THE COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT (CARE) ACT

Annual Report

August 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

Introduction

On September 14, 2022, Gov. Gavin Newsom signed Senate Bill (SB) 1338, which enacted the Community Assistance, Recovery, and Empowerment (CARE) Act. The CARE Act centers on a civil court process that jointly holds counties and individuals accountable for accessing and engaging in treatment and community services. Through CARE processes, adults living with an eligible diagnosis[1] who meet certain health and safety criteria can access behavioral health (BH) care, stabilizing medication, housing, and other community services. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent avoidable psychiatric hospitalizations, incarcerations, and Lanterman-Petris-Short (LPS) mental health conservatorships.

Pursuant to Welfare and Institutions (W&I) Code section 5985(e), the CARE Act Annual Report includes process measures used to examine the scope of impact and monitor the performance of CARE Act implementation. This report builds upon the 2025 CARE Act Annual Report, which focused on the first nine months of CARE Act implementation (October 1, 2023–June 30, 2024) by the seven Cohort I counties and Los Angeles County. This second CARE Act Annual Report—produced by the Department of Health Care Services (DHCS), in consultation with the Judicial Council (JC), county BH agencies, and state partners—covers the implementation of the CARE Act from October 1, 2023, through June 30, 2025, representing 21 months of CARE Act implementation.

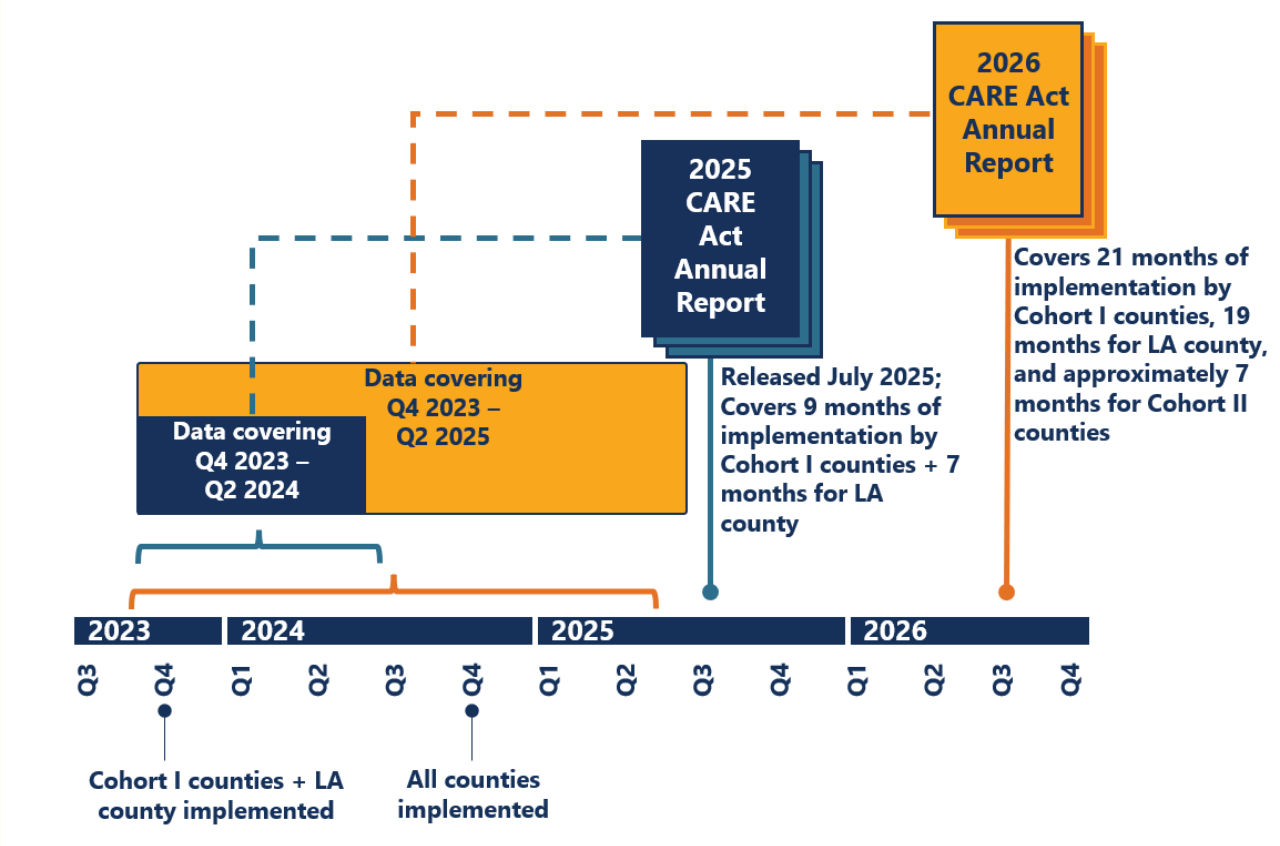
[1] Effective January 1, 2026, SB 27 expanded eligible diagnoses to include bipolar I with psychotic features, except for psychosis related to intoxication. Because this Annual Report includes data through June 30, 2025, it reflects eligible diagnoses that are limited to schizophrenia spectrum or other psychotic disorders.

