



Community Assistance, Recovery and Empowerment (CARE) Act

California Health & Human Services Agency
Person Centered. Equity Focused. Data Driven.

CARE Act Working Group Meeting

August 12, 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. CARE Act Data: Annual Report
4. Lunch
5. Housing Overview
6. Focus Group Updates: Families and Peers; Public Defenders
7. Closing Thoughts
8. Public Comment

Working Group Members

Dr. Alyce Belford-Saldana Jennifer Bender

Amber Irvine Jenny Bayardo

Bill Stewart Jerry May

Brenda Grealish Jodi Nerell

Dr. Brian Hurley Dr. Katherine Warburton

Dr. Clayton Chau Kent Boes

Harold Turner Keris Myrick

Herb Hatanaka Ketra Carter

Ivan Bhardwaj Khatera Aslami Tamplen

James Kwon Lauren Rettagliata

Mark Salazar

Meagan Subers

Monica Porter Gilbert

Nichole Zaragoza-Smith

Roberto Herrera

Ruben Imperial

Ruqayya Ahmad

Sarah Davis

Hon. Scott Herin

Stephanie Regular

Stephanie Welch

Susan Holt

Tim Lutz

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

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.

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.

Recap of May Meeting

1. Families and Peers Updates
2. CARE Act Data: Reporting and Evaluation Update
3. Fresno County CARE Act Implementation Update
4. San Bernardino CARE Act Implementation Update
5. Working Group Discussion of 2026 Priorities

CARE Act Implementation Updates

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



The Latest CARE Act Data (June 2026)

- 5,484 petitions
- 1,414 agreements
- 56 plans
- 4,887 diversions / redirections (through March 2026)

Yolo Site Visit Highlights (May 29)

- Attended two court hearings and met with judge, county counsel, public defenders and staff
- Discussion of BH continuum and CARE and local successes and challenges
- Visit to shelter, treatment and housing campus funded through BHCIP, Homekey, and City of Woodland.



July 7: Victorville Training: 78 attended CARE Act training and information session. [Press release](#) followed with information on future local training opportunities.



State and Local Leaders
Convene to Strengthen
CARE Act Implementation
in San Bernardino County



Three New CARE Act Questions in BHSA Integrated Plan

1. Identify service components & priority access for CARE participants in Integrated Plan
2. Describe integration of CARE referral pathways with existing referral and service pathways
3. Describe process for identifying & redirecting individuals potentially eligible for CARE to alternative pathways when appropriate & how county will confirm & document successful connection to services.

Responses: Four themes run across all three questions

1

A shared service backbone is forming

Housing (55 of 59) and FSP (47) anchor nearly every plan, consistently wrapped with care coordination (31), ACT/FACT (37) and field-based outreach (27).

2

Priority language outpaces priority mechanism

50 counties state priority or expedited access, ~18 describe how they deliver it (EHR flag, expedited intake, set-aside beds).

3

"No wrong door" integration, lightly equipped

46 route CARE through existing access pathways; only ~7 add a dedicated CARE channel — integration leans on what already exists rather than new infrastructure.

4

Redirection works; documentation maturity varies

Warm handoffs (22) and verification (36) are common, specific follow-up timeframes (2) and links to state reporting (9)

CARE Act Data: Annual Report

Summary

Reports

- **Annual Report** highlights progress made from October 2023 to June 2025.
- **Implementation Update** highlights key statewide trends, implementation progress, and emerging lessons from the first full year of statewide implementation with court data through June 30, 2026.
- **Independent Evaluation by RAND** preliminary report coming in December.

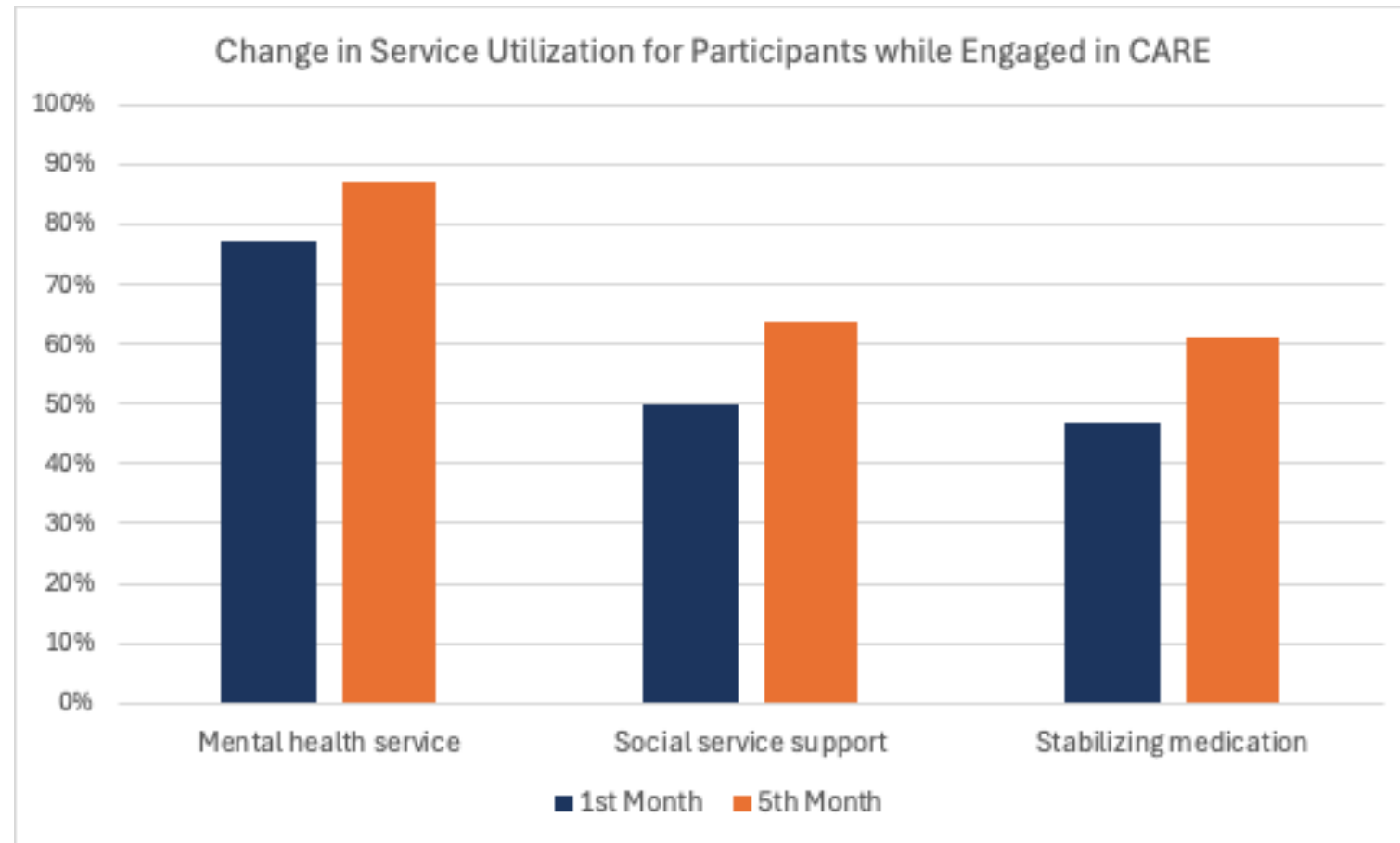
Key Findings

- CARE is functioning primarily as a pathway to services, supports, and often housing if needed, not court compulsion.
- Nearly all participants receiving ongoing services are doing so through voluntary CARE agreements built collaboratively among participants, providers, public defenders, county teams, and the courts.
- **Engagement Deepens Over Time:** Counties describe their approach as "relentless engagement" — building trust through repeated encounters – its about meeting the client wherever they are AND being tenacious with heart.



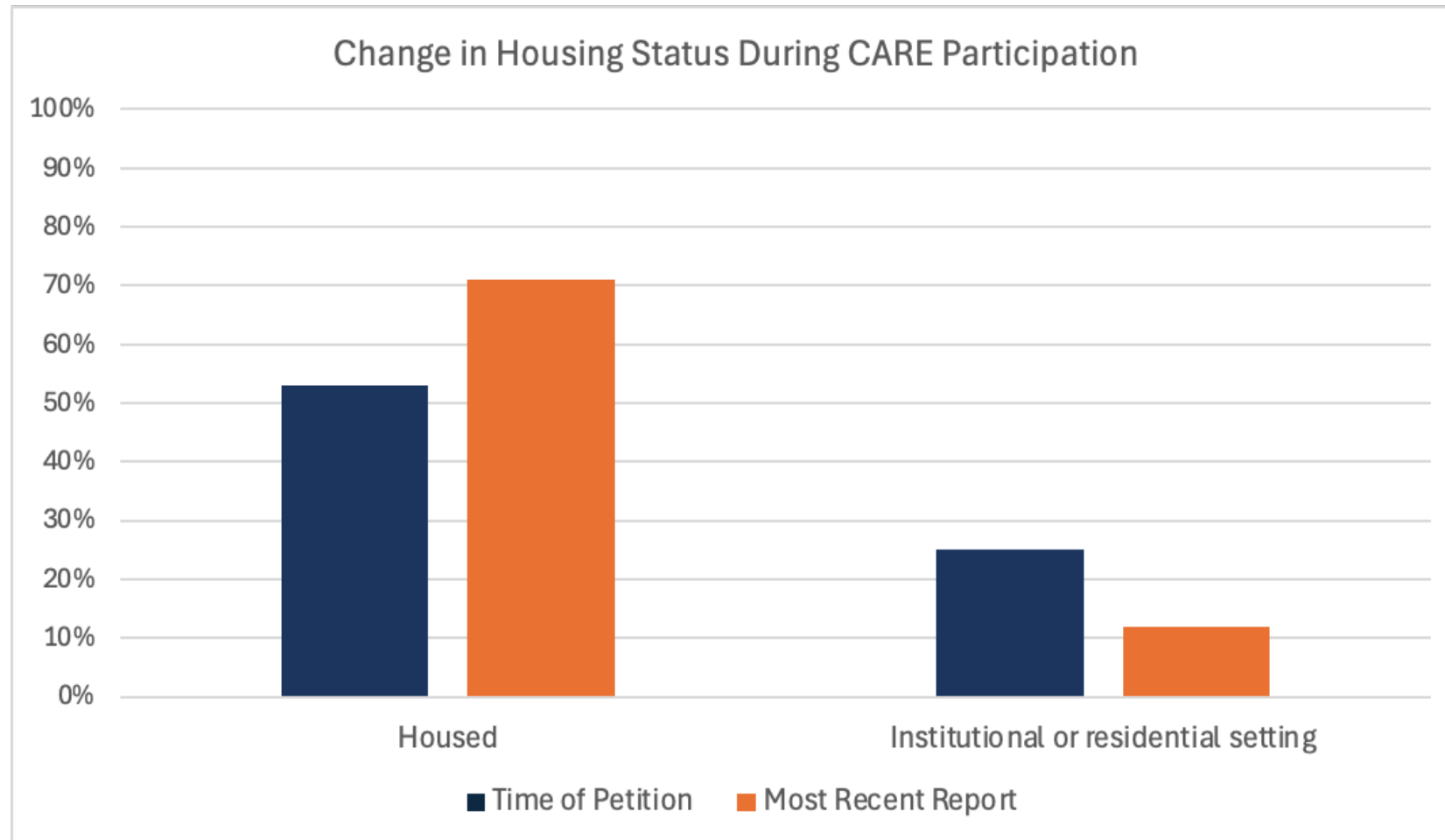
Engagement in services increases steadily throughout participation.

- Mental health service utilization rate increased from 77% to 87% for respondents over the first five months of participation.
- **Social service** engagement increased from **50% to 64%**.
- Stabilizing **medication** use increased from **47% to 61%**.
- Nearly two-thirds (**60%**) of active participants with **CARE agreements or CARE plans received all three foundational aspects of recovery** (i.e., stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports)."



CARE is Helping People Become and Remain Housed

- Housing rate increased from 53% to 71% during participation. (N=485).
- Unhoused rate decreased from 22% to 17%
- Those living in institutional or residential settings declined from 25% to 12%.
- Counties are braiding funding streams to get there: 42% of participants accessed county/state/federal housing supports, and 27% received CalAIM housing services.



Who CARE is Reaching & Where Petitions are Coming from:

- Participants are a diverse cross-section of California: 60% are 26–45 years old, 65% male; White (37%), Hispanic/Latino (22%), Black/African American (19%), and Asian (4%) participants represented.
- A notable shift in who initiates petitions:
 - System partners (hospitals, clinicians, public guardians) grew from 25% to 61% of petitions between December 2023 and June 2025
 - Family-filed petitions dropped from 67% to 26%
 - Outreach, training, and technical assistance to system partners is working, and petitions are increasingly coming from sources more likely to result in an actual CARE agreement.

In Summary

- These are early, promising indicators — not definitive long-term outcomes. Implementation is still maturing, and CalHHS is continuing to support counties to help CARE reach its full potential.
- Strong early engagement, meaningful housing gains, and a process that's working largely through voluntary participation.

