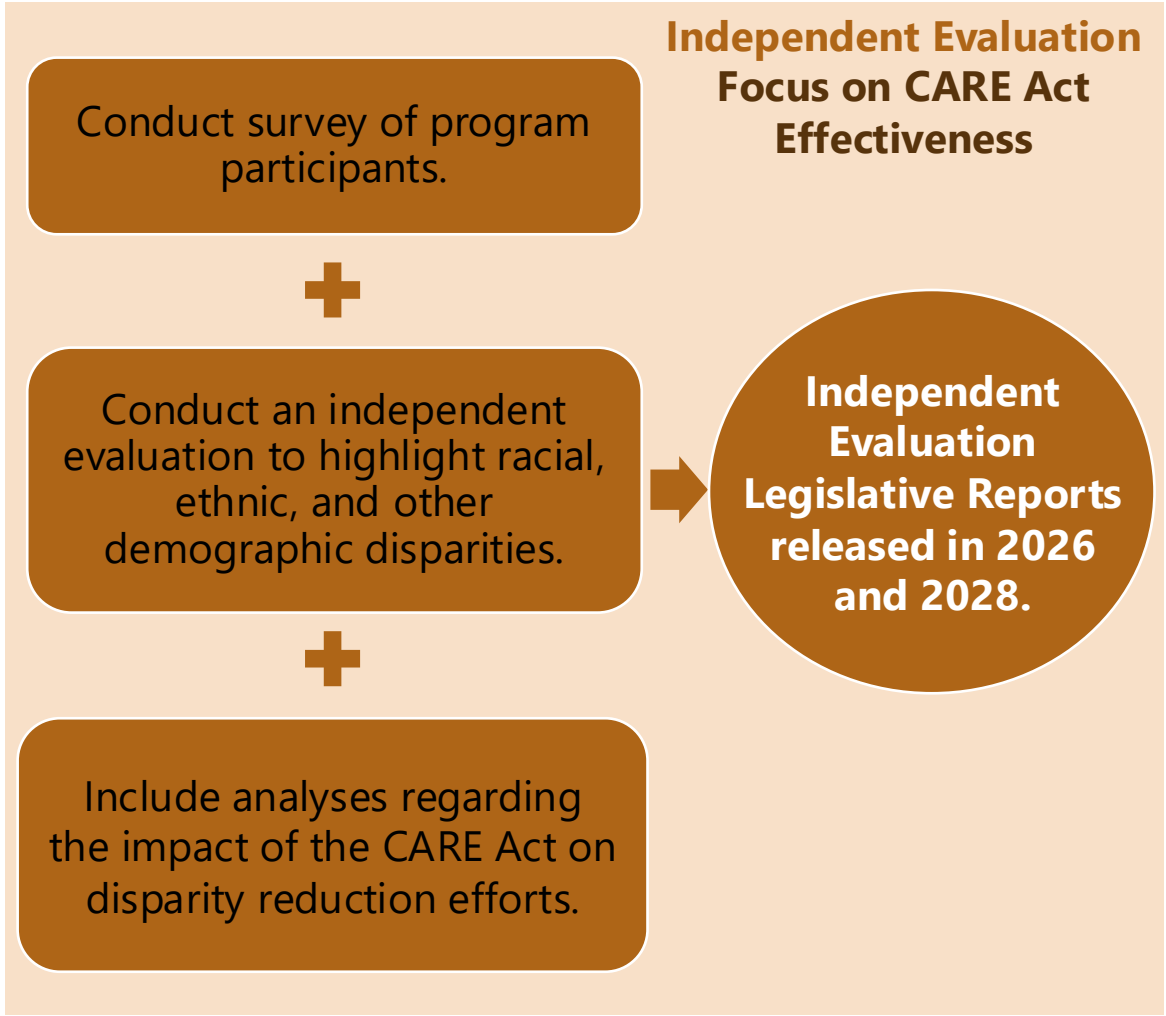
DHCS Reports: Annual Report vs. Independent Evaluation





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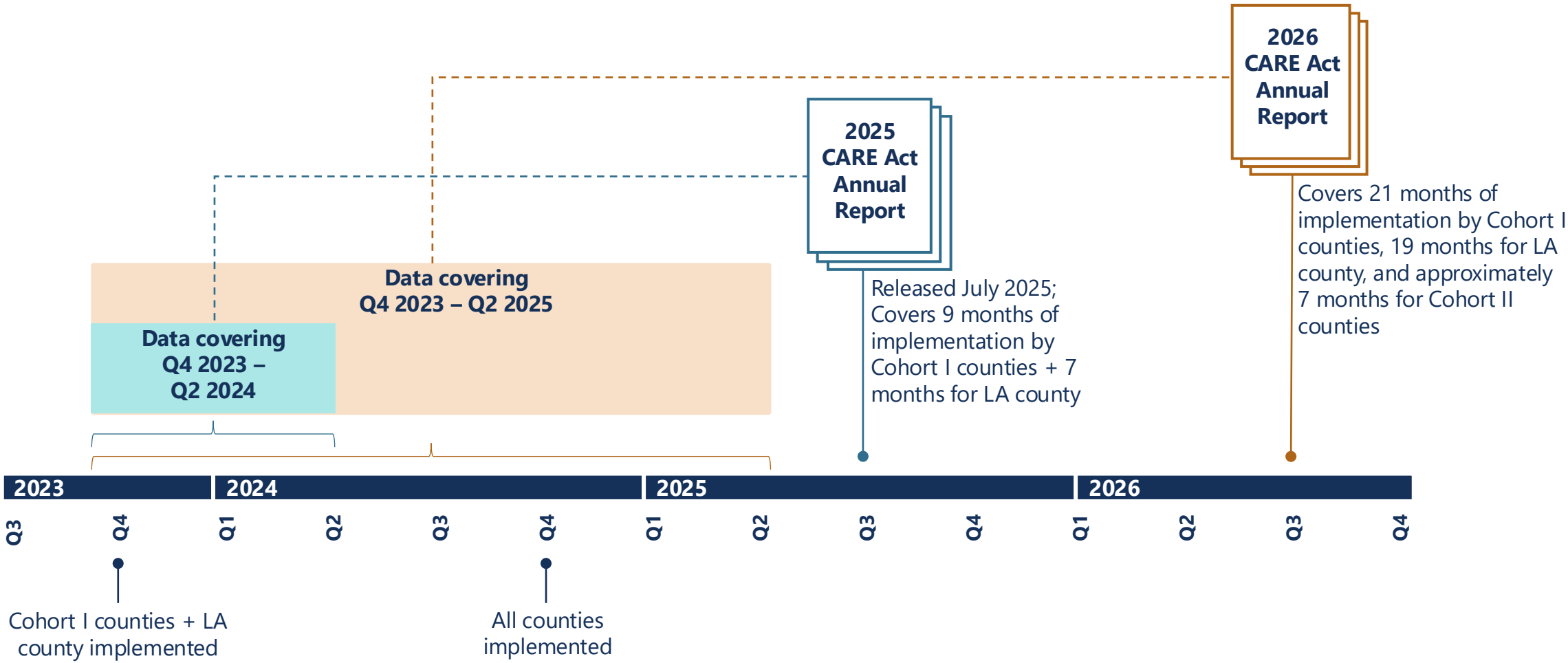
2026 Annual Report



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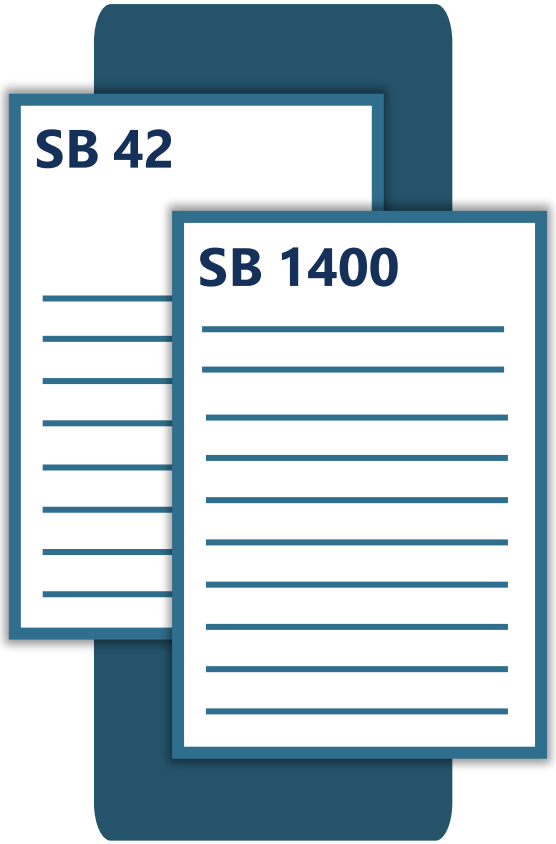
Legislative Impacts on Annual Reports



- Per SB 1400, DHCS is now required to include 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 will have contributed two reporting periods (six months) of this new data to the Annual Report.