How to Use the 2026 CARE Act Annual Report

The 2026 CARE Act Annual Report **covers the first 21 months of CARE Act implementation (October 1, 2023, and June 30, 2025)**. Large-scale behavioral health programs typically require multi-year investments in planning, training, and operational rollout. Because of the staggered statewide rollout of the CARE Act, Cohort I counties have implemented the CARE Act for only 21 months (19 months for Los Angeles County) and Cohort II counties for approximately seven months (**see Timeline below**).

County data systems are being developed in real time in response to evolving CARE legislation, which impacts definitions of the CARE population and data reporting requirements. Because of data lags and the time required to collect, submit, and process information on county implementation, **this report does not reflect current-day implementation or continuous quality improvement efforts by county BH agencies and their stakeholders**. Missing or unknown data remain significant for some variables, particularly for newer measures (e.g., pre-petition activities such as outreach and engagement) and for CARE participants no longer under court jurisdiction, though data quality has improved over time.

Findings and trends in this report should be viewed as a **snapshot of early implementation, rather than program effectiveness**. An independent evaluation of the CARE Act is under way, with preliminary results in December 2026 and a final report due December 2028.



CARE Participant Progression Through CARE Process

The CARE Act authorizes a range of individuals to file petitions with a civil court to initiate CARE Act proceedings, such as family members, health care or social service providers, and first responders. The CARE Act leverages existing resources available within the state for individuals who meet CARE criteria.

Following petitioning, CARE participants (individuals who are the subject of the petition for the CARE process and met the prima facie standard) enter their **CARE Process Initiation Period**. This period begins when a petition is filed or when the court orders a county to investigate and submit a report to determine whether the respondent meets, or is likely to meet, CARE eligibility criteria. The CARE Process Initiation Period concludes when the court orders an initial disposition to the petition (i.e., approves a CARE agreement, orders a CARE plan, or dismisses the petition).[1]

A CARE agreement and a CARE plan are documents that specify services to support the respondent's recovery and stability. After a court has determined that the respondent is eligible for the CARE process, the court may approve a **CARE agreement**, which is a voluntary agreement between the respondent and the county BH agency that includes an individualized range of community-based services and supports. If a CARE agreement is not reached, the court may then order a CARE plan. A **CARE plan** is a court-ordered plan that also includes an individualized range of community-based services and supports. Individuals who have an approved CARE agreement or an ordered CARE plan are referred to as **active CARE participants**. An individual may also choose to engage in services outside of court jurisdiction. These cases are dismissed, and these individuals are defined as **elective clients** throughout this report.

CARE participants and elective clients move into their **Active Service Period**, which begins at the conclusion of the CARE Process Initiation Period and continues for 12 months, with services and supports provided through a CARE agreement, CARE plan, or county services outside CARE Act proceedings. A CARE participant may be reappointed to a CARE agreement or plan for an additional 12 months, which would extend the Active Service Period for up to 24 months.

[1] An initial disposition is an outcome of a petition, which, in the CARE process includes: a CARE agreement approved, a CARE plan ordered, or a CARE petition dismissed (final resolution of petition). These dispositions are the result of an order by a judicial officer and are documented in an official court record or document.