2026 CARE ACT ANNUAL REPORT OVERVIEW

Data Collection & Reporting

Agenda

Overview of the 2026 Annual Report

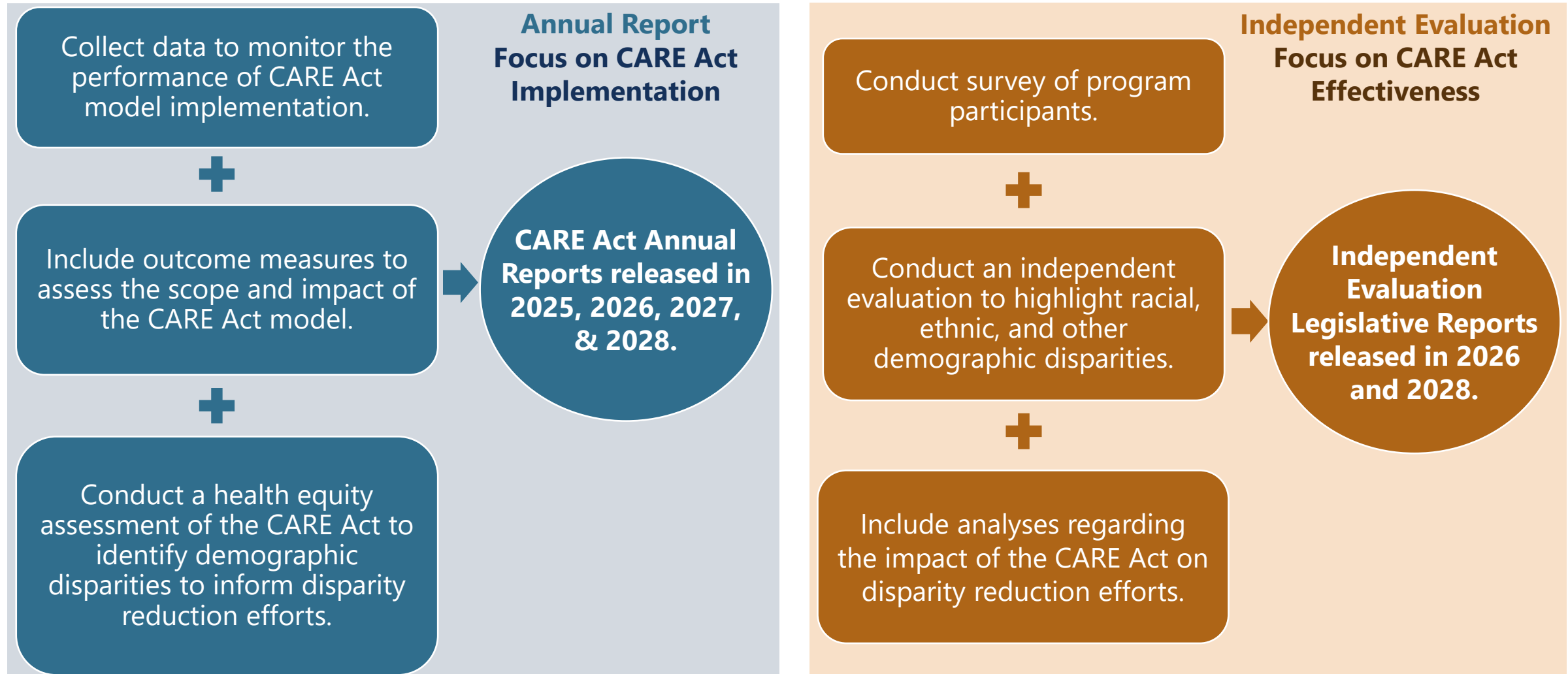
- Introduction and Objectives.
- Data Quality and Limitations.
- Findings.

Key Takeaways and Opportunities



2026 Annual Report: Introduction

DHCS Reports: Annual Report vs. Independent Evaluation



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 participants 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.

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:**
 - Reasons for petition dismissals and CARE ineligibility.
 - Outreach and engagement activities and 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).
- 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?

2026 CARE Act Annual Report Data

Timeframe

- CARE implementation between **October 1, 2023 – June 30, 2025 (21 months)**.
 - **Data Dictionary 1.0** used for October 1, 2023- December 31, 2024.
 - **Data Dictionary 2.0** used for January 1, 2025- June 30, 2025.

Population

- **Cohort 1** counties*: implemented starting October 1, 2023.
 - Los Angeles County implemented starting December 1, 2023.
- **Cohort 2** counties: implemented by December 1, 2024.

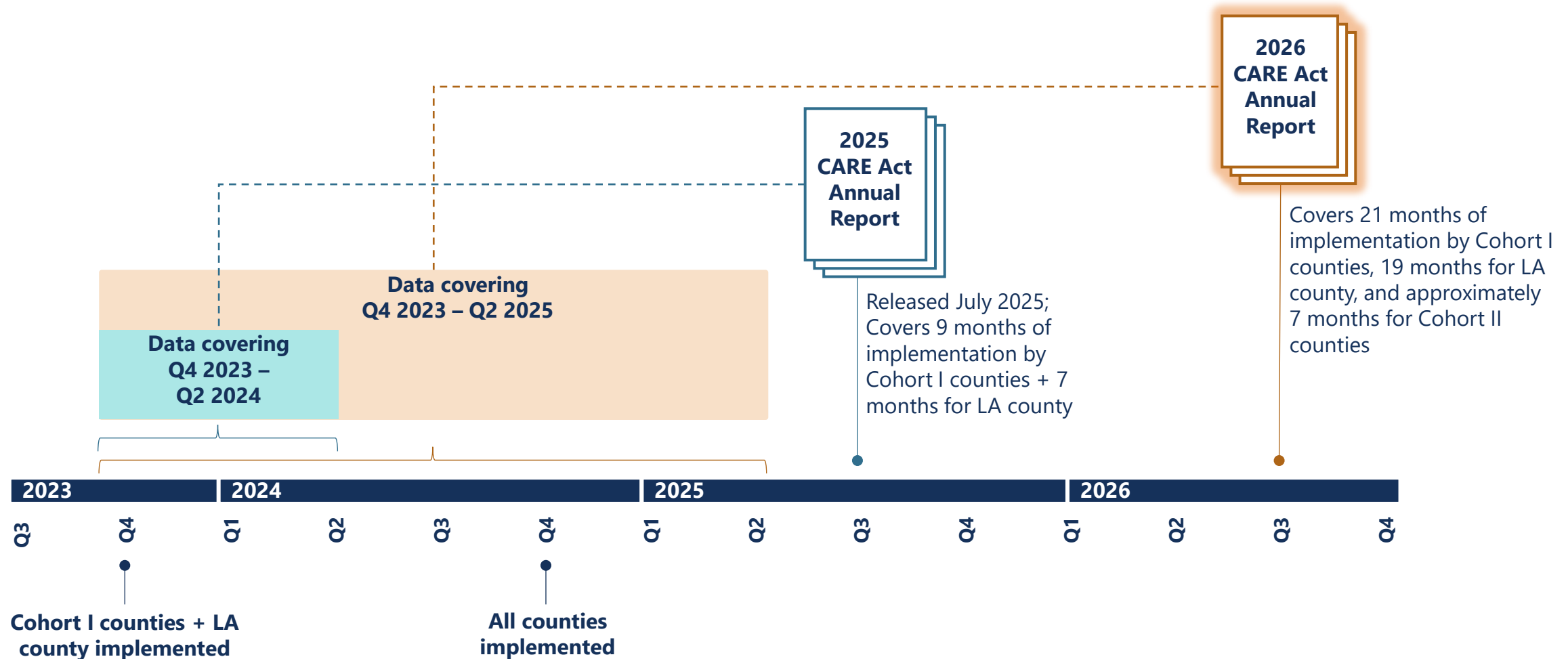
Data Sources

- **Judicial Council** (JC) aggregated data from county CARE courts.
- **County BH agency** aggregated data on actions related to CARE inquiries; individual-level data on CARE participants served by counties.

County Representation

- **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).

CARE Act Implementation and Annual Report Timeline



Data Quality and Limitations

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



Late release of expanded 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.

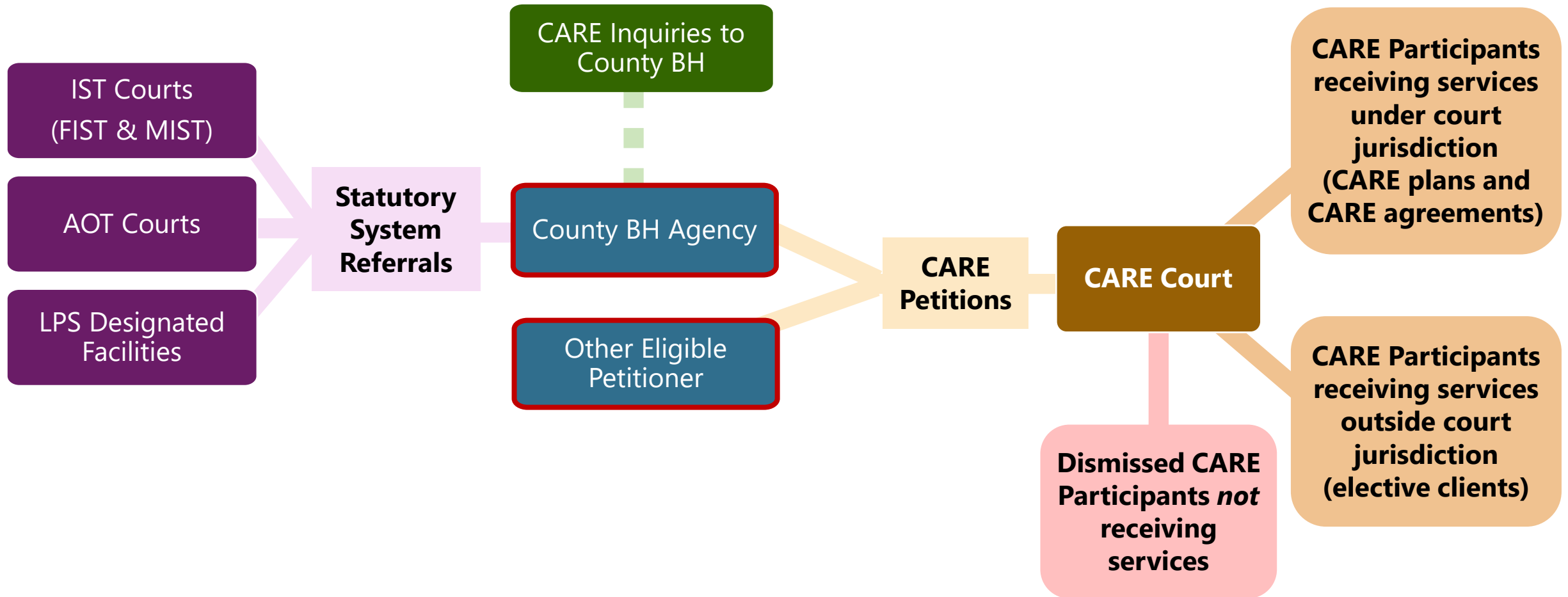


Data lags.

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

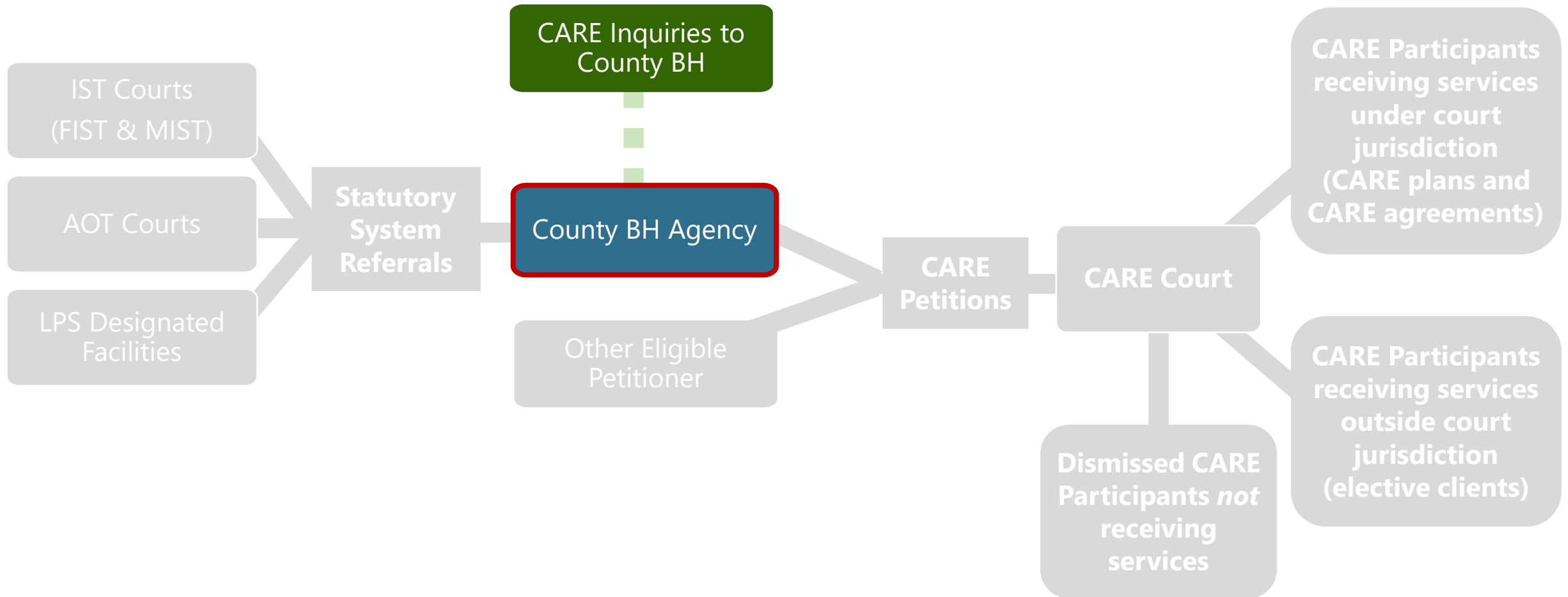
2026 Annual Report: Highlights and Findings

Entry Points into CARE At Time of Report



CARE Inquiries

County BH Reported Data



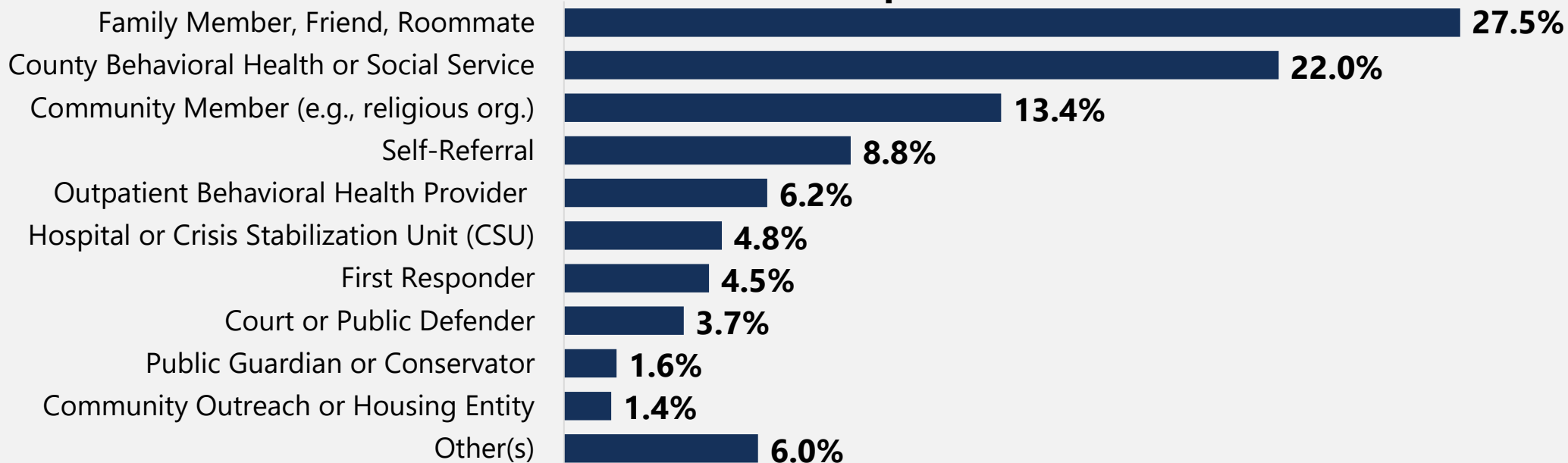
CARE Inquiries Received by Counties

County BH Reported Data

Between Jan 1- June 30, 2025:

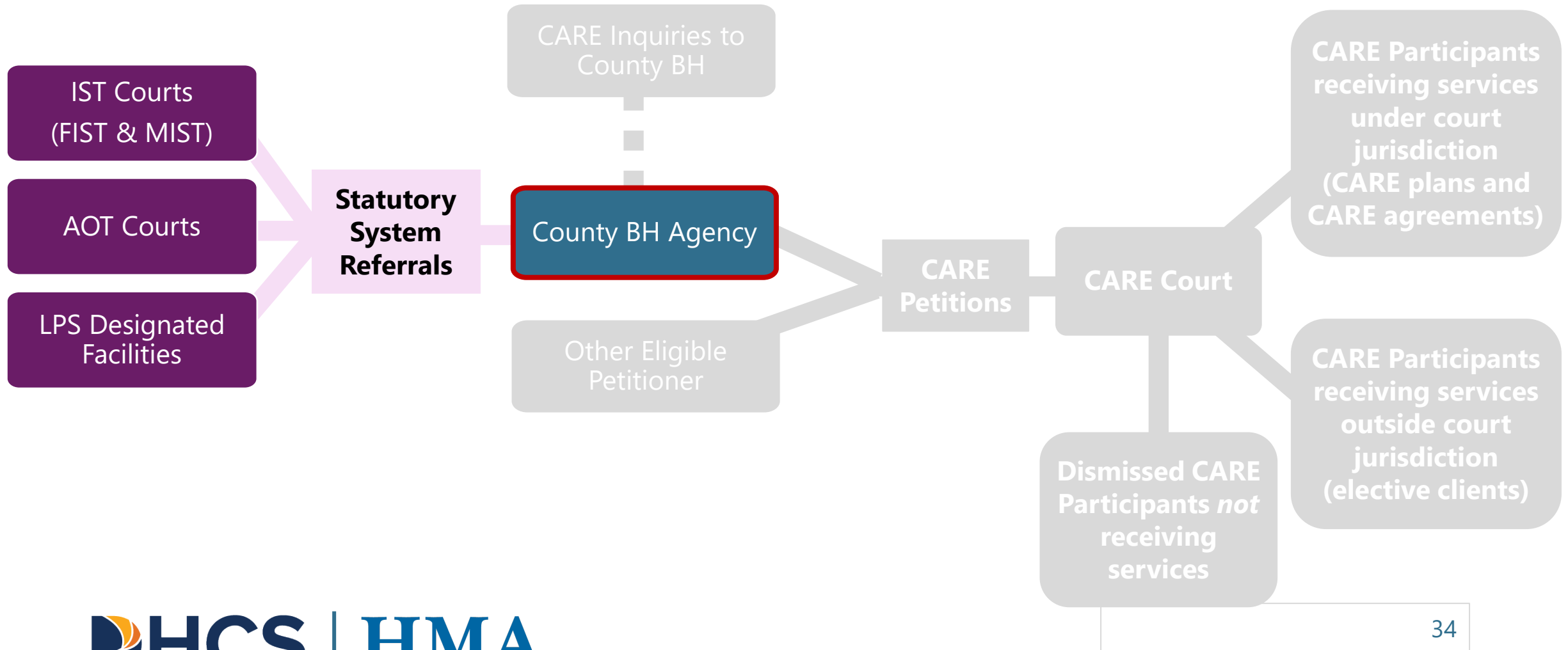
- **53 county BH agencies reported 1,794 inquiries**; most commonly from Family, Friend, Roommate; followed by other County BH/Social Service.
- Of these inquiries, **county BH agencies reported 710 actions**, commonly connections to MH services (290 actions), Social Services and Supports (105 actions) and to Full-Service Partnership (91 actions)

Source of CARE Inquiries Received



Statutory System Referrals

County BH Reported Data



Statutory System Referrals to County BH

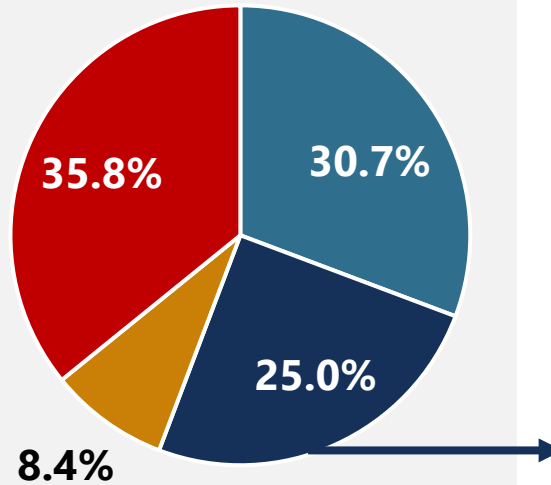
County BH Reported Data

Between Jan 1- June 30, 2025, **443 statutory system referrals** were reported by county BH agencies. Of these, **54% were from MIST proceedings** and **36% were from LPS-designated facilities**.

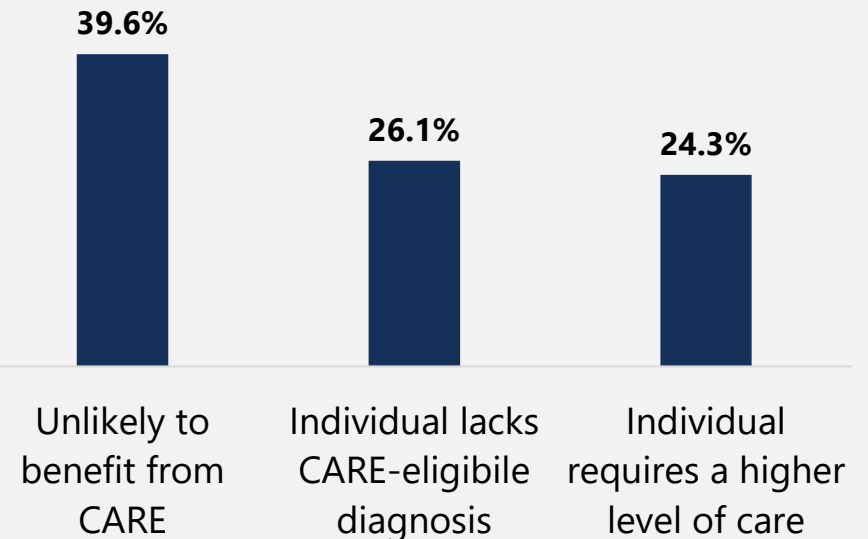
Among the 332 with an outcome assigned, about a third were petitioned to CARE; another third were not petitioned, but connected to county services and supports (8% enrolled in county services; 25% pending enrollment confirmation).

Outcomes of Statutory System Referrals to CARE

- Petitioned to CARE
- Not petitioned - Connected to county BH services/supports
- Not petitioned - Accepted voluntary treatment and enrolled in any other county service/support
- Neither petitioned nor connected to county BH services/supports

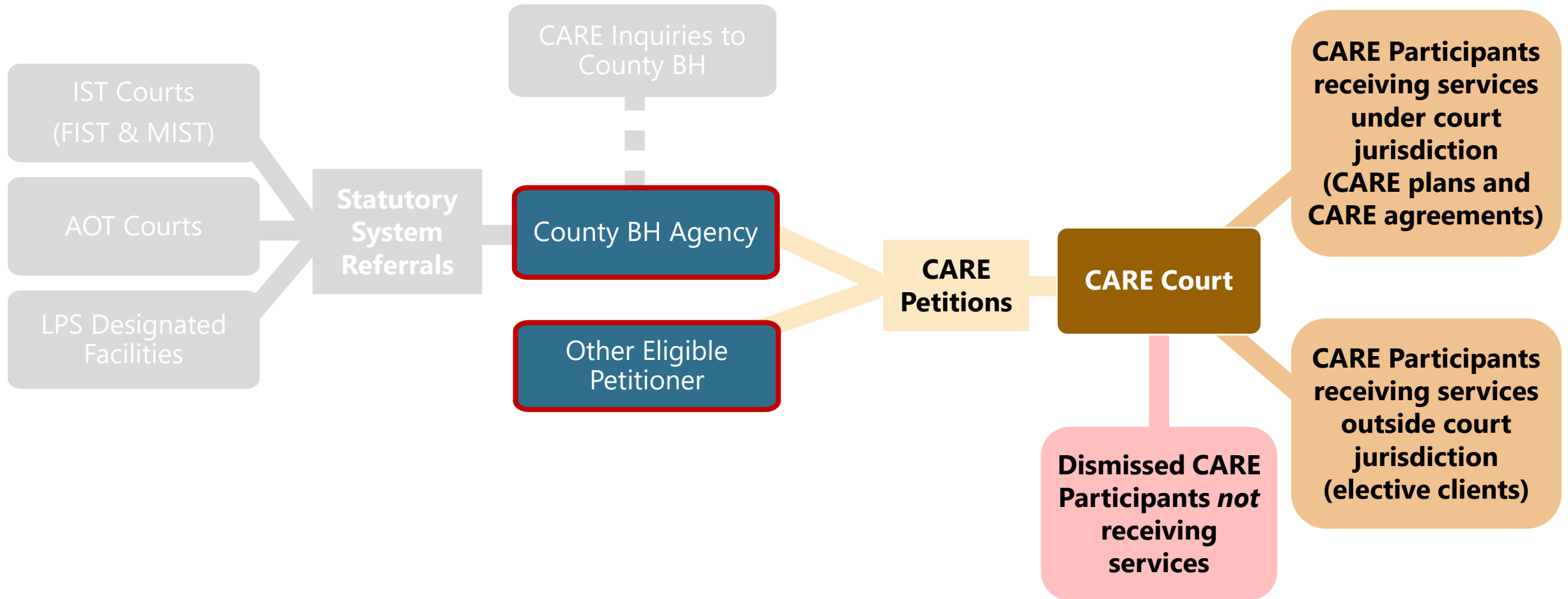


Reason for Not Petitioning to CARE



CARE Petitioned Individuals (CARE Participants)

County BH Reported Data



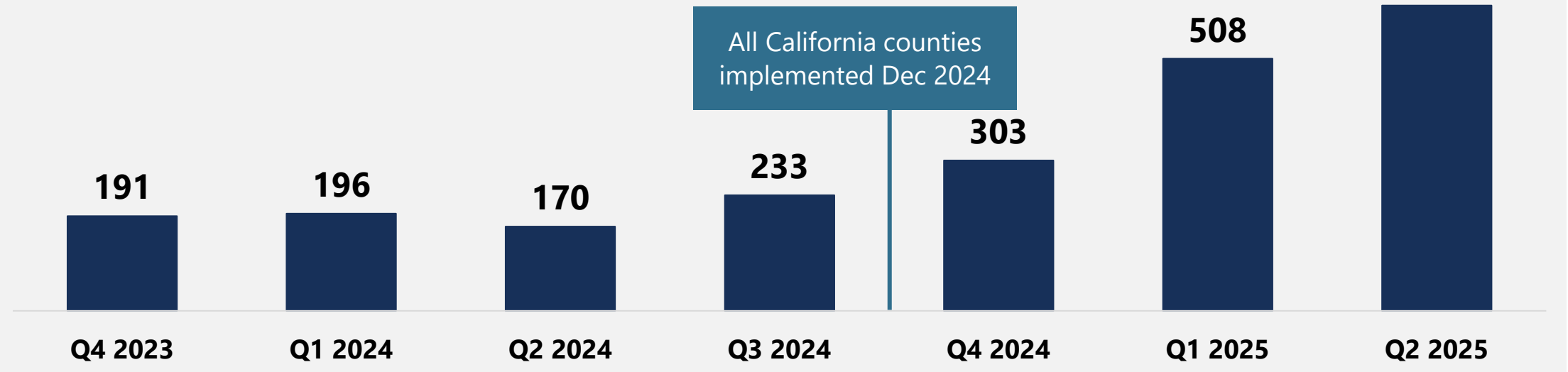
Volume of CARE Petitions Through Courts

Judicial Council Data

More than **2,200 CARE petitions** were filed during the first 21 months of **implementation**, with petition volume increasing each quarter.

As of June 2025, **23% resulted in a CARE agreement or ordered CARE plan**, while **44% were dismissed by the courts** at the initial disposition. The rest are still in process.

New CARE Petitions Submitted to Courts, by Reporting Quarter and Year

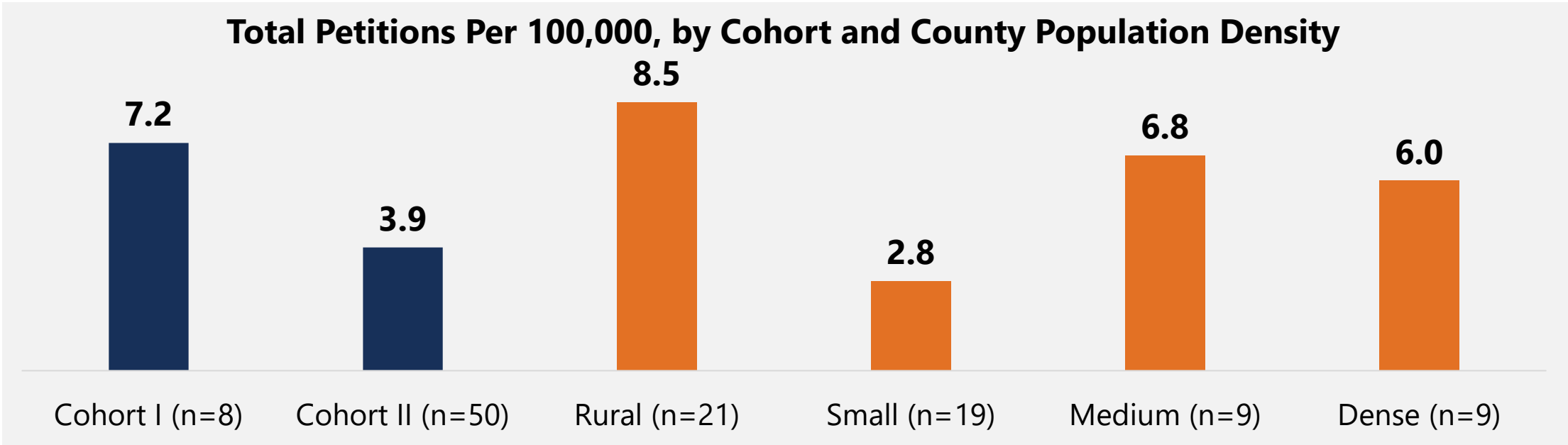


Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services. Note: All Cohort I Counties, including Los Angeles County, began implementing CARE by December 2023; All other counties implemented CARE no later than December 2024.

Total CARE Petitions per Capita

Judicial Council and State Census Data

As of June 30, 2025, 5.6 petitions had been filed per 100,000 residents across the state. Higher per capita petition rates were observed among Cohort I counties, potentially reflecting the maturity of CARE Act implementation among Cohort I counties.