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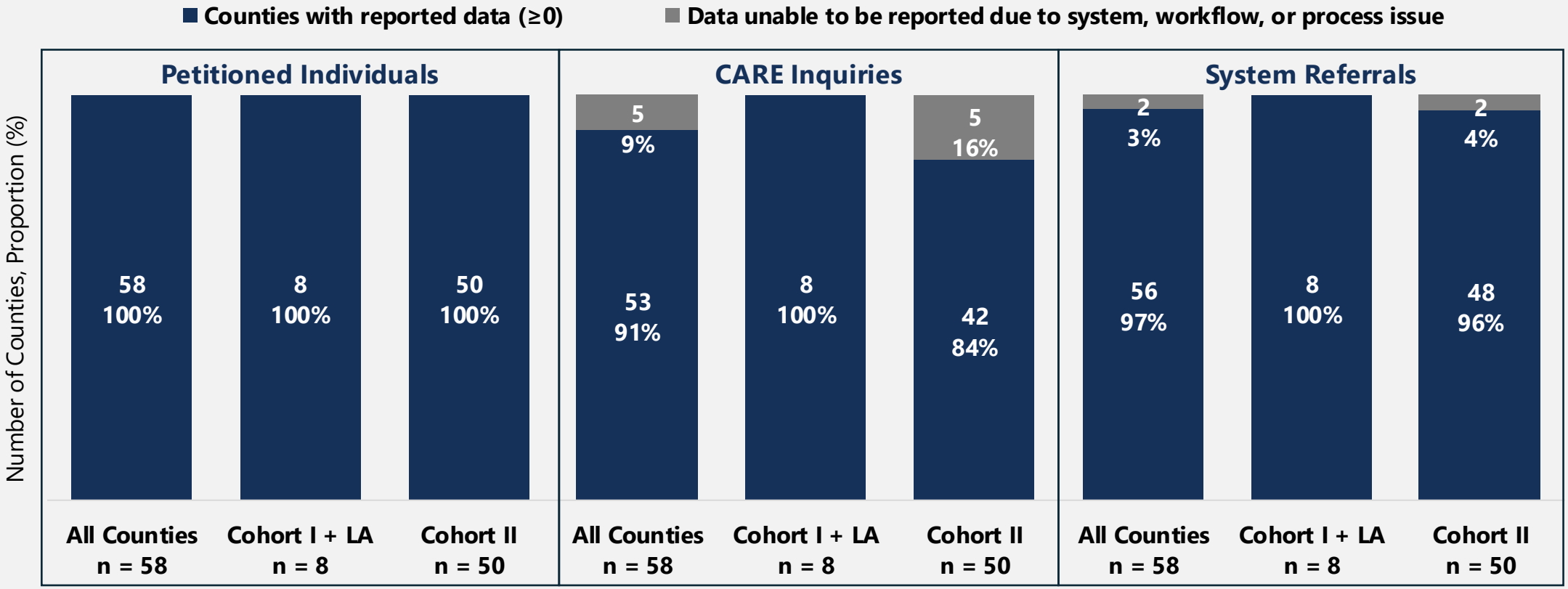
Statewide CARE Act Reporting

58 counties reported Petitioned Individual data (9 reported no petitions).
56 counties reported Statutory System Referral data (25 reported no system referrals).
53 counties reported aggregate data on CARE Inquiries (18 reported no CARE inquiries).



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.

Data Quality and Limitations

The CARE Act Annual Report is a **snapshot of early implementation efforts; not program effectiveness.**

Late release of expanded CARE Act Data Dictionary 2.0 impacted data quality

Missing and unknown data not randomly distributed

- More missing data among individuals served outside CARE court jurisdiction.
- Variability across data points.
- Cohort effects on data quality, with improvements over time.

Data lags

Findings do not represent current-day implementation and improvement efforts.

DHCS

Objectives of the Annual Report

Overall objective of the Annual Report is to:

- ✓ Provide an overview of early CARE Act implementation
- ✓ Identify opportunities for program enhancement.

- Volume of CARE inquiries to counties.
- Volume of system referrals from courts.
- Volume of CARE petitions through civil courts.
- Flow of CARE respondents sent to county BH agencies.
- Characteristics of CARE participants.
- Services and supports accessed among CARE participants.
- County BH agencies' capacity to meet CARE participants' needs.

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What's New in 2026 CARE Annual Report

EXPANDED: Petitioned Individuals

- **Trial court data from Judicial Council:** Petitions per 100K residents by county
- **County BH agency data:**
  - Outreach and engagement
  - Reasons for petition dismissals and CARE ineligibility
  - Services received while awaiting initial petition disposition from the courts
  - Trends in access to services and supports
  - Exits from CARE process (graduations, re-appointments, early exits)

NEW: System-Referred Individuals

- Referral source (MIST, FIST, AOT, LPS facilities)
- Outcomes: Conversion rates to CARE petitions
- Outreach and engagement

NEW: CARE Inquiries

- Volume and sources
- County actions

WHERE FEASIBLE: Disparity Analyses

- Does where you live matter? Does petitioner type matter? What do demographic differences among petitioned individuals tell us?

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CARE Act Independent Preliminary Evaluation Report Findings

CARE ACT WORKING GROUP MEETING

MAY 13, 2026

Today's Presentation

Agenda:

- Quick Evaluation Overview recap
- Data Sources and Methods
- Provide high-level overview of Preliminary Evaluation Report
- Share next steps

Overview of Evaluation Approach

Goals of RAND's CARE Evaluation

Document the theory of change for the CARE Act model

Evaluate the program implementation, outcomes, and impact

Document lessons learned related to the CARE Act model and policies

Make recommendations for ongoing implementation of the CARE Act

CARE Evaluation Logic Model

Evaluation Questions	CARE Act Strategies & Activities	Implementation Outcomes	Key Outcomes

Implementation:
1. How prepared were counties to implement the CARE Act model (CARE)?
2. How was CARE implemented?
3. What factors might be impacting the effectiveness of CARE?
	Individual-level
	• Participation in CARE process:
	  ○ Petition/Initiation
	  ○ Engagement
	  ○ Court process and development of CARE plan
	  ○ Service connection
	  ○ Service delivery
	• Engagement of advocates, including peers, family, and volunteer supporters
		Individual-level
		• Number and description of individuals on different pathways:
		  • Elective clients
		  • Voluntary CARE agreement status
		  • Ordered CARE plan status
		  ○ Developed
		  ○ Accessed
		  ○ Shared
		  ○ Adhered to
		• Psychiatric Advanced Directive status
		↑ Perceived appropriateness of care
		↑ Perceived quality of care/services
		↑ Perceived choice in care/services
		↑ CARE participant satisfaction with process
		↑ Family/caregiver satisfaction with process
		↑ Social support (emotional, tangible, informational)
		↑ Awareness of service options
			Community Assistance, Recovery and Empowerment:
			<u>3-legged stool:</u>
			↑ Engagement in services
			↑ Medication stabilization
			↑ Safe, stable, preferred housing
			
			↑ Personal recovery (CHIME framework):
			  ○ Connectedness,
			  ○ Hope,
			  ○ Identity,
			  ○ Meaning and purpose,
			  ○ Empowerment
			↑ Achievement of personal CARE goals
			↑ Meaningful work or community engagement –e.g., employment, volunteering, caring for others or enrollment in education
			↓ ED use
			↓ Hospitalizations
			↓ Arrests and incarceration
			↓ LPS and probate conservatorships
			
			• Equity/disparities in above outcomes

Community Assistance, Recovery and Empowerment: 4. Did CARE participants increase their engagement in needed services? 5. Was access to services equitable? 6. Did CARE participants experience increased mental illness recovery and empowerment? 7. Were recovery and empowerment outcomes experienced equitably?	**System-level** • County workflows to support CARE implementation • System coordination and linkage, including County BH, Public Defenders, Courts, and County Counsel • Data collection and sharing • Accountability levers	**System-level** ↑ Coordination between County BH, Public Defenders, Courts, and County Counsel • Barriers and facilitators to implementation • Availability of appropriate services • County accountability (e.g., claims, fines and sanctions) • Equity/disparities in above outcomes	

↑ Indicates an increase in a given outcome; ↓ indicates a decrease in a given outcome, Red boxes highlight what we reported on in our preliminary report