Highlights and Key Findings

The 2026 CARE Act Annual Report includes data from courts and county BH agencies across all 58 counties statewide.[2]

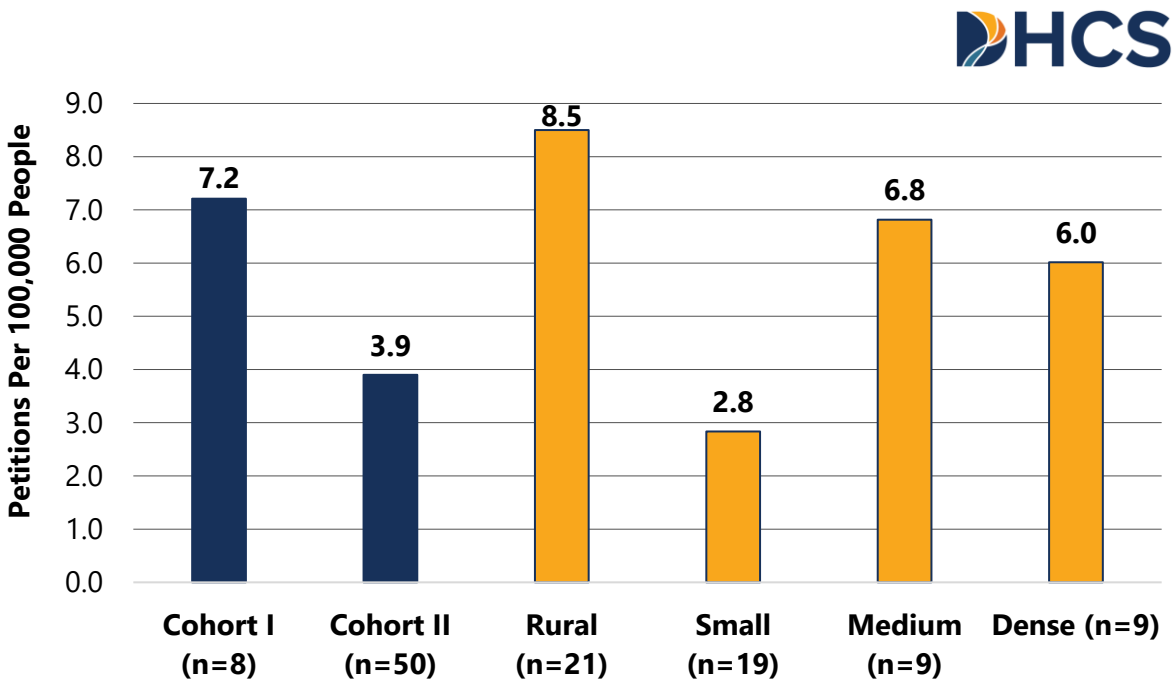
Petitions and Court Processes

Of the 2,216 petitions filed between October 1, 2023, and June 30, 2025, courts reported 500 approved CARE agreements and 17 court-ordered CARE plans. By the end of June 30, 2025, the courts had dismissed 984 petitions.

As of June 30, 2025, 5.6 petitions per 100,000 residents had been filed across the state. Cohort effects were observed, as shown in **Figure E.S.1**, left side. Higher per capita petition rates were observed among Cohort I counties (including Los Angeles County: 7.2 petitions per 100,000) than in Cohort II counties (3.9 petitions per 100,000), potentially reflecting the maturity of CARE Act implementation among Cohort I counties. The right side of **Figure E.S.1** shows per capita petitions stratified by county population density (Rural, small, medium, dense, as defined in the DHCS Network Adequacy Standards and **Appendix B**). Rural counties, given their small population size, had the highest per capita petition rate of CARE petitions despite a relatively limited number of petitions. Small counties were all part of Cohort II, and their per capita petition rates more closely resembled other Cohort II counties.