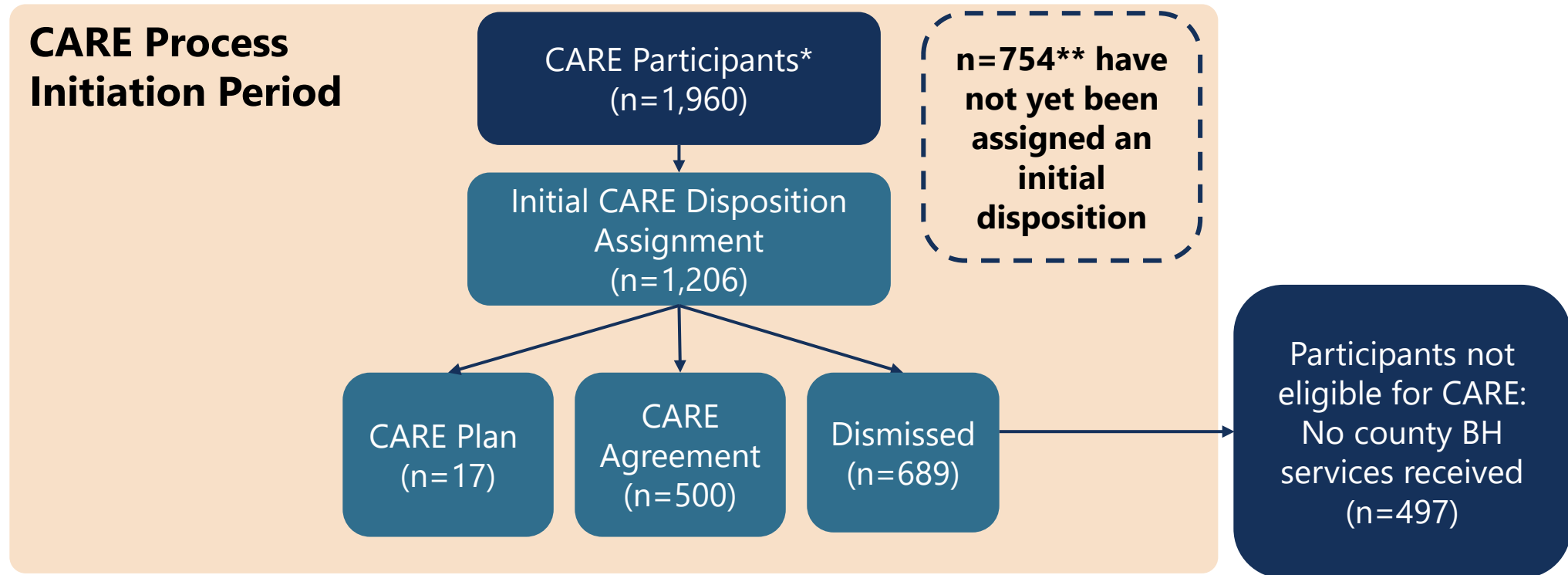


Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services. Note: Cohort I has no small counties.

Volume of CARE Participants through County BH

County BH Reported Data

County BH agencies reported receiving 2,008 petitions through June 30, 2025, representing 1,960 unique CARE participants. Of 1,206 CARE participants with a first petition disposition, 517 (43%) had an approved CARE agreement or ordered CARE Plan; 689 (57%) were dismissed.



*2,008 total CARE petitions, representing 1,960 unique CARE participants, were received by county BH agencies.

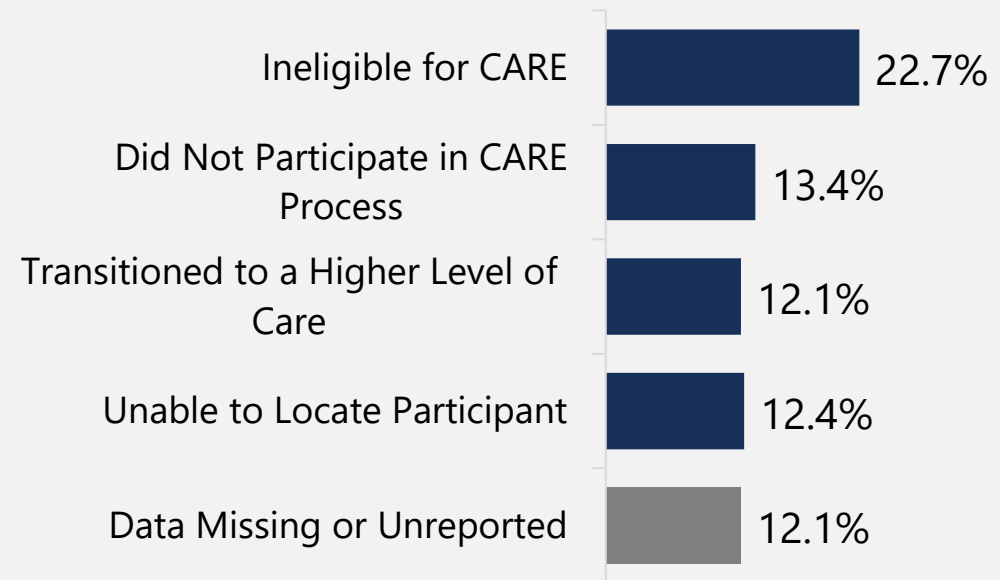
CARE Participant Petition Dismissals (First Disposition)

County BH Reported Data

The most common reason for dismissal was diagnostic ineligibility (23%), followed by, nonparticipation in CARE process (13%), transition to a higher level of care (12%), and inability to locate the participant (12%). Nearly two thirds of CARE participants who were dismissed at initial disposition did not go on to receive county and supports.

- » Among the 689 CARE participants dismissed by the CARE court at the initial CARE disposition:
 - **497 were dismissed and did not receive any county BH services.**
 - **192 were dismissed and received county BH services outside court jurisdiction (elective clients).**

County-Reported Rationale for Dismissal



Time to First Disposition Assignment

County BH Reported Data

Of the 1,206 CARE participants with a petition disposition, the **median number of days from petition to first disposition was 76 calendar days**, with wide variations observed. 15% of petitions had a disposition assigned within 30 calendar days of petition filing.

Participant Group	Calendar days from CARE Petition to Initial Disposition	
	Median	25 th – 75 th percentile range
All CARE Participants with a Disposition (n=1,206)	76	44 – 129
CARE agreements (n=500)	62	38 – 109
CARE plans (n=17)	75	25 – 106
Dismissed (elective clients) (n=192)	76	49 – 128
Dismissed (not receiving county services/supports) (n=497)	89	55 – 154

County Exemplars:

A few counties demonstrated efficiency in this process, including two cohort I counties with higher volume of petitions:

- **San Diego County** (n=315 CARE participants) reported a median time to disposition of **55** calendar days.
- **Stanislaus County** (n=61 CARE participants) reported a median time to disposition of **47** calendar days.

What Happens to Participants Waiting for a Court Disposition?

Outreach and Engagement to CARE Participants Prior to Initial Disposition

County BH Reported Data

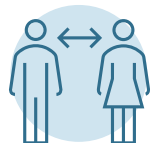
Between January 1 and June 30, 2025, 47 county BH agencies reported **4,427 one-way outreach attempts** and **12,739 engagements (two-way interactions)** to **1,328 participants still waiting on an initial petition disposition from the courts.**

Many counties report proactively engaging participants and offering services and supports before a petition receives a disposition.



4,427

One-way
outreach
attempts



12,739

Two-way
engagements

County Exemplar:

In **San Diego County**, the CARE team emphasizes an intensive, **proactive approach to reach individuals who have not historically been well served by the behavioral health system.** This includes **early one-on-ones** with CARE participants and **including family and supports**, where appropriate.

Services and Supports Provided In CARE Process Initiation Period (Prior to Initial Disposition) County BH Reported Data



759
(57.2%)

Accessed a service or support. The most common service accessed was mental health treatment services.



299
(22.5%)

Received stabilizing medications prior to first CARE petition disposition.



188
(14.2%)

Received a housing service or support (either through a CalAIM benefit or from a county, state, or federally funded program).



294
(22.2%)

Missing or unknown data reported for services and supports accessed during their Initiation Period.

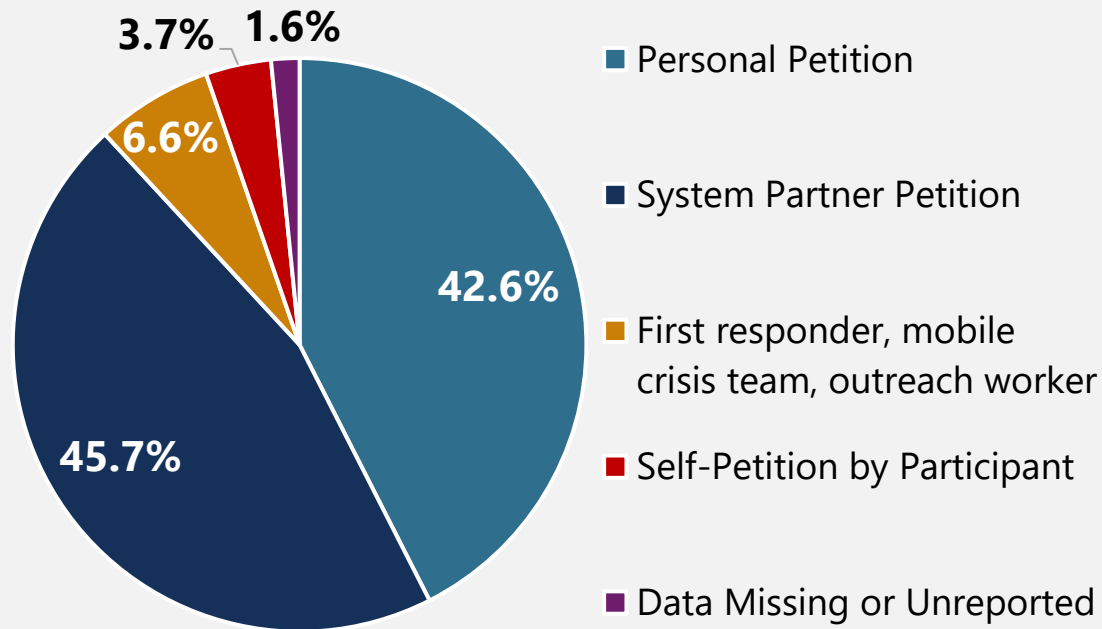
Who is Petitioning to CARE?

Original Petitioner Type

County BH Reported Data

Overall, **46% of CARE participants were petitioned by a system partner**, 42% were petitioned by someone with a personal relationship to them, 7% by a first responder, and 4% by themselves.

Original Petitioner for CARE Participants



CARE Petitioners: Changing Landscape

- The proportion of total CARE petitions by a **personal petitioner** *decreased* from **67% of petitions in Q4 2023 to 26% in Q2 2025.**
- The proportion of total CARE petitions from **system partners** *increased* from **25% of petitions to 61% percent from the first quarter of implementation to the most recent quarter included in this report.**

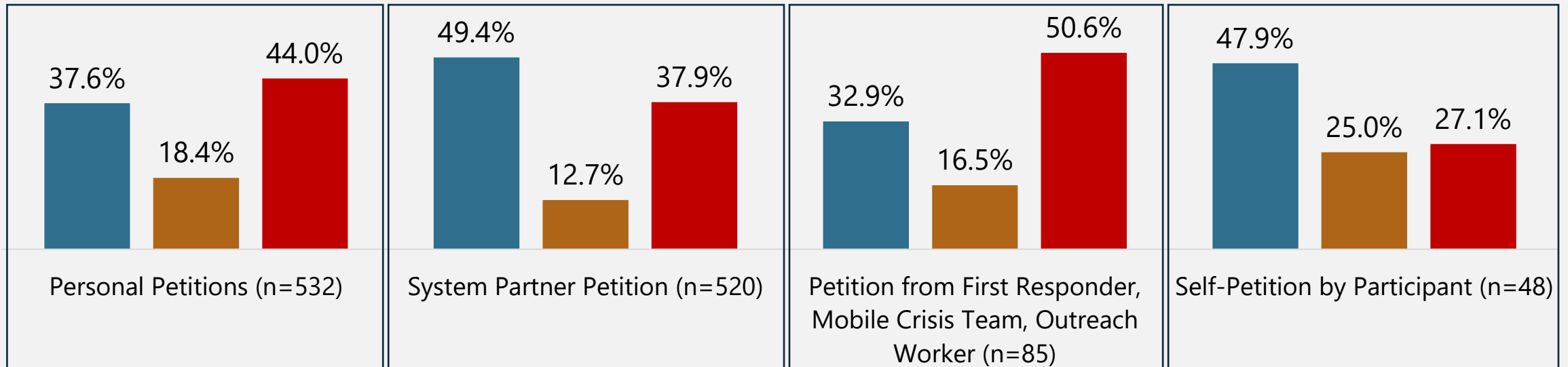
Differences in Initial CARE Disposition by Petitioner Type

County BH Reported Data

Certain petitioner types yield higher rates of CARE plans and CARE agreements. Education and training of system partners on the CARE Act may improve identification and referral of potentially eligible CARE participants

Origin of CARE Petitions by Disposition Type

■ CARE Agreements and Plans ■ Dismissed (Elective Clients) ■ Dismissed (Not Receiving County Services)

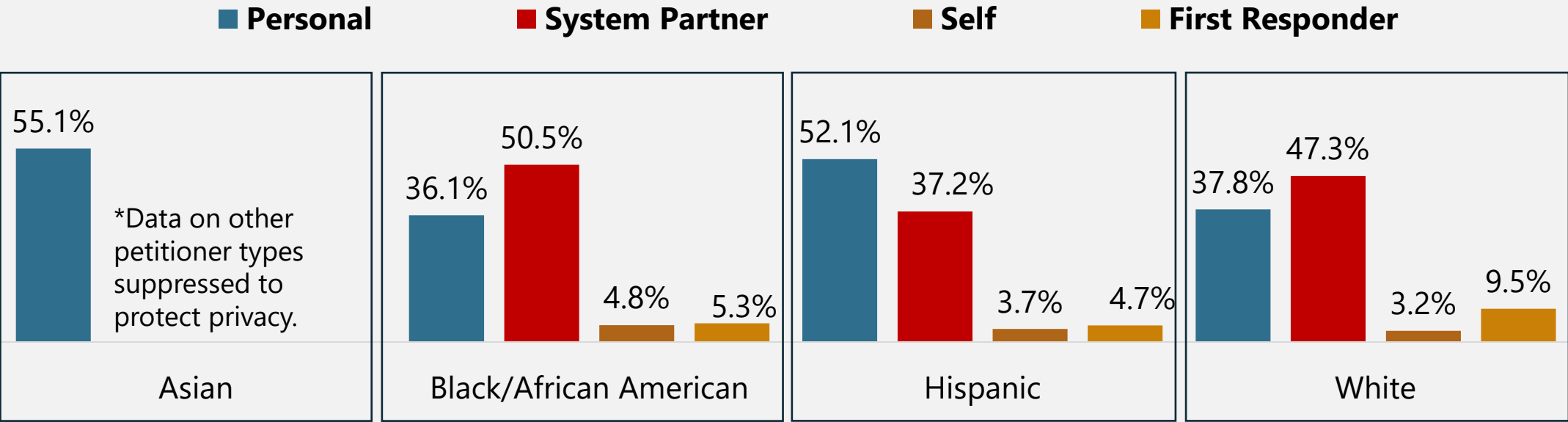


Origin of CARE Petitions, by CARE Participant Race/Ethnicity

County BH Reported Data

Differences were observed in the origin of CARE petitions across different races/ethnicities. This could inform opportunities for targeted outreach, engagement, and education to raise awareness about the CARE Act, especially among underserved communities.