Evaluation Questions and Data Sources

		Staff Interviews	CARE Participant Interviews	Petitioner Interviews	CARE Participant Survey	Administrative Data
Implementation Evaluation	Q1. How prepared were counties to implement the CARE Act model?	X	X	X		X
	Q2. How was CARE implemented?	X	X	X	X	X
	Q3. What factors might be impacting the effectiveness of CARE?	X	X	X	X	X
Outcome Evaluation	Q4. Did CARE participants increase their engagement in needed services?	X	X	X	X	X
	Q5. Was access to services equitable?	X	X	X	X	X
	Q6. Did CARE participants experience increased mental illness recovery and empowerment?	X	X	X	X	X
	Q7. Did CARE participants experience increased mental illness recovery and empowerment equitably?	X	X	X	X	X

Qualitative Methods

- Conducted interviews with 5 counties: San Mateo, San Diego, Stanislaus, Alameda, Los Angeles
- Interviewed 52 implementation partners
- Interviews included Behavioral Health leadership, judges, public defenders, clinicians, first responders, detention facilities, hospital partners

Quantitative Methods

- Administrative Data Sources Analyzed to Date
  - CARE Act administrative data reported by counties (October 2023-June 2025)
  - Medi-Cal claims and enrollment data (January 2022 through January 2026)
  - Substance use treatment records (CalOMS-tx) (January 2018 through January 2026)
- Analysis
  - Examined pre- and post-petition differences in outcomes among Active CARE participants, Elective participants, and Dismissed participants using difference-in-differences approach
  - Outcomes included outpatient mental health utilization, psychotropic medication use, housing, substance use treatment, emergency department visits, and inpatient stays

Summary of Independent Preliminary Evaluation Report Findings

How Prepared Were Counties to Implement the CARE Act Model (Evaluation Question 1)?

- Interviews revealed that CARE implementation required collaboration from a broad range of partners:
  - Individuals who would have day-to-day roles in program implementation (e.g., behavioral health, judges, public defenders)
  - Potential petitioners (e.g., community members)
  - Service providers (e.g., housing organizations)
  - Community members
  - Individuals with lived experience of severe mental illness (SMI).
- Perceptions of readiness varied:
  - It was beneficial to have 6 to 12 months of planning time
  - Some still had to rush to finalize staffing and cross-agency agreements leading up to the launch of CARE.

How Was CARE Implemented (Evaluation Question 2)?

- Implementation partners reported that the CARE petition process is more labor-intensive in practice than it appears on paper.
- County data indicated petitions came from a range of sources, including family members, behavioral health (BH) providers, criminal justice pathways, hospitals, and outreach teams.
  - The number of petitions increased over time, with a very steep increase in petitions from BH providers and a notable increase from family members as well.
  - Interviewees from multiple counties said that their counties developed supports to help petitioners navigate the process.
- There are many factors that shape eligibility determinations
  - Diagnosis
  - Engagement and willingness on the part of the participant
  - Ability to locate the individual
  - The match between the person's needs and level of care available (e.g., is a higher level of care, such as conservatorship, more appropriate?)

Note that findings presented on this slide are preliminary and are subject to change

How Was CARE Implemented (Evaluation Question 2)? Cont.

- Implementation partners described the three main CARE pathways (i.e., voluntary engagement, CARE agreements, and CARE plans)
  - Partners generally prefer CARE agreements over CARE plans.
- Implementation partners noted that services are similar across pathways. They included case management, therapy, medication management, substance use counseling, benefits support, and housing-related assistance.
  - Some counties emphasized gaps in high-acuity treatment settings and housing options.
- Equity analysis of county data indicated that Black individuals are represented at higher rates and Hispanic individuals are at lower rates in the CARE population, relative to those with Lanterman-Petris Short (LPS) admissions and detainments, full service partnership (FSP) participants, and Medi-Cal specialty mental health services recipients with schizophrenia.

What Factors Might Be Impacting the Effectiveness of CARE (Evaluation Question 3)?

- Implementation partners largely viewed CARE as effective for its participants. Many saw CARE as filling an important gap between voluntary outpatient services and conservatorship and said it has been life-changing for some participants and families.
- Interviewees had mixed opinions about the inability of the court to compel treatment.
  - Some viewed it as a core strength that protects rights, promotes trust, and supports long-term recovery through client choice.
  - Others felt the lack of ability to compel treatment limited CARE's ability to reach those with the highest needs.

What Factors Might Be Impacting the Effectiveness of CARE (Evaluation Question 3)? Cont.

- Interviewees also had mixed views about the "black robe effect"*
  - Many said judicial oversight increased accountability for behavioral health teams and service providers.
  - Others were concerned that the court setting might confuse or intimidate clients.

*Black Robe Effect: This phrase refers to the sense of solemnity and authority that the presence of a judge and courtroom has on the people in the courtroom.

Did CARE Participants Increase their Engagement in Needed Services (Evaluation Question 4)?

- Medi-Cal claims data suggest that CARE participants increased engagement in needed services, particularly in the three core domains of outpatient mental health visits, medication, and housing status:
  - Outpatient mental health services increased among Active CARE participants and Elective participants. The increase was greater among Active CARE participants.
  - Overall antipsychotic medication use increased among Active CARE participants and Elective participants, and long-acting antipsychotic use nearly doubled among Active CARE participants.
  - Among the Active CARE group only, rates of permanent/temporary housing increased while rates of homelessness and institutional placement decreased.
- There were no statistically significant changes among Dismissed participants in the above outcomes.

Note that findings presented on this slide are preliminary and are subject to change

Did CARE Participants Increase their Engagement in Needed Services (Evaluation Question 4)? Cont.

- Implementation partners similarly reported that CARE increased engagement in outpatient and supportive services for many participants, particularly through intensive outreach and connection to care.
  - However, ongoing CARE engagement is constrained by housing shortages, service gaps, and the complexity of co-occurring substance use.

- This increased engagement in needed outpatient services may decrease utilization of acute inpatient services:
  - Claims data indicate that Active CARE participants experienced an increase in hospitalizations in the months preceding and immediately following the petition date (suggesting a crisis period), followed by a **decline in hospitalization** around six months after the petition.

Was Access to Services Equitable (Evaluation Question 5)?

- Implementation partners have not directly observed bias, though they are not necessarily tracking the data to detect inequities in implementation and some noted that the numbers have been too low to adequately measure.
- There are some racial and ethnic differences in CARE participants when compared to other similar populations (e.g., Full-Service Partnership Participants). Black individuals are represented in CARE at a higher rate, and Hispanic individuals are enrolled in CARE at a lower rate when compared to FSP.

Did CARE Participants Experience Increased Mental Illness Recovery and Empowerment (Evaluation Question 6)?

- Implementation partners reported that CARE participants showed progress toward mental health recovery and empowerment, with recovery described as gradual, individualized, and encompassing both tangible and emotional improvements.
- Implementation partners noted gains in stability, communication, confidence, and self-awareness, alongside deeper changes in hope and connection.
- Overall, implementation partners observed that participants experienced improved health, stability, and satisfaction. They reported that families expressed gratitude for the program's impact and the persistence of CARE staff.

Did CARE Participants Experience Increased Mental Illness Recovery and Empowerment Equitably? (Evaluation Question 7)?

- RAND was unable to address this question with current available data

Next Steps Cont.

- Preliminary Evaluation Report submitted to DHCS May 1, 2026
  - Currently undergoing several rounds of review
  - Preliminary Evaluation Report will be submitted to the legislature in December 2026
- RAND will:
  - Continue to conduct qualitative interviews with 7 additional counties
  - Begin CARE participant and petitioner survey recruitment in June
  - Begin CARE participant and petitioner interviews later this summer
  - Continue to conduct quantitative analysis to analyze CARE Act outcomes
- Final Report due from RAND to DHCS September 2028
- Final Report due to legislature in December 2028

For any questions, please contact:

RAND Independent Evaluation Team:

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DHCS Quality and Population Health Management (QPHM):