Origin of CARE Petitions by Race/Ethnicity

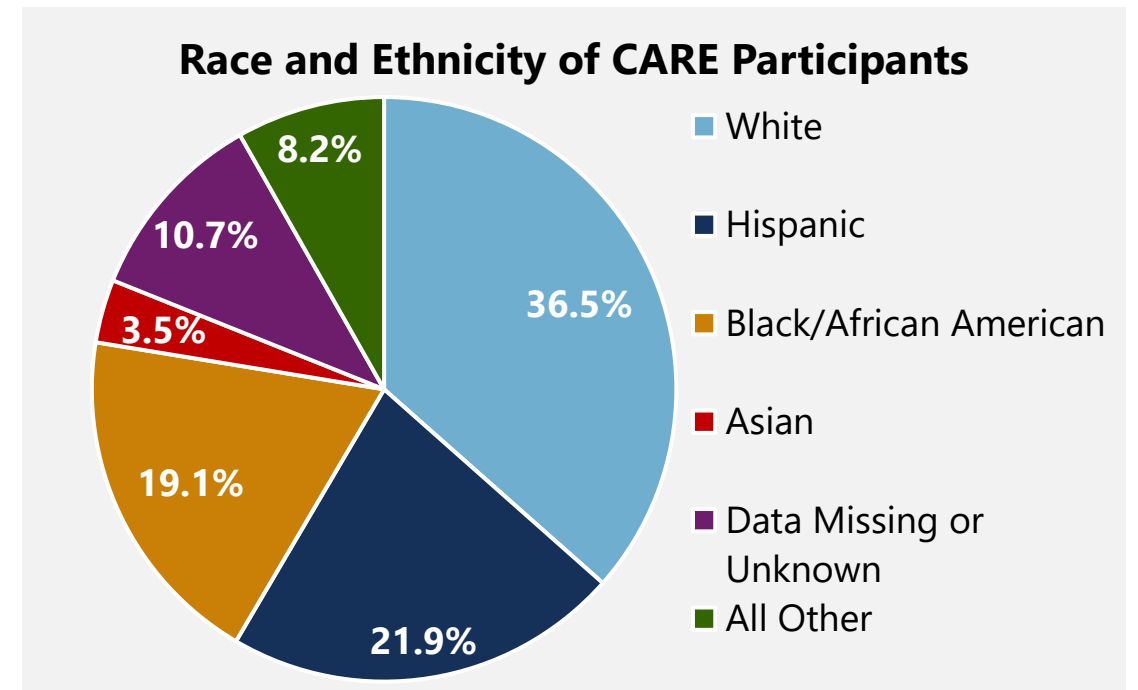
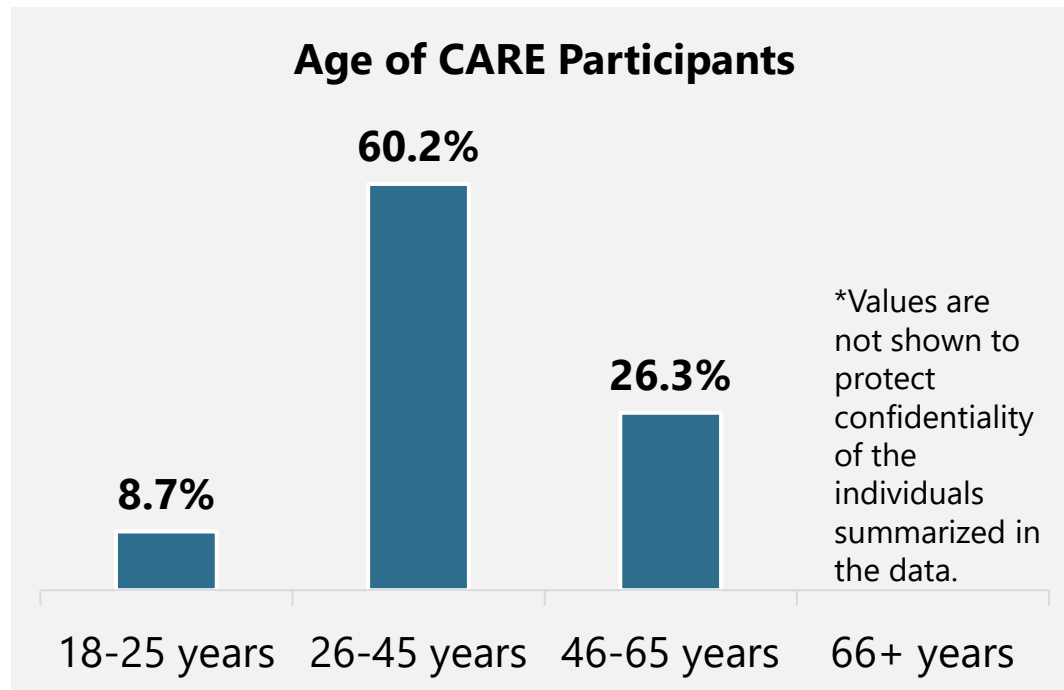


Who is Being Petitioned to CARE?

CARE Participants: Age and Race/Ethnicity

County BH Reported Data

The majority of CARE participants were between the ages of 26 and 45 years (60%) and male (65%) (data not shown). Over a third (37%) identified as White, 22% as Hispanic, 19% as Black or African American, 4% as Asian, and 11% were missing or unknown.



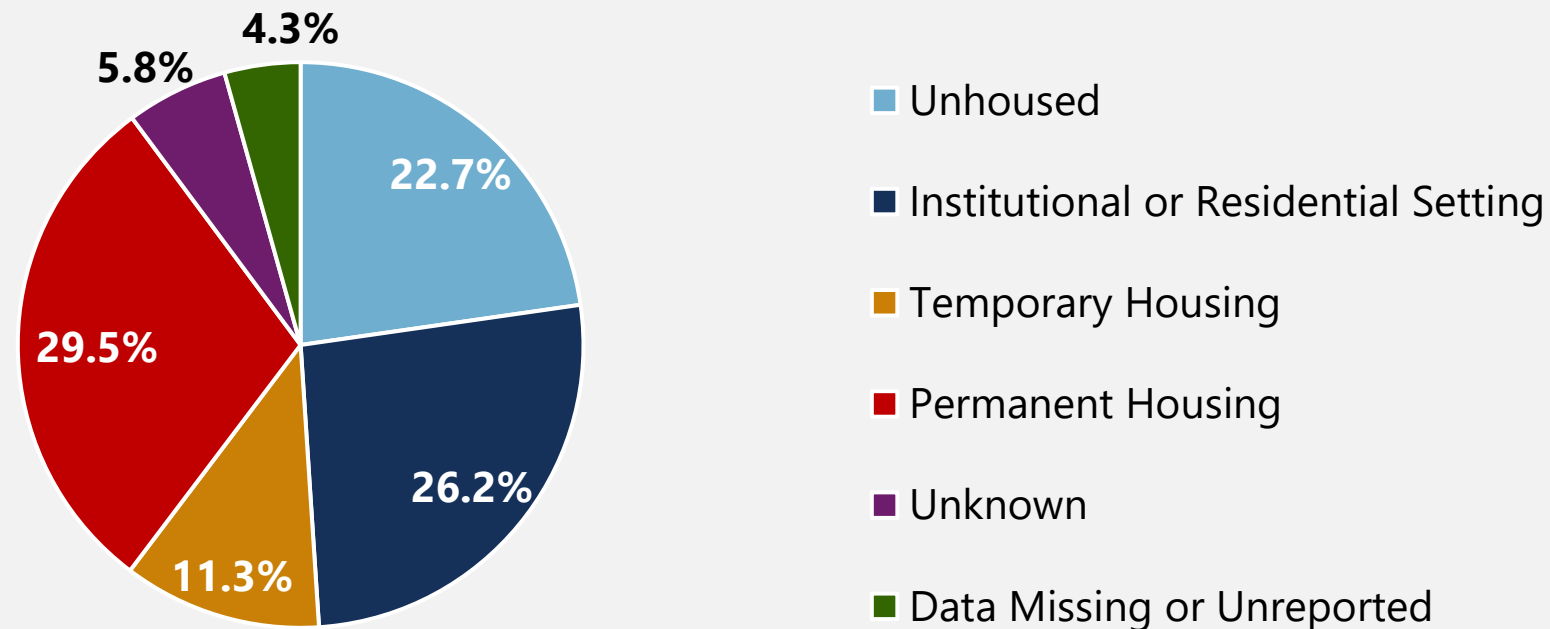
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.

CARE Participants: Housing Status at Time of Petition

County BH Reported Data

At the time of petition, **800 (41%) were housed (in permanent, or temporary housing), and 444 (23%) were homeless or unhoused, and 513 (26%) resided in an institution or residential treatment program.**

Housing Status/Living Situation of CARE Participants at Time of Petition



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

Participants with CARE Agreements or CARE Plans

Are Participants Accessing Services?

Service and Support Access Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

Majority of those with CARE plans or CARE agreements received mental health treatment services (88.6%) and social services or supports (73.9%).

Service or Support Category	Active CARE Participants: CARE Agreements and CARE Plans (n=517)
Any Mental Health Treatment Service	458 (88.6%)
Any Social Service or Support	382 (73.9%)
Stabilizing Medication at Any Time	321 (62.1%)
Any CalAIM Community Support	164 (31.7%)

County Differences Observed

Participants residing in medium counties may face fewer barriers to MH treatment access than others, with **99% of participants in medium counties accessing at least one MH treatment service**, versus **85% and 83%, respectively, in dense and small counties**

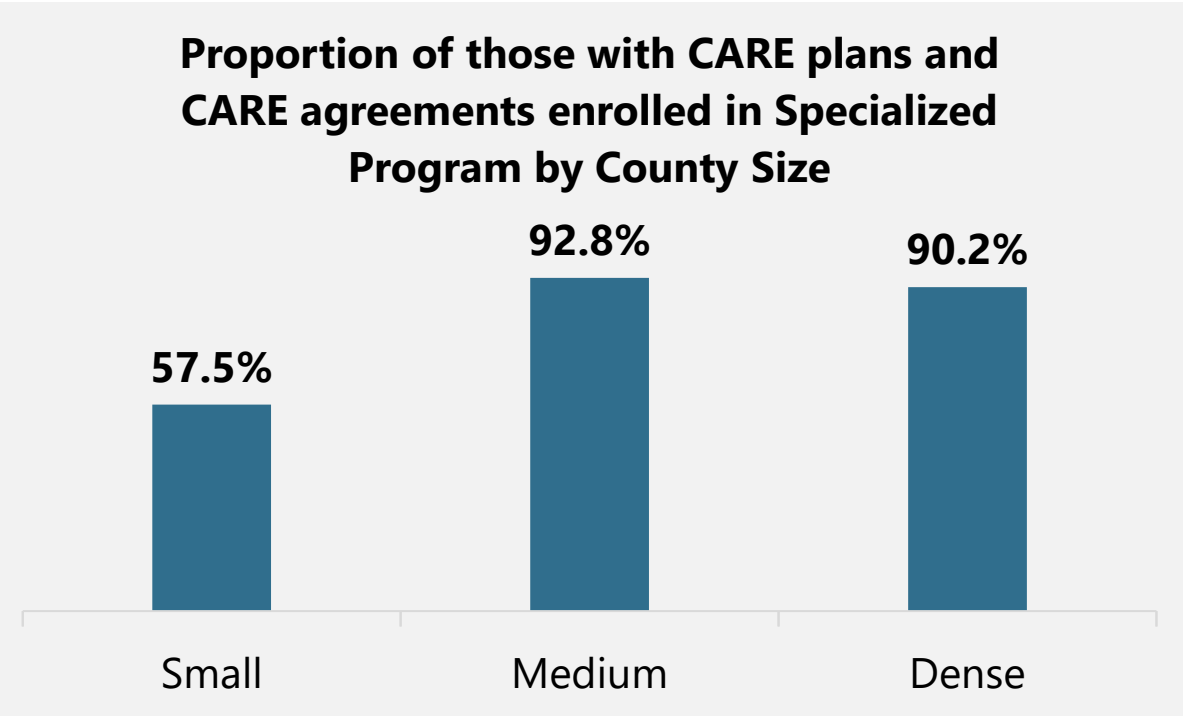
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services. Medication support services include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Detailed definitions for all mental health services are included in the CARE Act Data Dictionary 2.0, Appendix C: Mental Health Treatment Services Descriptions.

Access to Specialized Programs Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

Almost 9 out of 10 individuals with a CARE agreement or CARE plan accessed a specialized program for individuals with serious mental disorders.

Program	Active CARE Participants: CARE Agreements and CARE Plans (n=517)
Specialized Program - Any	451 (87.2%)
Full-Service Partnership (FSP)	224
Assertive Community Treatment (ACT)	138



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

Housing Supports Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

Over one quarter of CARE participants received a CalAIM housing service or support, and 42 percent received a county, state, or federally funded housing service or support.



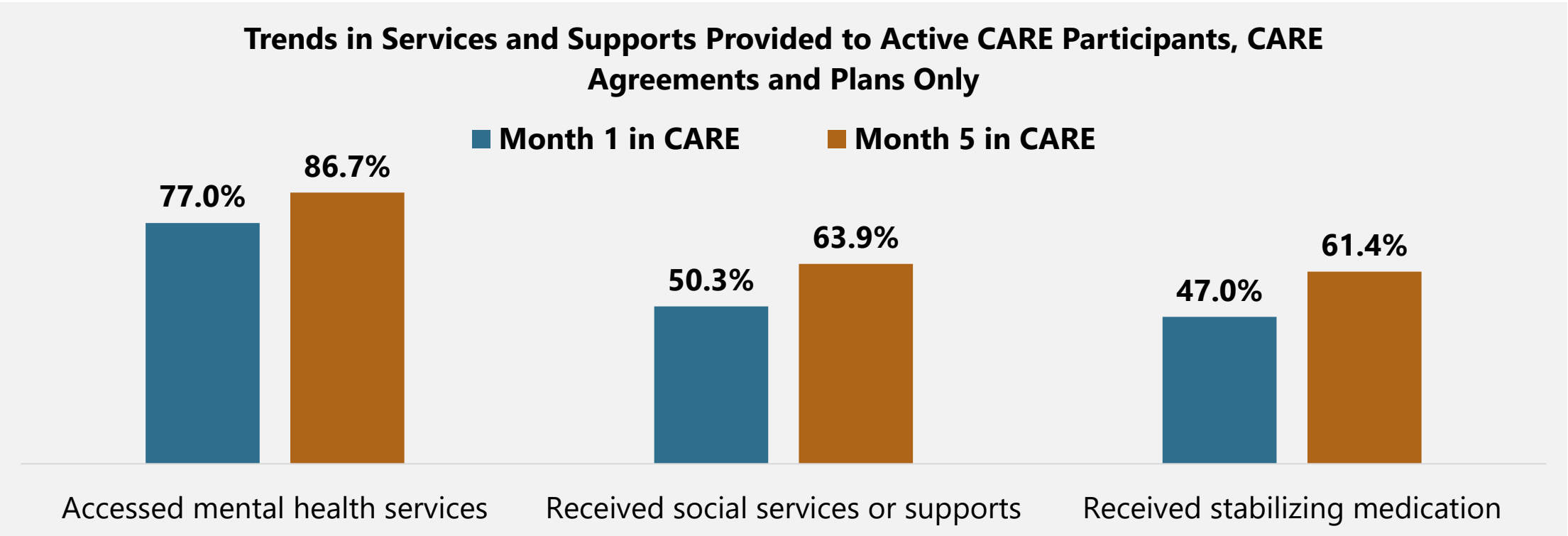
Housing Service or Support Category	Active CARE Participants: CARE Agreements and Plans (n=517)
Any CalAIM Housing Support	138 (26.7%)
Any County, State, or Federally Funded Housing Support (Not CalAIM)	218 (42.2%)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services. Note: CalAIM housing supports include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, or transitional rent, as defined in the CARE Act Data Dictionary 2.0, Appendix E: Definitions for CalAIM Community Support Services. Non-CalAIM housing supports funded through county, state, or federal mechanisms include a variety of programs, as outlined the CARE Act Data Dictionary 2.0, data point 3.6.2 Type of Housing Support. These categories are mutually exclusive.

Trends in Service and Support Access Over Time Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

Positive trends in the proportion of individuals who accessed mental health services, social services and supports, and stabilizing medications over their first five months on a CARE plan or CARE agreement.

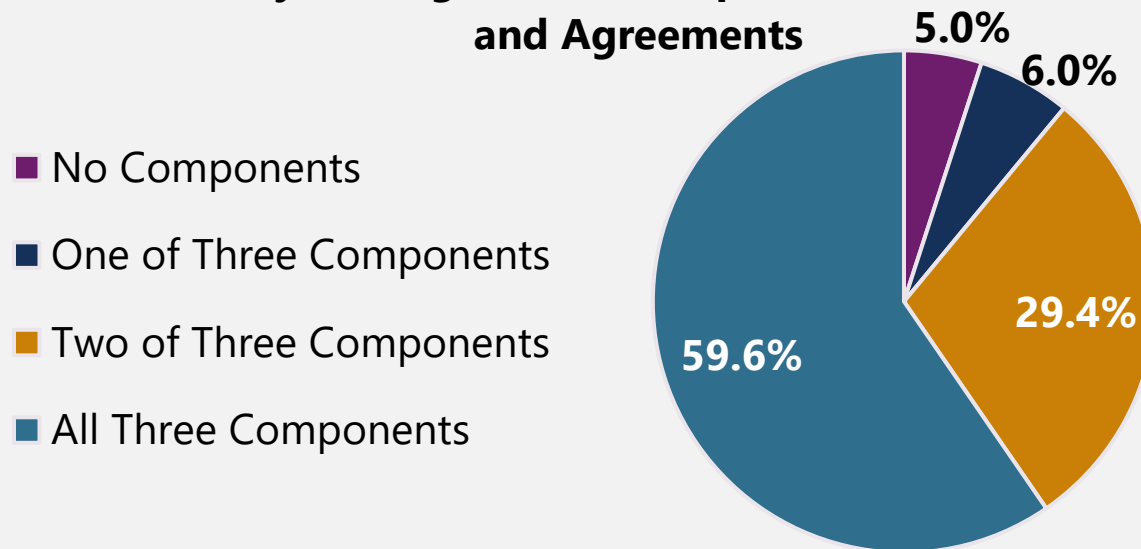


Receipt of Key Recovery-Supporting Services Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

60 percent of CARE participants received all three critical services—stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports.

Access to Three Evidence-Based Components for Recovery Among CARE Participants with CARE Plans and Agreements



County Exemplars

Stanislaus County reported that **89%** of participants with CARE agreements or CARE plans received all three key services.

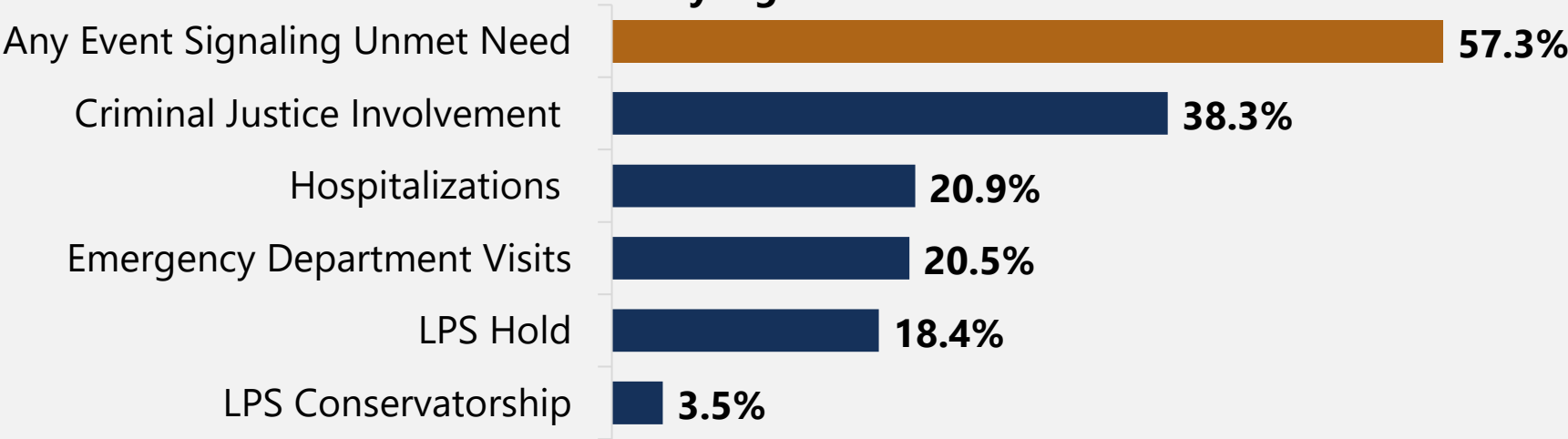
San Diego County reported that **73%** of participants with CARE agreements or CARE plans received all three key services.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.± Collectively, three evidence-based components of care form the foundational aspects of recovery for CARE participants: stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports. For the purposes of this analysis, a CARE participant is 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 Short-Term Post-Hospitalization Housing); or (c) were in permanent, temporary, or institutional housing.

Acute Medical, Psychiatric, or Law Enforcement-Related Events Among Participants with CARE Plans or CARE Agreements County BH Reported Data

County BH reported one or more events signally unmet need among those on a CARE agreement or CARE plan. No observed variation in these events over the first five months while on a CARE agreement or plan.

Proportion of Participants with CARE Agreement or CARE Plan with Any Event that May Signal Unmet Need

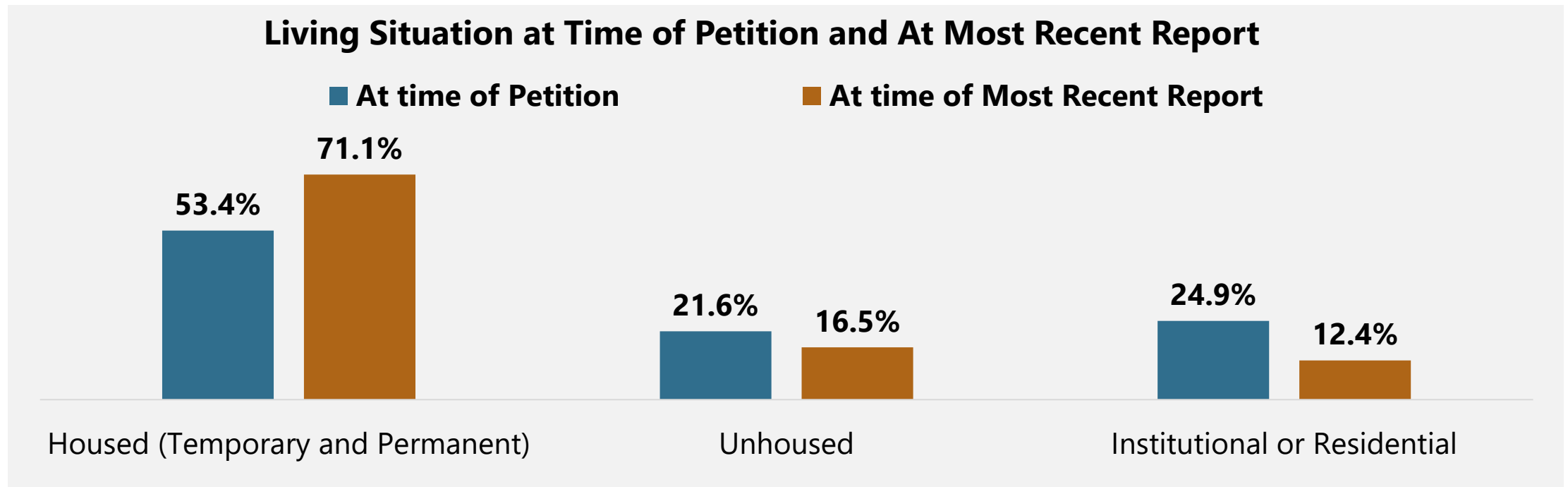


Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services. Note: High data missingness or unknown responses were reported by counties for these data points. Among the 517 CARE participants with CARE agreements or plans, the proportion of missing or unknown data for a participant's total time in CARE was 17.2 percent for hospitalization data, 11.2 percent of ED Visit data, 6.2 percent of both LPS hold and conservatorship data, and 5.0 percent of criminal justice involvement data.

Housing Status Among Participants with CARE Plans or CARE Agreements

County BH Reported Data

Positive trends were observed among participants with CARE plans and CARE agreements who gained or maintained housing during their time in CARE.



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

Are Participants Exiting CARE?

Exiting the CARE Process

County BH Reported Data

Early insights highlight mixed exits from the CARE process among individuals with CARE agreements or CARE plans; with exits collaboratively determined.

» Graduations and Re-Appointments

- **32** with CARE agreements or CARE plans **graduated from CARE** (median time spent on agreement/plan was 13 months).
- **26 were reappointed** (mostly voluntarily) after 12 months on their CARE agreement or CARE plan.

» Exit Prior to 12 Months on CARE agreement or CARE plan

- **61 were dismissed before graduating or completing 12 months** on a CARE agreement or CARE plan (median time spent on CARE agreement/CARE plan was 6 months).
- **Rationale for exit prior to 12 months:** unable to locate participant (23%), participant sentenced to long-term incarceration (21%), participant transitioned to higher level of care (18%).

Are Elective Clients Accessing Services Outside of Court Jurisdiction?

Elective Clients

County BH Reported Data

During the first 21 months of CARE Act implementation, 192 CARE participants became elective clients and received county services and supports outside of court jurisdiction.



A high proportion of missing and unknown data were reported by county BH for services and supports accessed by elective clients (21 – 54% missing data).

- 59% reported access to any mental health treatment services.
- 54% reported enrollment in a specialized program.
- 25% reported access to a stabilizing medication.

Due to county-identified barriers in tracking these elective clients served outside of court oversight, the findings **should be considered unreliable and interpreted with caution.**

2026 Annual Report: Key Takeaways

Key Takeaways

Initial dispositions often take time and vary by county, but many participants access services while awaiting disposition.

- » The median time to an initial disposition was 76 calendar days.
- » 15% of petitions received an initial disposition within a month.
- » Between the petition filing and initial disposition, over half (57%) accessed services or supports.
- » Counties are identifying successful approaches to engaging CARE participants prior to initial disposition.

Key Takeaways

Participants with CARE agreements or CARE plans increasingly access mental health treatment, social services, stabilizing medications, and foundational recovery supports.

- » Positive trends observed in the proportion who accessed mental health services, social services and supports, and stabilizing medications during the first five months while on a CARE agreement or CARE plan.
- » Nearly two-thirds (60%) received all three foundational aspects of care that support recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports).
 - An additional 29% received two of the three support types (most often a combination of housing supports and psychosocial treatment and community-based treatment).

Key Takeaways

Increasing proportions of participants with CARE agreements or CARE plans gained or maintained housing.

- » The CARE Act may be promoting creative housing solutions across counties and increasing access to housing services and supports.
- » Positive trends in participants gaining and maintaining housing were observed among participants with CARE plans and CARE agreement.
 - The proportion of CARE participants who were housed in either temporary or permanent housing grew nearly 20 percentage points (53.4% at the time of their petition to 71.1% at the most recent month of available data)

Key Takeaways

Variations in CARE Implementation and Process Outcomes highlight opportunities for targeted training, outreach, and coordination.

- » Nearly three-quarters of CARE participants dismissed without a CARE agreement or plan were not receiving county services and supports at dismissal, with variations across counties.
- » System partners and self-petitions yielded higher rates of CARE plans and CARE agreements. Education and training about the CARE Act appear to improve identification and referral of eligible CARE participants.
- » Differences among petitioner types within racial groups highlight opportunities for targeted outreach, engagement, and education to raise awareness about the CARE Act, especially among underserved communities.
- » Conversion rates from statutory system referrals to CARE petition varied widely across counties, indicating substantial variation in local referral practices, capacity, and system coordination.

Opportunities to Leverage Findings

Improve timeliness and consistency of CARE processes

Strengthen service engagement and care continuity

Expand housing access and stabilization strategies

Improve petition quality, eligibility screening, and referral pathways

Advance equity through culturally responsive engagement

Strengthen statutory referral coordination across systems

Improve data quality and reporting infrastructure

Questions?