CAREActIndEvaluation@dhcs.ca.gov

TRAINING AND TECHNICAL ASSISTANCE UPDATES

CARE Act Working Group

May 13, 2026

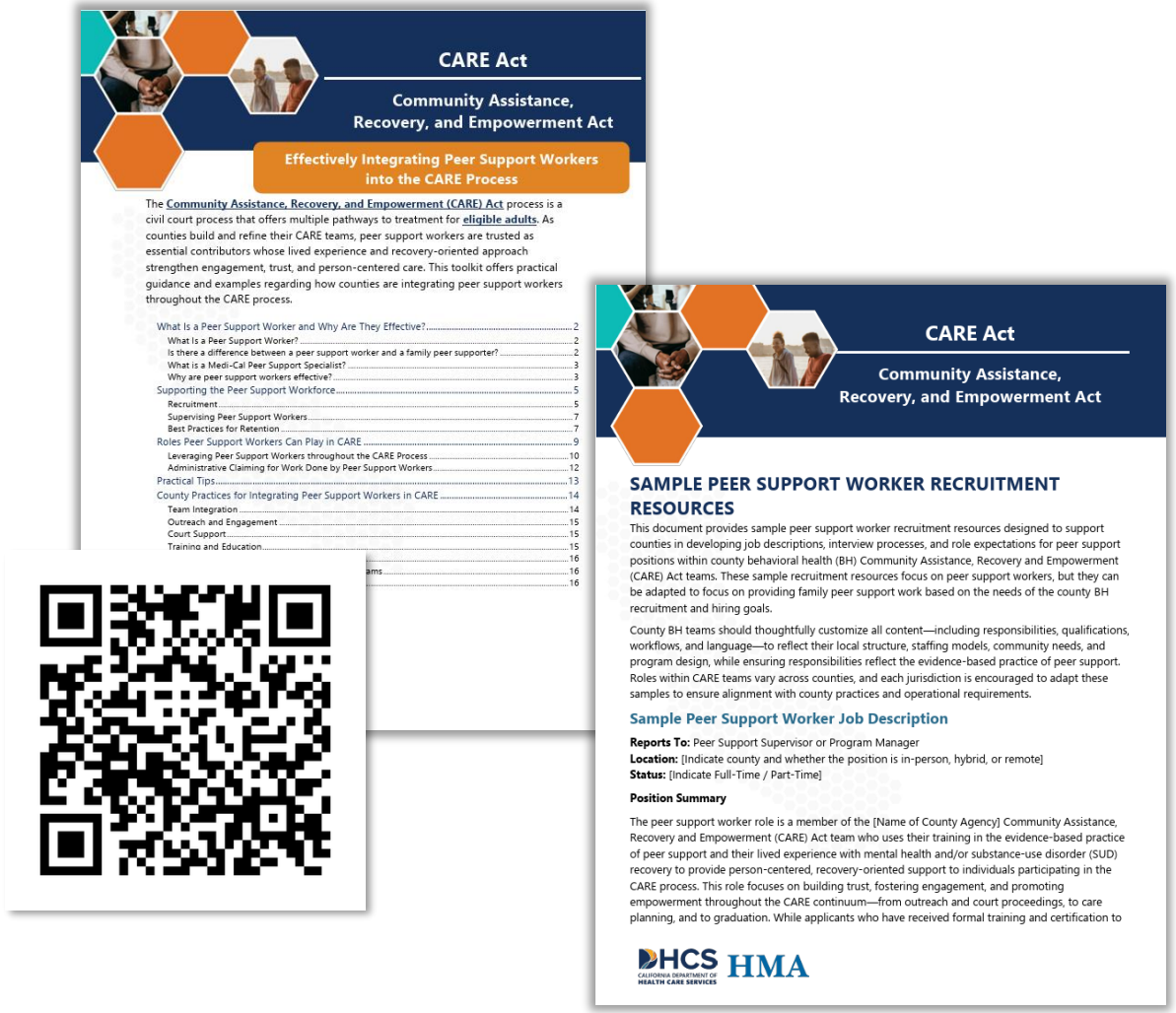
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

HMA

Effectively Integrating Peer Support Workers into the CARE Process

Peer support workers strengthen engagement, trust, and participant-centered care across the CARE process through lived-experience expertise.

- How peer support workers can be integrated into CARE.
- How counties staff and sustain roles.
- What's working statewide.
- Companion hiring tools, including job descriptions and interview guidance.



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Recent TTA Activities

Office Hours

- Preparing a CARE Participant for Court
- Addressing "Whole Person" Health
- LPS Facility Referrals
- Data Collection & Reporting

Trainings

- Considerations for CARE Act Eligibility: Initial, Ongoing, and Complex Cases
- Moving from CARE Planning to Graduation Planning

Resources

- Understanding the Volunteer Supporter Role in the CARE Act Process: Video and Discussion Guide
- Effectively Integrating Peer Support Workers into the CARE Process

Ongoing TA

- Stakeholder communications
- Ad hoc and scheduled TA activities

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Upcoming TTA Activities

Office Hours

- Collaboration along the Housing Continuum
- CARE & the Assertive Community Treatment (ACT) Model
- Collaborating with Department of State Hospitals
- Data Collection & Reporting

Trainings

- Live session on PADs
- Updated trainings on administrative claiming and justice system partners
- Data collection and reporting trainings, including Data Dictionary revisions and the Annual Report

Resources

- CARE Graduation Planning Brief & Checklist
- Housing Strategies & BHSA Opportunities Brief
- County Strategies & Best Practices Series

Ongoing TA

- Stakeholder communications
- Ad hoc and scheduled TA activities

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Lunch!


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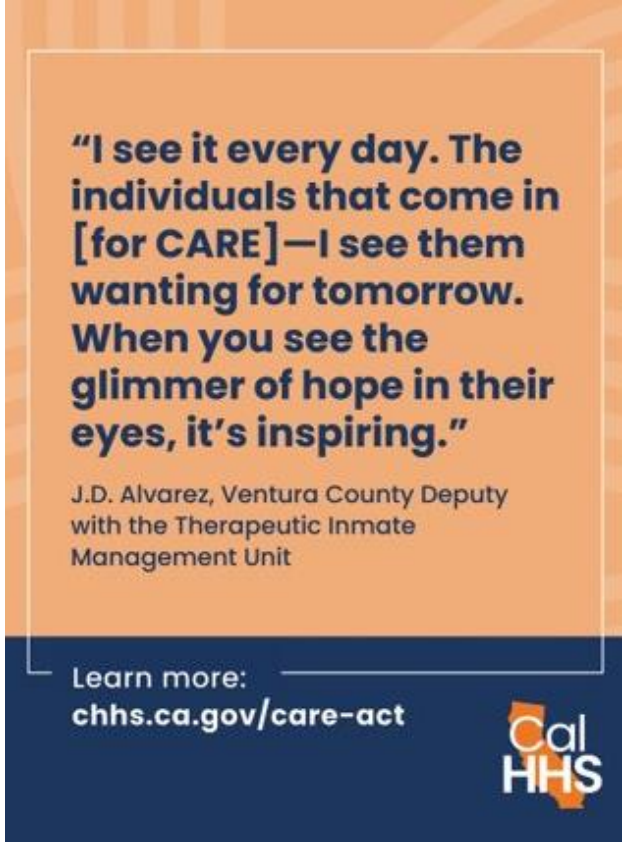


Social Media Posts

San Bernardino County Implementation Updates: Data, Outcomes, and Best Practices

Dr. Alyce Belford-Saldana, Deputy Behavioral Health Director

San Bernardino County Behavioral Health

SAN BERNARDINO COUNTY

Behavioral Health

San Bernardino County Opportunity Lives Here

CARE Act

Community
Assistance
Recovery and
Empowerment

Overview

- CARE Act Development and Planning
- CARE Act Implementation
- Next Steps

CARE Act – San Bernardino County

The San Bernardino County Board of Supervisors formally approved the launch of the CARE Act implementation in 2023, authorizing the Department of Behavioral Health and the Superior Court to begin implementing services. This approval established the framework for partnerships, communication strategies, and mobile court outreach to ensure countywide access to CARE Act programs.

Purpose of Approval

- **Expand Access:** Create a new pathway for individuals with untreated schizophrenia or other psychotic disorders to receive voluntary treatment and housing support.
- **Reduce Barriers:** Reduce the risks of homelessness and incarceration through proactive, early-stage interventions.
- **Community Integration:** Ensure CARE Act services are embedded within existing DBH programs and court processes

Partnerships Authorized

- **System Partners:** Superior Court, Public Defender, Legal Aid, Probation, Office of the Public Guardian, Patients' Rights advocates.
- **Community Stakeholders:** Families, law enforcement, homeless outreach programs, hospitals, and health care systems.
- **Regional Collaboration:** Collaborate with state agencies (DSH, CDCR) on petitions related to institutional releases

CARE Act – San Bernardino County

Impact of Approval of CARE ACT

Planning and coordination began in January of 2024.

- **Service Expansion:** Approval allows DBH to integrate CARE Act clients into crisis services, outpatient programs, and recovery-based teams.
- **Multi Agency Collaboration:** Communication began with Courts, Legal partners, and other County agencies. Creating a united effort to assist CARE Act clients.
- **Petitions Filed:** First date of Court process began in December 2024.
- Multiple petitions were filed by families, corrections, homeless outreach, and state hospitals.

Developing Communication

Monthly meetings are held with engagement staff and management to discuss program implementation

Multi-disciplinary meetings are held with system partners to streamline the petition process and discuss areas of improvement

Email inboxes were created for direct correspondence with court and counsel

Weekly meetings are scheduled with County Counsel to discuss client progress

Website created to address community questions about CARE and to provide direction for the petition process

Templated emails were created, with attachments and links, to send to individuals calling to inquire about the CARE process

Communication with the Courts

1

Pre-Hearing consultations are scheduled every week between the CARE program, County Counsel, Legal Aid, and the Judge

2

Regular meetings are scheduled with the Criminal Courts and the Mental Health Court to develop a process for internal court referrals for CARE and discuss implementation

3

Partnered with Superior Court Self-Help Center, to ensure that additional Department of Behavioral Health resources are available to the public

- Attended mobile court events in remote areas

4

The program partnered with the Superior Court Self-Help Center to ensure additional Department of Behavioral Health resources are accessible to the public.
Staff participated in mobile court events in remote communities.