Focus Group Updates: Families and Peers; Public Defenders

Families and Peers: Lauren Rettagliata and Monica Porter Gilbert

Public Defenders: Jennifer Bender

August 7, 2026

CARE Peers + Families

Draft Working Group
Recommendations



What the recommendations are designed to do

Recommend tangible actions to strengthen ongoing CARE implementation by advancing the following core goals:

- **Center all dimensions of recovery (health, home, purpose, community), not just services**
- **Ensure person-centered processes and impact measures**
- **Expand opportunities and resources for involving and supporting peers, families, and volunteer supporters across the CARE process**

Strengthen processes, supports, and guidance in accordance with core goals across several areas of implementation:

- **Training & technical assistance**
- **Structuring county teams & local processes**
- **Expanding resource connections & supports**
- **Evaluation**





Training & Technical Assistance

- Expand guidance on **recovery-oriented, community-based approaches** within CARE that emphasize social connection, community participation, and natural supports alongside clinical services.
- Ensure CARE teams, including peers and court personnel, have access to **clinical guidance and best practices** for working with fluctuations in insight and decision-making capacity, such as LEAP training and Recovery-Oriented Cognitive Therapy. Guidance should also include strategies for adapting engagement approaches (e.g., providing paper checklists of available services) and revisiting participants' goals throughout the CARE process.
 - Support expanded access to LEAP training for families and volunteer supporters.





Training & Technical Assistance

- Expand education for counties, courts, contracted providers, and participants on the **role of peer support** (including family peers) in the CARE process:
 - Develop guidance for counties and providers on when and how peer support should be introduced and how to integrate and leverage peer staff in FSP/ACT teams.
 - Identify the competencies and training needed to prepare peers and family peers to effectively support participants and families through court proceedings.
 - Provide counties with best practices for hiring, training, and supervising peer staff, including guidance on billing for peer and family peer services.
 - Develop CARE-specific training and recommend existing training (e.g., Crisis Response Peer Certification) for paid peer support staff and family peers focused on the specific needs of the CARE-eligible population and of families navigating the CARE process.





Training & Technical Assistance

- Expand education for counties and courts on **family involvement**, including guidance on:
 - Recognize the diversity of family circumstances and avoid assumptions about families' capacity to provide housing, caregiving, or ongoing support.
 - Encourage individualized, ongoing conversations with CARE respondents/participants about family involvement and the information they wish to share with family members, rather than treating consent as a one-time yes/no decision
- Supplement existing training resources for counties and courts on the **volunteer supporter role** to expand guidance on:
 - Discuss the option of a volunteer supporter with CARE participants at various points in the CARE process with the goal of promoting participant choice and empowerment.
 - Leverage existing support networks when discussing volunteer supporters, recognizing that trusted friends, neighbors, faith leaders, former providers, or other community members may already serve supportive roles.





Structuring County Teams & Local Processes

- Clarify the **existing and potential roles for peer support** in the CARE process, including outreach, court appearances, treatment engagement, and graduation planning, with guidance distinguishing the roles of paid peer specialists and natural peer supports.
- **Expand roles for paid peer staff** (including paid family peers) across the CARE process, with particular focus on:
 - Embed peers in outreach teams to support early engagement and trust.
 - Ensure peers are integrated into FSP and ACT teams.
 - Integrate peers into the court process and public defender teams.
 - Support access for all families to family/parent partner peers.





Structuring County Teams & Local Processes

- Support greater use of **community-based peer organizations** to provide peer services where feasible, recognizing their expertise in peer hiring, supervision, and recovery-oriented practice.
- Advance system-level changes to **reduce barriers that prevent peers with lived carceral experience** from obtaining jail clearances.
- Explore opportunities to **integrate family peers and family coordinators as core members of CARE teams** to support family members and facilitate communication and connection between participants and family members, when appropriate.





Expanding Resource Connections & Supports

- Expand **access to family peer specialists** and **family-to-family peer support** through NAMI and other networks.
- Provide counties with strategies to **expand participant and family resource connections** and support families outside traditional business hours, including connections to peer respites, community-based organizations, and other resources outside of the traditional service system.
- Support counties in **helping participants build broader networks of support**, rather than relying on a single supporter, to strengthen long-term recovery and community connection.





Evaluation

- Develop **person-centered measures of impact** for peer and family involvement, including participant and family activation, autonomy, connection to supports and relationships, and wellbeing.
- Ensure outcome measurement **extends beyond system goals** to also measure CARE team support of participants' stated goals as a core outcome of interest, recognizing the importance of creating ongoing space and support for participants to express and evolve their goals throughout the CARE process.
- Provide **opportunities for all participants to share honest feedback** about their experiences with the CARE process to inform ongoing implementation and improvement efforts.



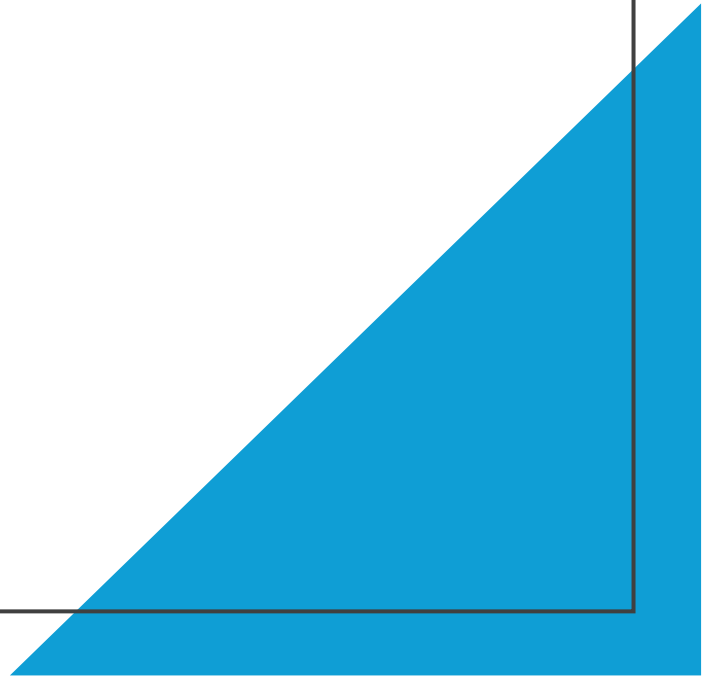
Suggested Frameworks & Trainings

Recommended frameworks and trainings to consider in support of core goals:

- The LEAP Method
- Recovery-Oriented Cognitive Therapy (CT-R)
- Crisis Response Peer Certification training

CARE Public Defenders

Discussion Update





Overview – August 6 Discussion Group

- Public defenders from multiple counties (representing Cohorts 1 + 2) shared experiences implementing the CARE Act and representing respondents as caseloads continue to grow.
- Discussion focused on collaboration with behavioral health, respondent engagement, CARE agreement and plan development, judicial oversight, funding and workloads, and opportunities to improve statewide implementation.
- Participants noted that many implementation challenges have become more pronounced as county caseloads have increased.

Key Themes:

Preliminary Local
Solutions and
Promising Practices

**Participants
described advancing
creative strategies in
collaboration with
local implementation
partners**

Adapting CARE agreement templates to provide clearer service options and improve consistency in agreement development.

Starting permanent supportive housing planning early to help reduce the risk of housing loss after CARE graduation.

Continuing CARE proceedings (rather than dismissing cases) when respondents are hospitalized, where permitted, to support continuity upon discharge.

Expanding outreach and engagement, including conducting jail in-reach and coordinating discharge planning to improve continuity of care for respondents leaving custody.

Partnering closely with the court to improve respondent engagement, including holding proceedings in alternative locations to increase accessibility.

Encouraging broader identification of supporters beyond immediate family members to strengthen respondents' support networks.

Key Themes:

Preliminary Suggestions and Opportunities

Develop and Share	Clarify	Strengthen	Align	Refine
Develop and share implementation resources, including: • Sample CARE agreement template • Sample motion to seal	Clarify timelines and statutory processes for respondents who are: • Hospitalized in state hospitals or incarcerated (e.g., allowing CARE proceedings to be stayed) • Spending significant time in MHRCs or other institutional settings	Strengthen supports across the CARE process, including: • Family education, reunification, and family support • Resources to support successful transitions at graduation	Align funding with implementation realities, including: • Funding allocations that reflect actual CARE caseloads • Reimbursement for criminal legal work performed when directly related to CARE representation • Consideration of resources for PDs to support graduation ceremonies	Refine performance measures and data collection by: • Expanding measures of success • Identifying additional data elements that better capture public defender work and respondent outcomes

Lunch!

Social Media Snapshot: CARE Champion Quotes

"Success means this is the longest someone's ever been sober. Success means this is the longest someone's stayed out of custody. I've had clients say, 'This is the longest I haven't been arrested,' and that gives me goosebumps."

Katia Benthale, Deputy Public Defender,
Ventura County

Learn more: chhs.ca.gov/care-act



"These are individuals who were not [successful] in mental health services in the past. CARE allows us to provide what we call relentless engagement."

Martin Jones Jr., Program Manager, LA
County Department of Mental Health

Learn more: chhs.ca.gov/care-act



"Progress is not a straight line. It zigs and zags, and progress looks different for everyone. The goal is not perfection. The goal is progress."

Claude Winship, Program Manager, San
Diego County CARE Act

Learn more: chhs.ca.gov/care-act





Stories, Spotlights and Voices from the Field:

CARE
Graduation
Day





**Stories,
Spotlights and
Voices from the
Field:**

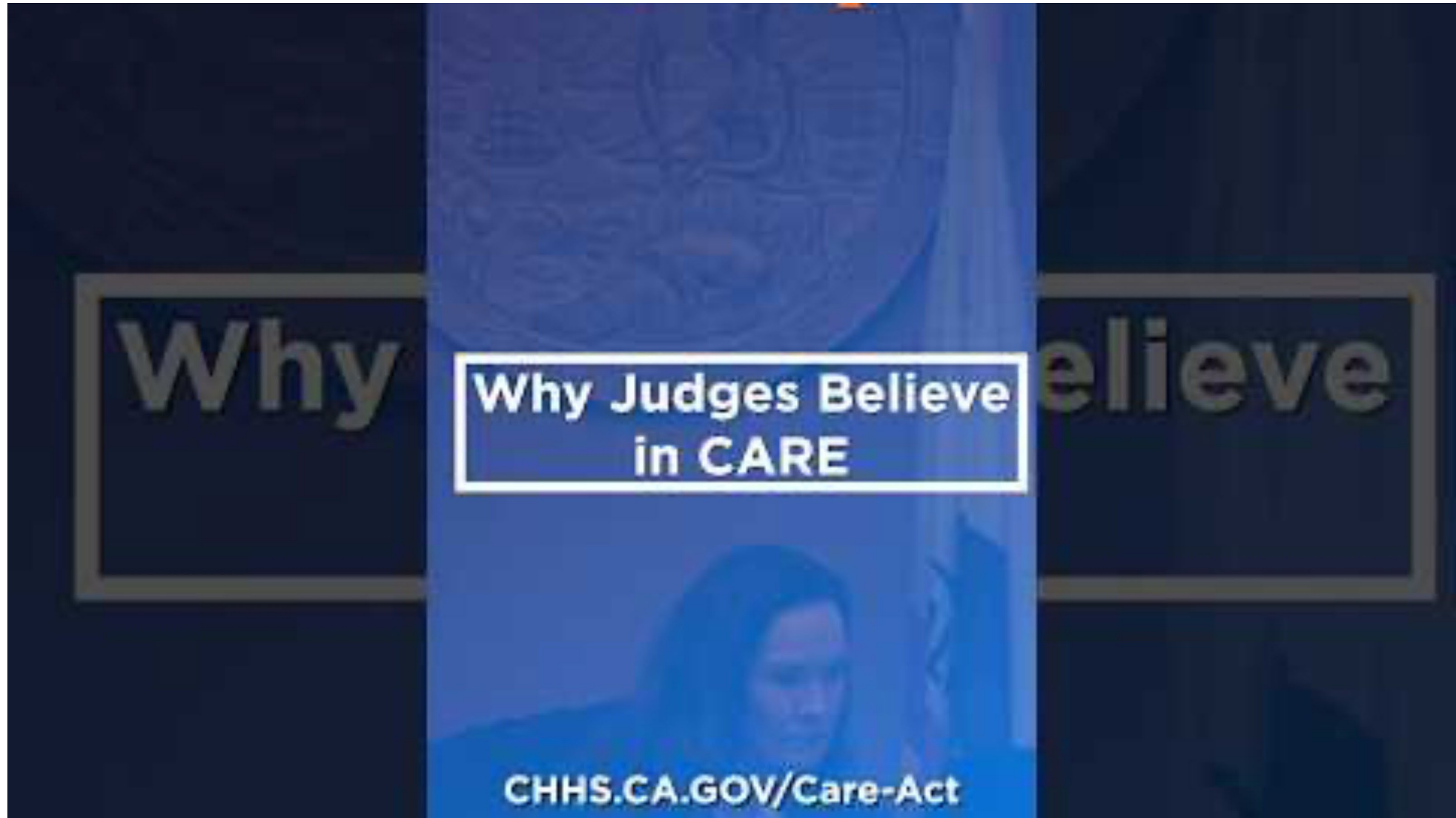
First Responders
Transforming CARE
in Ventura County





Stories, Spotlights and Voices from the Field:

Why Judges
Believe in CARE



Housing Overview

Glen Tsang, Policy Advisor for Homelessness and Housing, DHCS

CARE Act Working Group

August 12, 2026

By: Glenn Tsang, Policy Advisor for Homelessness and Housing

Housing for Health

Homelessness in California

California accounts for more than a quarter of all homeless people in the U.S., with more than 180,000 Californians facing homelessness each night.¹

Who is Experiencing Homelessness in California (2023)¹

- » **38%** of all people experiencing homelessness are chronically homeless
- » **66%** are unsheltered homeless
- » **37%** identify as Latino/x
- » **Higher proportions of people identifying as Black or Native American** are homeless compared to the overall California population

Homelessness is a Health Care Issue²

- » **35%** are individuals experiencing chronic substance use
- » **66%** are individuals experiencing untreated mental health conditions, including serious depression, anxiety, memory problems, and hallucinations
- » **60%** have at least one chronic condition, like hypertension, asthma or COPD
- » Experience more **frequent and longer hospital stays**

1. Data from [U.S. HUD 2024 Point-in-Time Estimates](#).

2. Data from [UCSF - California Statewide Study of People Experiencing Homelessness Report \(June 2023\)](#).

California Advancing and Innovating Medi-Cal (CalAIM)

Housing Efforts as Part of DHCS' Medi-Cal Transformation

California is transforming Medi-Cal to improve health care quality, access, and outcomes for Medi-Cal Members.

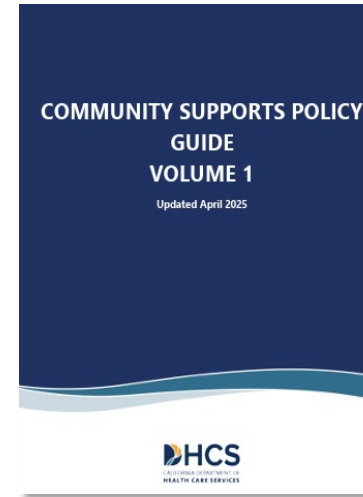
- » In 2022, California Advancing and Innovating Medi-Cal (CalAIM) introduced:
 - The **Enhanced Care Management (ECM) benefit**, for the highest-risk, highest-need Members; and
 - A menu of **14 Community Supports**, which are services that help improve the health and well-being of Medi-Cal managed care plan (MCP) Members by addressing their health-related social needs, supporting healthier lives, and avoiding higher, costlier levels of care.
- » **Transitional Rent is the newest Community Support and will go live across California in 2026.** Transitional Rent was authorized under the BH-CONNECT* Section 1115 demonstration waiver. With this launch, California joins a number of other states in offering up to 6 months of rental assistance through Medicaid.

*BH-CONNECT = Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment

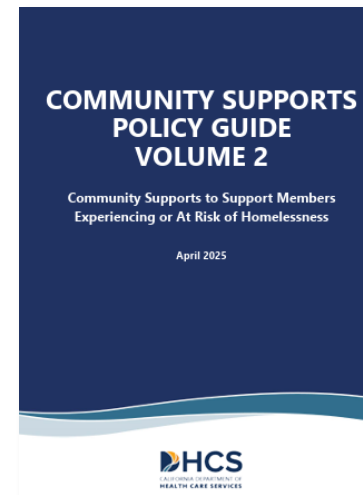
Introducing the Updated Community Supports Policy Guide

DHCS has released an updated Community Supports Policy Guide—reorganized into two separate volumes available on the [Community Supports webpage](#).

- » **These updates:**
- » Include the newest 15th Community Support, Transitional Rent.
- » Are in response to stakeholder feedback from the initial years of program implementation, in alignment with DHCS' [ECM and Community Supports Action Plan](#).



UPDATED [Community Supports Policy Guide Volume 1](#) contains the service definitions for eight of the Community Supports that address Members' health-related social needs.



NEW [Community Supports Policy Guide Volume 2](#) contains Transitional Rent and other Community Supports for Members experiencing or at risk of homelessness.

DHCS' Menu of Community Supports Services

The updated Community Supports Policy Guide organizes the services into two volumes.

Volume 1

1. Respite Services
2. Assisted Living Facility Transitions*
3. Community or Home Transition Services*
4. Personal Care and Homemaker Services
5. Environmental Accessibility Adaptations (Home Modifications)
6. Medically Tailored Meals/Medically Supportive Food
7. Sobering Centers
8. Asthma Remediation

Volume 2

9. Housing Transition Navigation Services
10. Housing Deposits
11. Housing Tenancy and Sustaining Services
12. Day Habilitation Programs
13. Recuperative Care (Medical Respite)
14. Short-Term Post-Hospitalization Housing
15. *New* Transitional Rent

Focus of today's webinar

**Names of these Community Supports have been updated*

CalAIM - Transitional Rent

Housing Efforts as Part of DHCS' Medi-Cal Transformation

California is transforming Medi-Cal to improve health care quality, access, and outcomes for Medi-Cal Members.

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*BH-CONNECT = Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment

The Newest Community Supports Service: Transitional Rent

Under Transitional Rent, MCPs will cover up to six months of rental assistance for Members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria.

The policies governing Transitional Rent are driven by three key objectives:

- 1) Ensure a connection to long-term housing supports**, such as rental subsidies, for Members receiving Transitional Rent to provide a pathway to housing stability and prevent a return to homelessness.
- 2) Use the temporary housing stability afforded by Transitional Rent as an opportunity to help Members connect to needed health care services.**
- 3) Minimize administrative barriers** (without compromising program integrity), so that Members experiencing or at risk of homelessness can readily access Transitional Rent.



Reminder: Transitional Rent Eligibility Criteria

Eligible high-need members enrolled in a MCP may be eligible for up to 6 months of Transitional Rent if they meet the following criteria:



MEET CLINICAL RISK FACTORS

- Meet the access criteria for Medi-Cal Specialty Mental Health Services (SMHS), *or*
- Meet the access criteria for Drug Medi-Cal (DMC), *or*
- Meet the access criteria for Drug Medi-Cal Organized Delivery Systems (DMC-ODS) services, *or*
- Have one or more serious chronic physical health conditions, *or*
- Pregnant to 12-months postpartum, *or*
- Have physical, intellectual, *or* developmental disabilities



+ EXPERIENCING OR AT RISK OF HOMELESSNESS (SOCIAL RISK FACTOR) +

- As defined by US Department of Housing and Urban Development's (HUD's) current definition as codified at 24 CFR part 91.5, with certain modifications



MEET CRITERIA FOR SPECIFIED "TRANSITIONING POPULATIONS"

- Transitioning out of an institutional or congregate residential setting, *or*
- Transitioning out of a carceral setting, *or*
- Transitioning out of interim setting, *or*
- Transitioning out of recuperative care or short-term post-hospitalization housing, *or*
- Transitioning out of foster care, *or*
- Unsheltered homeless, *or*
- Eligible for Full Service Partnership (FSP)

Transitional Rent Populations of Focus (POFs)

Under both start dates, MCPs have the option to go live with additional POFs under Transitional Rent, beyond the required BH POF for the January 1, 2026 launch.

- POF 1** **Behavioral Health POF** (*went live on 1/1/2026*)
- POF 2** Pregnant and postpartum (up to 12 months)
- POF 3** Transitioning out of an institutional or congregate residential setting
- POF 4** Transitioning out of a carceral setting
- POF 5** Transitioning out of an interim setting
- POF 6** Transitioning out of recuperative care or short-term post-hospitalization housing
- POF 7** Transitioning out of foster care
- POF 8** Experiencing unsheltered homelessness

Note: Individuals who qualify for the BH POF must meet the access criteria for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS), be experiencing or at risk of homelessness and be within a specified transitioning population OR unsheltered OR Full Service Partnership (FSP) eligible.

Behavioral Health Transformation

Behavioral Health Transformation – Prop 1

In March 2024, California voters passed Proposition 1, a two-bill package, to modernize the state's behavioral health care system. It includes a substantial investment in housing for people with behavioral health care needs.

Behavioral Health Bond (AB 531)

- » Funds behavioral health treatment beds, supportive housing, and community sites
- » Directs funding for housing to veterans with behavioral health needs

Behavioral Health Services Act (SB 326)

- » Reforms behavioral health care funding to provide services to Californians with the most significant behavioral health needs
- » Expands the behavioral health workforce to reflect and connect with California's diverse population
- » Focuses on outcomes, accountability, and equity

Behavioral Health Infrastructure Bond Act

\$6.38B

Behavioral Health Bond

\$4.4B

Up to \$4.4 billion for **competitive grants to build, enhance, and expand behavioral health treatment settings.**

\$1.065B

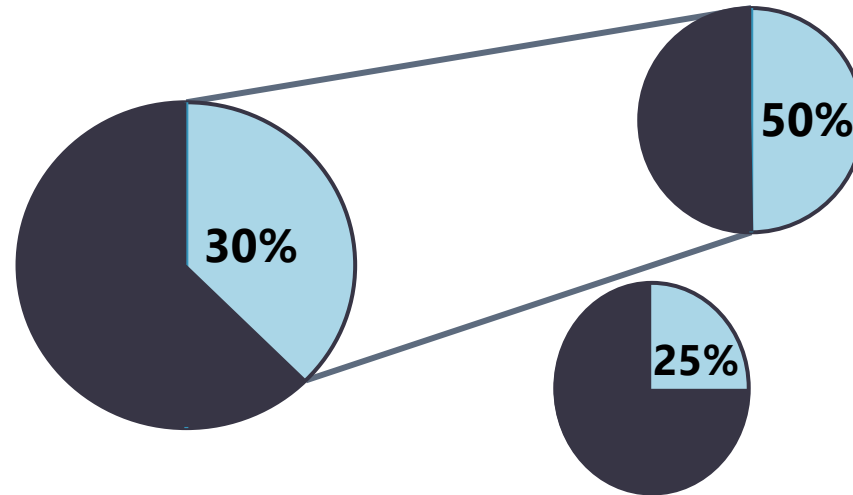
Up to \$1.065 billion for **housing investments for veterans** experiencing or at risk of homelessness who have behavioral health conditions

\$922M

Up to \$922 million for housing investments for **persons at risk of homelessness** who have behavioral health conditions

Housing Interventions Legislative Funding Requirements

30% of the funds distributed to counties must be used for Housing Interventions



50% of the Housing Intervention funds must be used for persons who are **chronically homeless**, with a **focus on individuals living in encampments**

Up to 25% of the Housing Intervention funds may be used for **Capital Development projects**

- » Counties have the flexibility to move 7% of funds to/from Housing Interventions into another category (Full Service Partnership (FSP) or Behavioral Health Services Supports)
- » Counties with a population of less than 200,000 may request an exemption from the required 30% allocation of Behavioral Health Services Act funds for Housing Interventions* (*Note: exemption process under development*)

*(Section 95(1)(B)) of SB 326, Section 5892 of the WIC

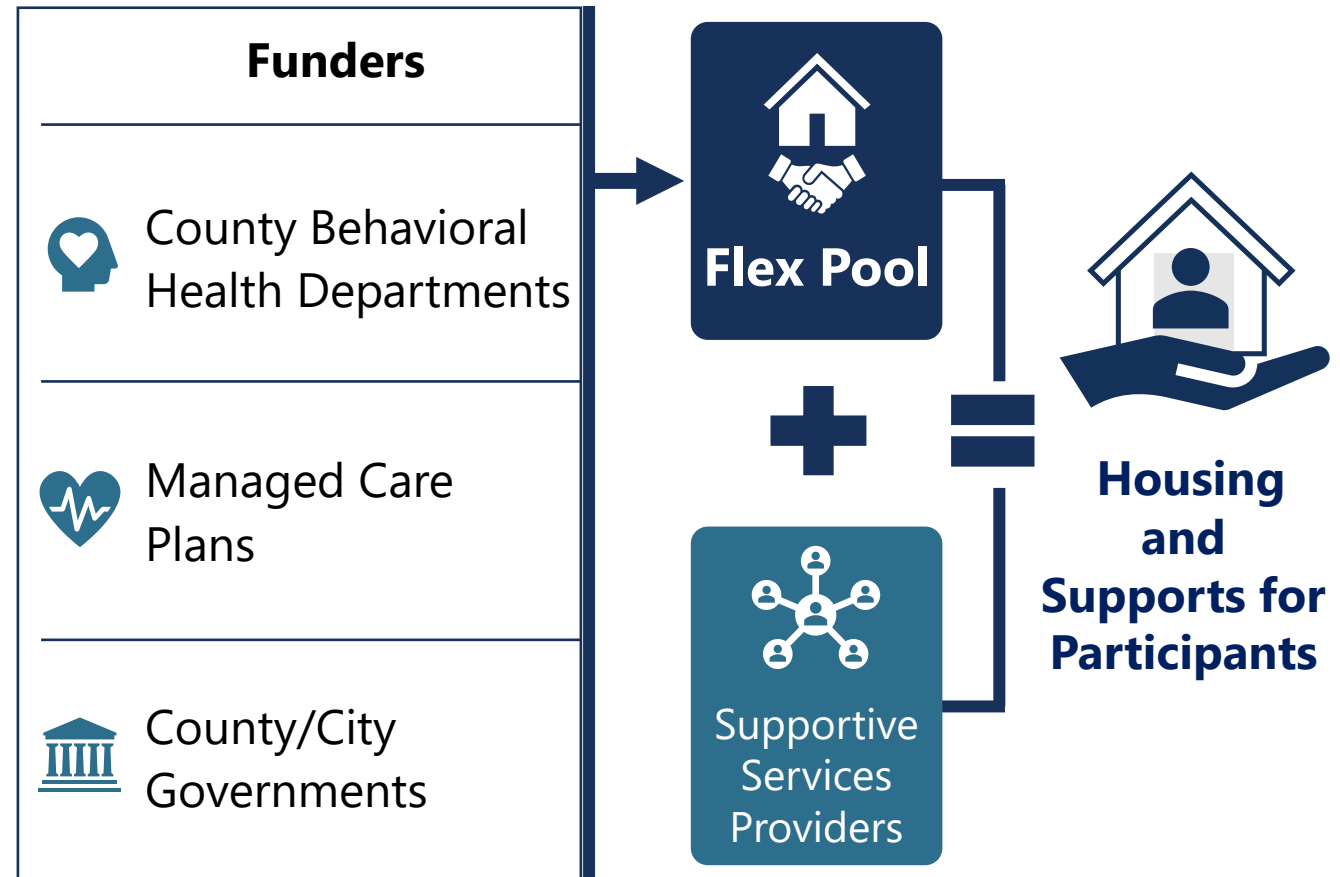
Flexible Housing Subsidy Pools (“Flex Pools”)

A decorative graphic consisting of two overlapping, wavy horizontal lines. The bottom line is a dark navy blue, and the top line is a teal or slate blue color. They flow from left to right across the middle of the slide.

New! Flexible Housing Subsidy Pools Request for Applications

DHCS encourages the development of Flexible Housing Subsidy Pools (“Flex Pools”) as an effective model to streamline and simplify administering Transitional Rent and coordinating related housing supports.

- » Flex Pools are a locally designed model for streamlining provision of housing supports and engaging landlords.
- » **The Flex Pools RFA**, invited applicants for two opportunities in support of Flex Pools:
 - 1. Participation in the Flex Pools Academy**, which offers individualized technical assistance.
 - 2. \$150k Planning Grants** for county behavioral health agencies and/or tribal entities to launch and operationalize a Flex Pool.
- » The RFA closed on **Friday, June 13, 2025**.



Questions?



Additional Resources



» Resources

- [BHSA Policy Manual Section 7.C. Housing Interventions Volume 3](#)
- [Community Supports Policy Guide Volume 2](#)
- [Transitional Rent Payment Methodology](#)
- [BHSA Housing Interventions Policy and Implementation FAQ \(Updated March 2026\)](#)
- [Housing for Health webpage](#)
 - DHCS strategies to assist members experiencing Homelessness
- [Behavioral Health Transformation](#)
 - Discover additional information and access resources including the [January](#) and [February](#) 2026 DHCS County Housing Office Hours
 - Sign up on the DHCS [website](#) to receive monthly Behavioral Health Transformation updates



» Questions and Feedback

- Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov and/or about Transitional Rent to CaAIMECMILOS@dhcs.ca.gov

Thank you!





Closing Thoughts

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

Next Working Group Meeting: November 4, 2026

New Location: Department of Health Care Services
West Sacramento Campus: 830 Stillwater Rd., West
Sacramento, CA 95605



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**.

Thank You!

California Health & Human Services Agency
Person Centered. Equity Focused. Data Driven.