Planning for Services

CARE clients are assigned to an already existing program with a long history of engaging this population in voluntary services

Internal policies, procedures, and workflows were implemented to ensure staff are adequately trained on all court processes

Engagement teams were developed to better meet the individual clients' needs

- Multidisciplinary teams
- Teams meet regularly to discuss client progress and care coordination

Partnering with Internal Programs

Strengthened partnerships with other department programs to leverage in-house services or contract providers

Transitional Services	Crisis Services	Outpatient Services	Engagement Services
• Locked Residential • Community-Based Residential • Homeless Supportive Services	• Crisis Residential Treatment • Community Crisis Services • Crisis Stabilization Unit • Crisis Walk-In Center	• Full-Service Partnerships • Assertive Community Treatment • Community Clinics • Other Specialty Outpatient and Forensic Programs	• Recovery Based Engagement Support Teams • Assisted Outpatient Team • Triage Engagement and Support Teams • Community Outreach and Support Team

In alliance with the BHSA initiative Department of Behavioral Health will implement an Intensive Care Model for FSP clients, whereas ACT level services will be provided by a contracted provider.

FSP Level Services Provided

Services may include:

- Intensive engagement services
- Employment support
- Behavioral Health services
- Applying for benefits such as Medi-Cal and Social Security Income (SSI)
- Linkages to food banks, clothing, and shelter
- Linkages for substance use treatment
- Assistance with primary care physician referrals
- Psychoeducation for families
- Initially DBH was planned to be both the FSP provider and Engagement Team.
- Housing-Shelter Services

Current CARE Data

Total CARE Petitions: 58

Petitioners:

- Family: **23**
- Transfer: **6**
- Homeless Outreach: **4**
- State Hospital: **12**
- Corrections: **9**
- Public Guardian: **4**

Petition Status:

- Initial Phase: **21**
- Developing Agreement: **4**
- Agreement Approved: **12**
- Evaluation Ordered: **2**
- Dismissed: **19**

Disposition for those Dismissed:

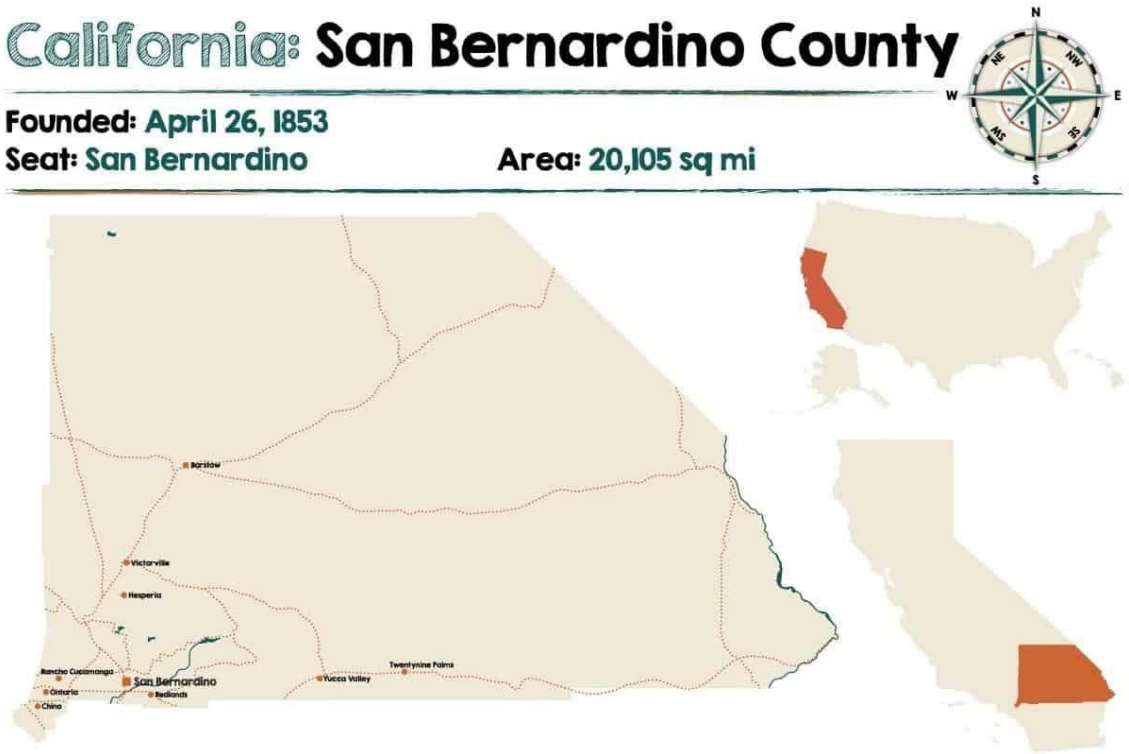
- Prima Facie Not Met: **3**
- Unable to Engage: **3**
- Unable to Locate: **2**
- Transfer to Other County: **3**
- Unwilling to Participate: **5**
- LPS Conservatorship: **2**
- Long Term Incarceration: **1**

Challenges Encountered

- DBH receives petitions from the courts after individuals are released from institutional settings
- Geographical challenges include diverse terrain (mountains, desert, urban and rural areas), as well as over 20,000 square miles of land
  - Some of our unhoused clients are traveling over 50 miles in the course of one day
- Understanding that treatment and housing services are limited to what the county can provide
- It is difficult to balance the level of service that this population requires with the understanding that the client has a right to refuse services
- Communication with community partners in neighboring counties is limited
- Recent statutory changes required us to pivot quickly, prompting meetings with the criminal courts regarding Step Down planning and navigating the funding process for clients with a Payee
- Despite ongoing collaboration, bureaucratic processes and interagency coordination requirements can create delays in treatment, service linkage, or case progression for this population, highlighting the need for continued system-level streamlining.
- Collection of data points and verification of accuracy over multiple programs and system partners, such as CARE inquiries to the county.

Challenges Encountered Cont.

Received From	Amount
Chino, California	3
Fontana, California	5
Ontario, California	1
Rancho Cucamonga, California	3
Redlands, California	1
Rialto, California	1
San Bernardino, California	6
Twentynine Palms, California	1
Upland, California	1
Victorville, California	8
Department of State Hospitals	12
CDCR	9
Out of County	7
Total	58



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Lessons Learned

It is imperative to have an open line of communication with system partners prior to petition.

- We have partnered with DSH and CDCR to communicate when a petition is going to be filed as a stipulation of release

Developing partnerships with local law enforcement and homeless outreach agencies can alleviate some of the barriers that arise from having such a large region to service

Continue to emphasize services provided by the department and contract providers during the development of the CARE agreements

Regular engagements are scheduled with the client even when the client is insisting that they do not want our services

When clients cross over to neighboring counties it is important to have open lines of communication without violating the client's privacy, or county policies

Future Opportunities

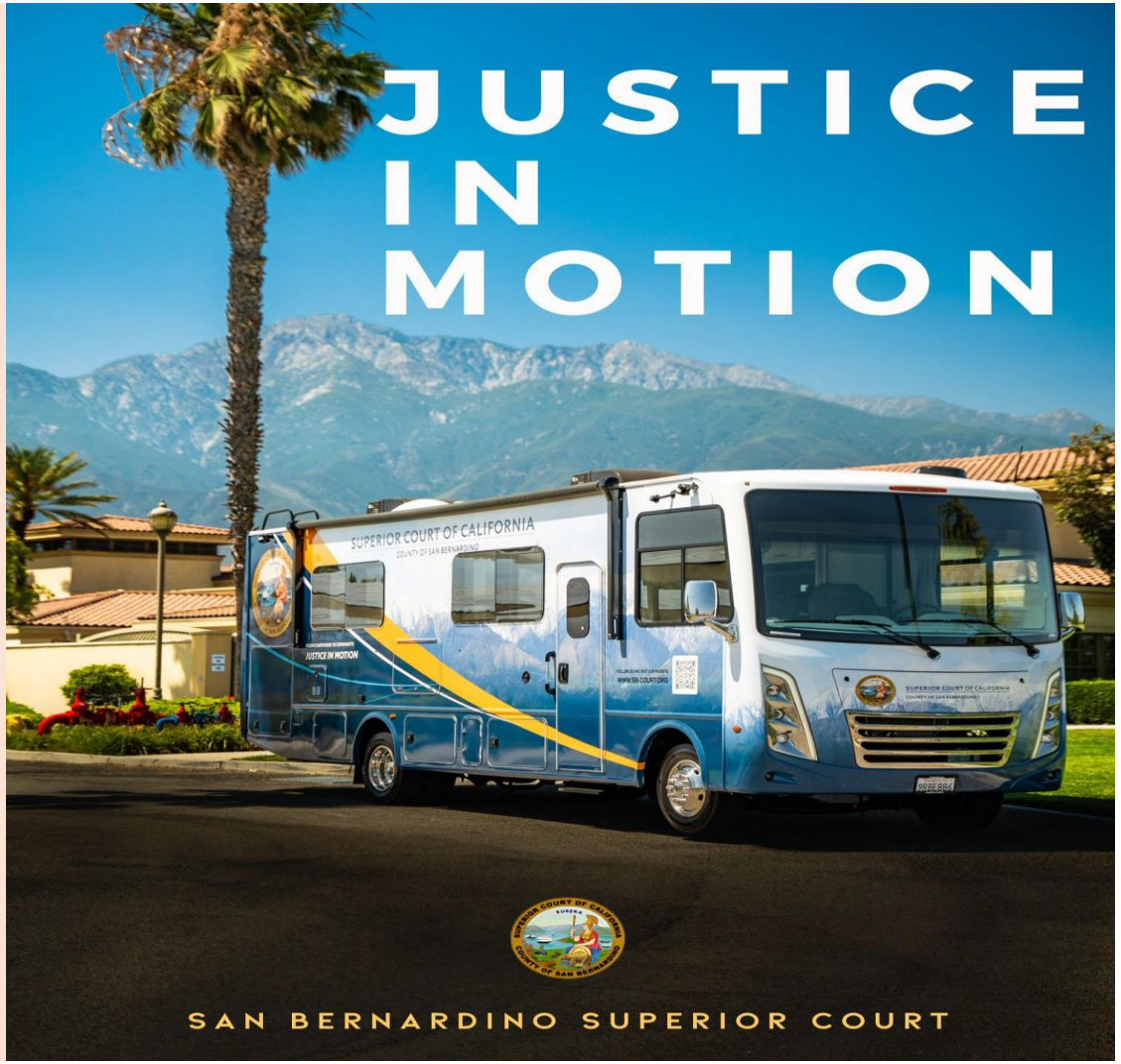
Mobile Court Integration

- The Superior Court launched the Court Community Vehicle to conduct hearings in remote areas, with DBH partnering in outreach and service coordination.
- This innovation ensures CARE Act petitions and related services are accessible across San Bernardino County's **20,000+ square miles** of diverse terrain
- The 30-foot mobile courtroom, a converted Thor Hurricane RV, is designed to bring court services directly into communities across the largest county in the nation, reducing barriers for residents who live far from traditional courthouses.

The Court Community Vehicle will serve multiple roles:

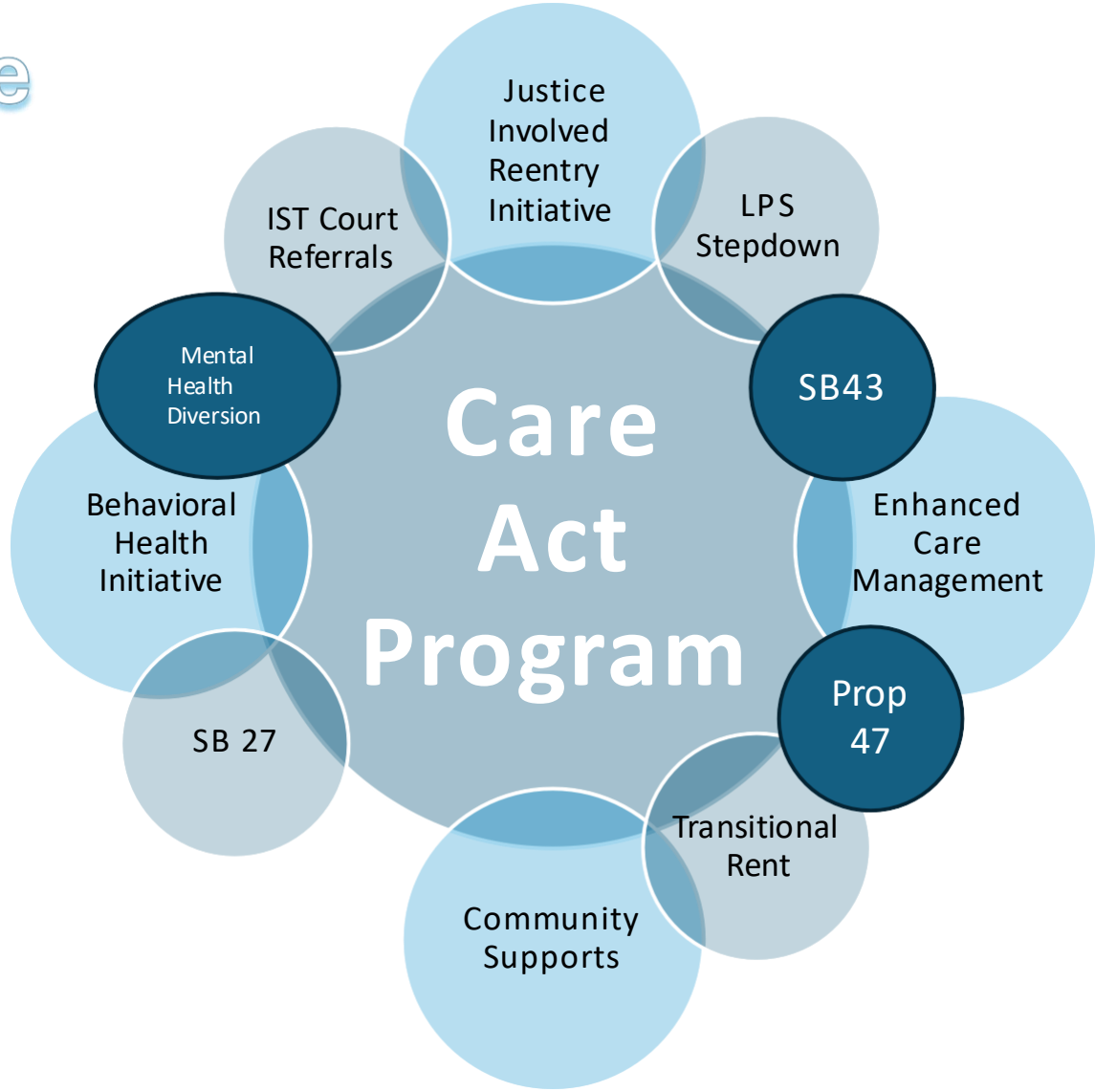
- A mobile courtroom for judicial hearings.
- A community outreach hub for civic education and Self-Help services.
- Emergency operations post during disasters or crises.

- **Launch first outreach and CARE Court event in Morongo on 12/12/25**



Future Opportunities

Cal Aims Initiative
And CARE



Future Opportunities: Expand outreach to rural and outlying areas

Community Partnerships

Collaboration with local law enforcement, homeless outreach, and health care providers in rural regions.

Engagement with faith-based and civic groups to raise awareness of CARE services.

Accessibility Strategies

- Outreach events in underserved areas to educate residents on petition rights and processes.
- Transportation support and mobile engagement teams to reach unhoused clients traveling long distances.
- Continue to work with Superior Courts for Criminal Step Down from IST.
- Statutory changes will broaden the scope of who is eligible.
- Legal Aid use of Kiosk
- Strengthen collaboration with LPS facilities
- SB County strategic plan to expand and build out our Continuum of Care to include supportive services and Housing options-interdepartmentally
- Strengthen and incorporate FSP services through Cal Aim EBP's-contract out
- Building out SUD Services and incorporating into the EBP service delivery
- Impact:
- Greater equity in access to CARE Act services across San Bernardino County's 20,000+ square miles.
- Strengthened trust between rural communities, DBH, and the Superior Court.
- Increase Housing options

Future Opportunities: Updated Policies and Procedures

Enhanced our EHR with Care Manager to increase data relevance

- Allows us to collect data from other Justice Involved programs.
- Enhances communication with other systems of care.

Enriched communication with partners

- Allows us to collaborate on challenges faced across multiple systems, such as the Hospitals, courts, and public guardian.
- Improves services for client and creates a collaborative system of care.
- Include Cities in the educational process

Increased awareness with partners

- Developing easier transitions through the care system, allowing for an increase of referrals into CARE.
- Informing and collaborating with partners on ways to address challenges with the petition process.
- Include Cities in Educational process

Contact Information

For more information about **CARE:**

- **Email:** DBH-CAREQuestions@dbh.sbcounty.gov
- **Call:** 909-421-9452
- **Visit DBH's CARE Website:** https://wp.sbcounty.gov/dbh/careact/
- **Visit Superior Court's CARE Act Website:** https://www.sb-court.org/divisions/probate/care-act

- For more information about **Petitioning:**
  - Petition forms can be found on the Judicial Council's CARE Act Forms website: https://selfhelp.courts.ca.gov/care-act/forms
    - Assistance provided through the Superior Court of California, County of San Bernardino Self-Help Center.
  - Completed petitions can be filed at Fontana District Courthouse:
    - 17780 Arrow Boulevard, Fontana, CA 92335

Contact Us

Visit our website at: ***sbcounty.gov/dbh/***

Helplines available 24/7/365

Access Unit (Behavioral Health Helpline)
(888) 743-1478

Screening Assessment and Referral Center (Substance Use Disorder Helpline)
(800) 968-2636

Community Crisis Response Teams
Call (800) 398-0018 or text (909) 420-0560

Fresno County Implementation Updates: Data, Outcomes, and Best Practices

Susan Holt, Director

Emma Rasmussen, Deputy Director

Fresno County Department of Behavioral Health

Fresno County Department of Behavioral Health

CARE Act Overview

Department of Behavioral Health

County of Fresno Demographics

- Population: 1,008,654 (U.S. Census Bureau, 2020)
- Medi-Cal Recipients: 524,430 (DHCS, October 2025)
- Persons Served by Fresno County Department of Behavioral Health System of Care: 30,675

Department of Behavioral Health

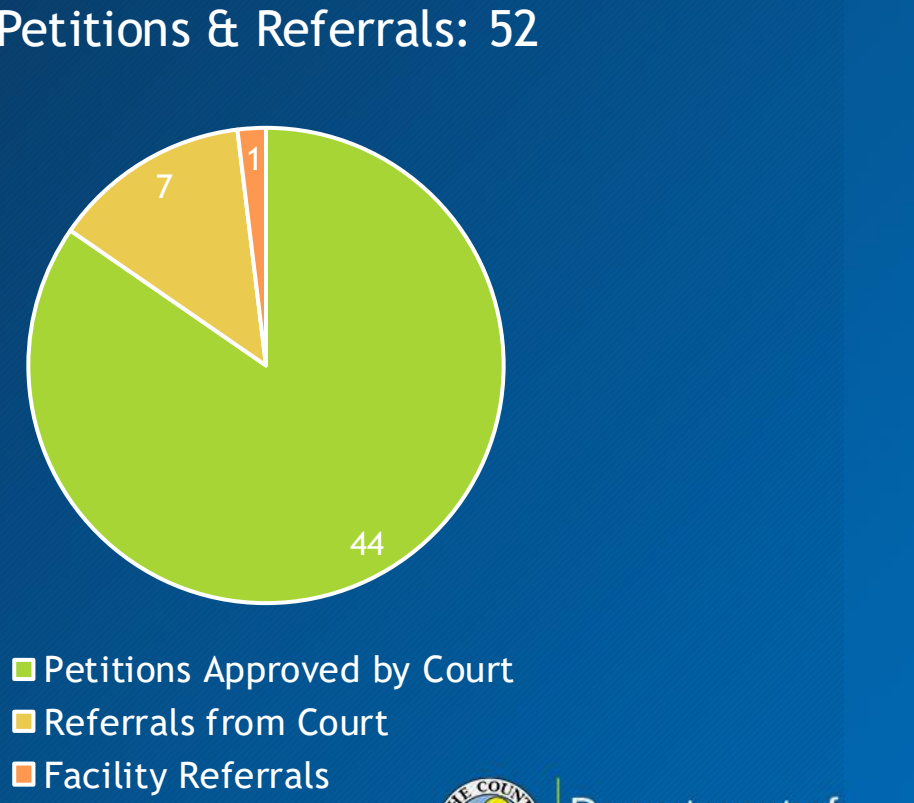
Community Outreach

CARE Act presentations were provided to:

1. Law Enforcement
2. LPS Facilities/Hospitals
3. Department of Social Services
4. MH Providers/FSPs
5. Substance Use Disorder Providers
6. DBH Adult MH Providers and all Supervisors
7. Better Business Bureau/Chamber of Commerce
8. NAMI
9. Court Self-Help Desk
10. Fresno Madera Continuum of Care
11. County Administrative Office
12. Behavioral Health Board
13. Suicide Prevention Collaborative
14. Univision (Local Spanish Television Station)

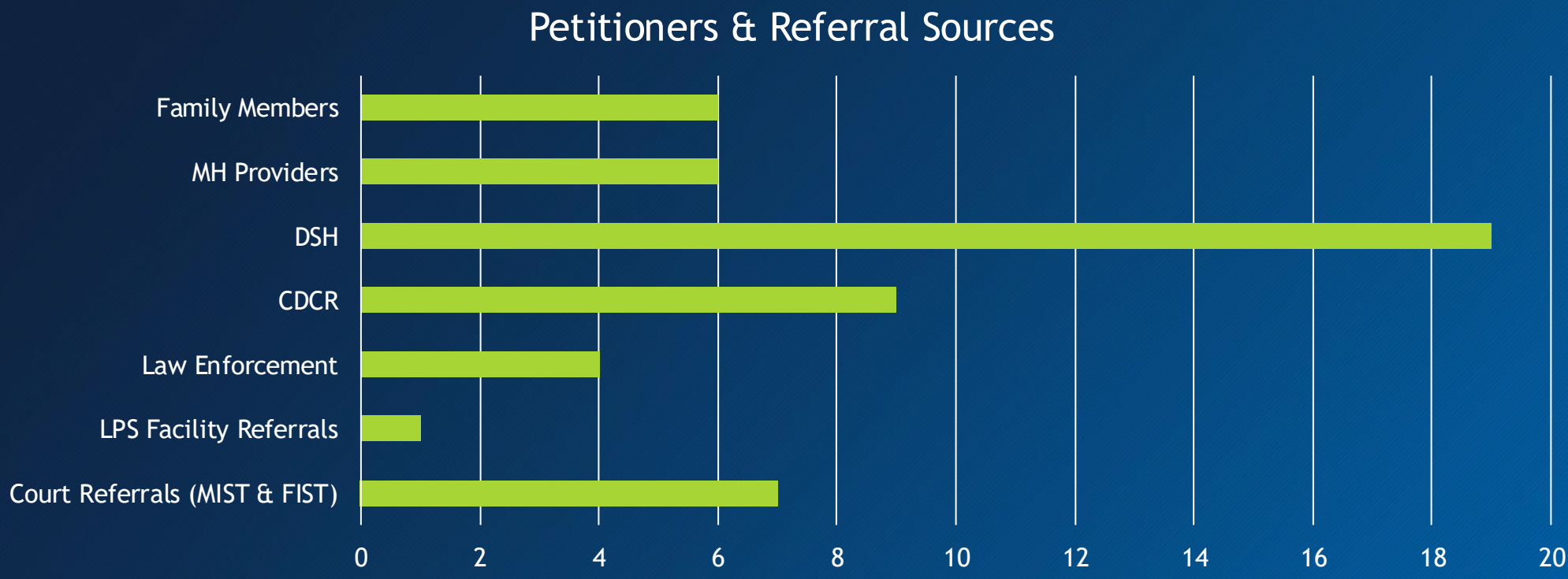
Statistics for 2025

- 52 Petitions filed with the court
- 8 Petitions did not meet Prima Facie
- 44 Petitions met Prima Facie and O&E began
- 7 Referrals from the Court (1 petition filed)
- 1 Facility Referral
- 14 Petitions Dismissed
- 29 Current Active Petitions and Referrals
- 9 Connected to Voluntary Services
- 6 CARE Agreements
- 0 CARE Plans



Department of Behavioral Health

2025 - Petitioners & Referral Sources



44 Petitions met prima facie & 8 Referrals

Department of Behavioral Health

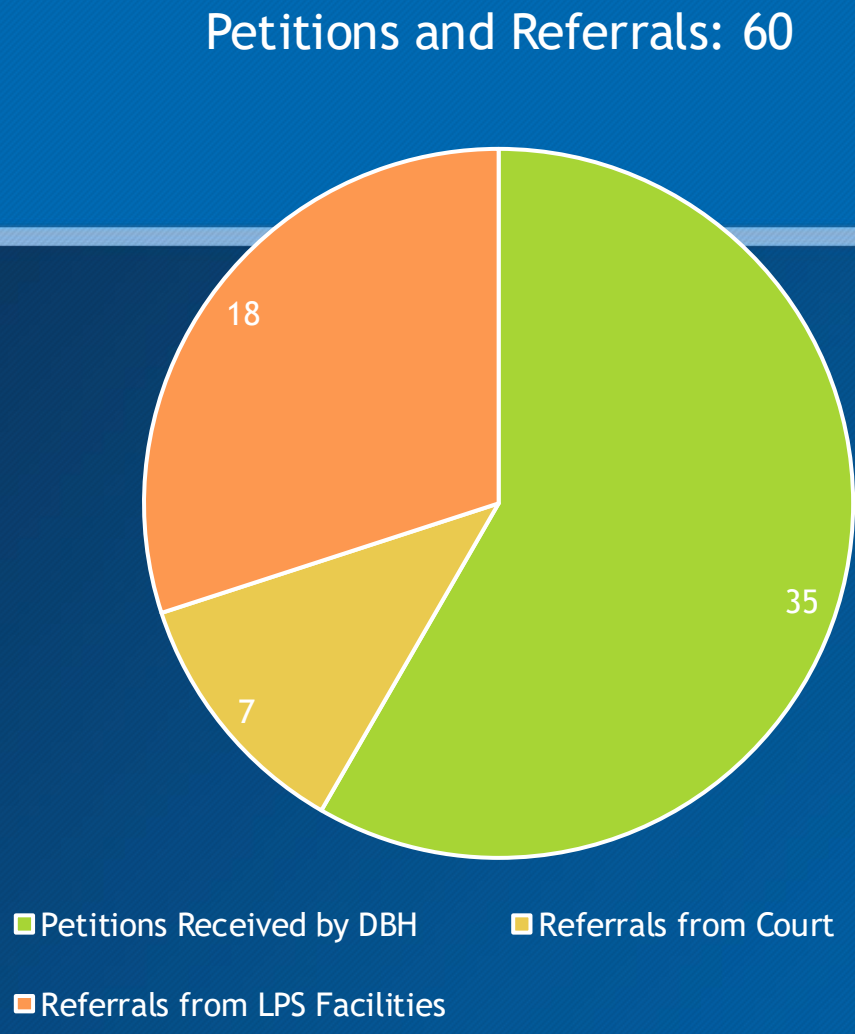
What we learn from the 2025 data

Gaps in Petitions/Referrals:

- Internal referrals
- LPS Facility referrals
- Conservatorship
- Law Enforcement

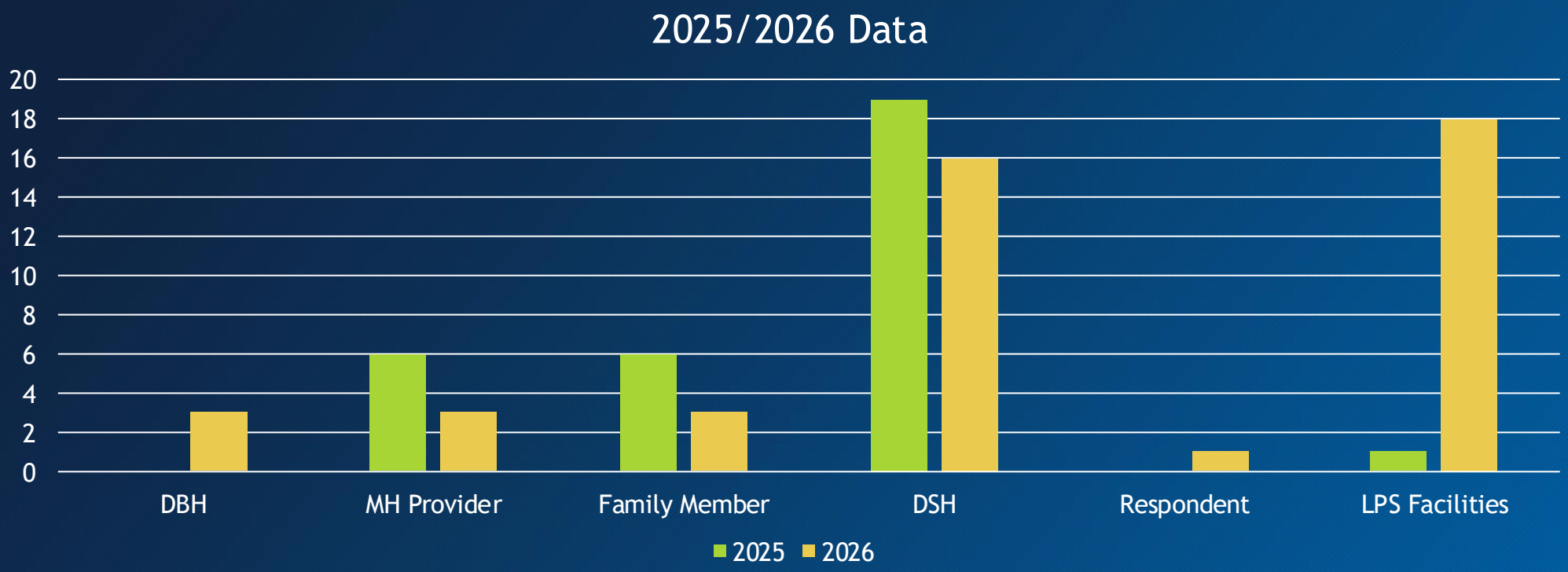
Statistics for 2026

- 35 Petitions filed with the court
- 0 Petitions did not meet Prima Facie
- 7 Referrals from the Court (1 Petition filed)
- 18 Facility Referral (4 Petitions filed)
- 16 Petitions Dismissed
- 63 Current Active Petitions and Referrals
- 5 Connected to Voluntary Services
- 2 CARE Agreements
- 2 CARE Plans



Department of Behavioral Health

2025/2026 - Petitioners & Referral Sources



Department of Behavioral Health

GRADUATION

6/9/26 – Fresno's first CARE Act Graduation!

Department of Behavioral Health

2026 Projections

- Quarter 1 – 25 petitions submitted (based on actuals)
- Quarter 2 – 30 (15 petitions submitted so far this quarter)
- Quarter 3 – 35
- Quarter 4 – 40

- Total Projected Petitions for 2026 = 130

Pivots/Accommodations/Successes

CARE Act Hearings - Court Accommodations

- Virtual court appearances are available via Zoom
- DART West will provide a space in office for a Zoom hearing or in the field when needed
- DART West provides transportation assistance for respondents who need support traveling to court
- Court provides incentives to respondents upon initial hearing and each subsequent hearing
  - Backpack containing essentials at initial hearing(toiletries, blanket, etc.)
  - Gift Card of respondent's choice at each hearing (Wendy's, Chick-fil-A, Taco Bell, Dollar Tree, Ross, etc.)

DBH Behavioral Health Bridge Housing (BHBH)

- Behavioral Health Bridge Housing (BHBH) is a low-barrier emergency housing program designed for people who are experiencing homelessness, and have a serious mental illness (SMI) or substance use disorder (SUD)
- Program Sites
  - Sierra Sunrise: 60 Beds; 5 Beds for CARE Act
  - Phoenix Landing: 120 Beds; 5 Beds for CARE Act

*** 2026 we expanded CARE Act beds due to increased demand**

Department of Behavioral Health

LPS Conservatorship Stepdown Criteria

- Deputy Conservator and Psychiatrist will collaborate to recommend a step down from Conservatorship for CARE Act consideration.
- The following criteria is used when considering appropriateness for CARE Act.
    1. Following a well developed and structured daily routine for hygiene, food, participation in community (social, groups, activities), and with medication adherence.
    2. Safety.
    3. Medical/physical health.
    4. Substance use disorder plan.
- Deputy Conservator and Community Conservatorship team will assess possible referral to CARE Act based on clinical appropriateness.
- Should a person served be dismissed from LPS Conservatorship, staff will review appropriateness for a referral to either, CARE Act, AOT, FSP, or an internal DBH treatment team for ongoing support and services.

***Quarter 3 focus on implementing LPS stepdown to CARE considerations**

Fresno County Strengths

- Collaborative Relationships:

CAO, Multiple DBH Divisions, FSPs, Courts, Law Enforcement, Public Defender, DSH, Jail MH Provider, CDCR, Probation, Housing Provider, HMA

- Changed focus due to data

CARE Act Working Group Discussion of 2026 Priorities

CARE Act Working Group Members

Discussion Question

1. What would you like to see addressed in remaining CARE Act Working Group meetings?

CalHHS
California Health & Human Services Agency

Closing Thoughts

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health
California Health and Human Services Agency

Next Working Group Meetings:

August 12, 2026
November 18, 2026 (tentative)

Public Comment

Public Comment will be taken on any item on the agenda

There are 3 ways to make comments:

1. In person, please come to designated location
2. Raise hand on zoom to speak. If joining by call-in, press *9 on the phone.
3. We encourage email comment to CAREAct@chhs.ca.gov

NOTE: members of the public who use translating technology will be given **additional time**.

CalHHS
California Health & Human Services Agency

Thank You!

California Health & Human Services Agency

Person Centered. Equity Focused. Data Driven.