[2] All county BH agencies were compliant with reporting on petitioned individuals and all courts were compliant with reporting aggregate data. During the time period covered by this report, nine counties informed both the Judicial Council and DHCS that no CARE petitions were filed in their county: Alpine County, Colusa County, Lassen County, Mariposa County, Mendocino County, Plumas County, San Benito County, Sierra County and Trinity County. Six county BH agencies informed DHCS that they did not have data to report for all three CARE data modules (i.e., CARE petitions, CARE inquiries, statutory system referrals): Alpine county, Lassen county, Mendocino county, Plumas county, Sierra county, and Trinity county. Five counties were unable to report CARE inquiry data due to a process, system, or workflow issue: Contra Costa county, Fresno county, Santa Barbara county, Sonoma county, and Yuba county. Two counties were unable to report statutory system referral data due to a process, system, or workflow issue: Santa Barbara county and Sonoma county.

Figure E.S.1. Total Petitions Per 100,000 by Cohort and County Population Density



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.*
Note: Cohort I has no small counties.

CARE Participants Sent to County Behavioral Health Agencies

Of the 2,216 petitions submitted to the courts by June 30, 2025, county BH agencies reported receiving 2,008 petitions, which represented 1,960 unique CARE participants.[3,4]

[3] A total of 47 individuals were petitioned more than once as of June 30, 2025; 12 people were petitioned more than twice, and 11 were petitioned in more than one county. These 11 individuals are attributed to both counties for their respective service period for the purposes of monitoring county behavioral health agency accountability.
[4] JC and county BH agencies independently report on the number of CARE agreements and CARE plans. For this Annual Report, county BH agencies collectively reported 34 more CARE agreements and six more CARE plans than JC. Among the 29 counties with discrepant numbers of CARE agreements or CARE plans, most of the discrepancies were limited (one or two), with notable outliers among five counties with five or more discrepancies. Some of these variances may reflect differences in timing when courts and counties record a CARE agreement or CARE plan.

About two-thirds of the 1,960 CARE participants being tracked at the time of this report (1,206 participants, 61.5 percent) had an initial disposition and moved from their CARE Initiation Period into their Active Service Period; the remaining third were still under court review. An initial disposition following a CARE petition may include an approved CARE agreement, an ordered CARE plan, or a dismissal. Overall, 517 of 1,206 CARE participants (42.9 percent) had a CARE agreement approved (500 participants) or a CARE plan ordered (17 participants) and 689 CARE participants (57.1 percent) were dismissed.

Among the 689 CARE participants dismissed by courts at the time of initial CARE disposition:

- 497 (72.1 percent) were dismissed and received no county BH services
- 192 (27.9 percent) were dismissed and received county BH services (also referred to as elective clients in this report) and were tracked similarly to those with a CARE agreement or CARE plan[5]

The most common county-reported reasons for initial CARE petition dismissal included the participant being ineligible for CARE (22.7 percent), the participant not participating in the CARE process (13.4 percent), the participant transitioning to a higher level of care (12.1 percent) and not being able to locate the participant (12.4 percent). Among CARE participants dismissed because they were ineligible for CARE, the most commonly cited rationale was that the individuals did not have a qualifying diagnosis of schizophrenia spectrum and other psychotic disorders (47.0 percent), followed by the county reporting that it was unlikely that these individuals would benefit from participation in a CARE plan or CARE agreement (23.5 percent).

CARE Petitioners

Of the 1,960 unique CARE participants, 896 (45.7 percent) were petitioned by a **system partner** (defined as a hospital director, licensed BH professional, public guardian, or conservator); 816 (41.6 percent) by someone with a personal relationship to the participant (referred to as a personal petition); 130 (6.6 percent) by a first responder,

[5] Beginning in January 2025, the definition of an elective client was revised to include CARE participants who receive services and supports outside CARE court jurisdiction, regardless of whether they were found to be eligible for CARE. This may include receipt of services under Assisted Outpatient Treatment (AOT) or LPS. Prior to January 2025, counties were only responsible for reporting on dismissed participants who were CARE-eligible and, rather than enter into a CARE agreement or CARE plan, chose to receive county services and supports as an elective client.

mobile crisis team, or outreach worker; and 72 (3.7 percent) by the participant themselves. Among people with CARE agreements or CARE plans, a lower proportion (38.7 percent) came from personal petitions than from system partners (49.7 percent).

Differences in the origin of CARE petitions were observed across CARE participants of different races/ethnicities. Asian and Hispanic participants were more often petitioned by individuals with personal relationships, and Black/African American and White participants more frequently petitioned by system partners.

CARE Petitioners: Changing Landscape

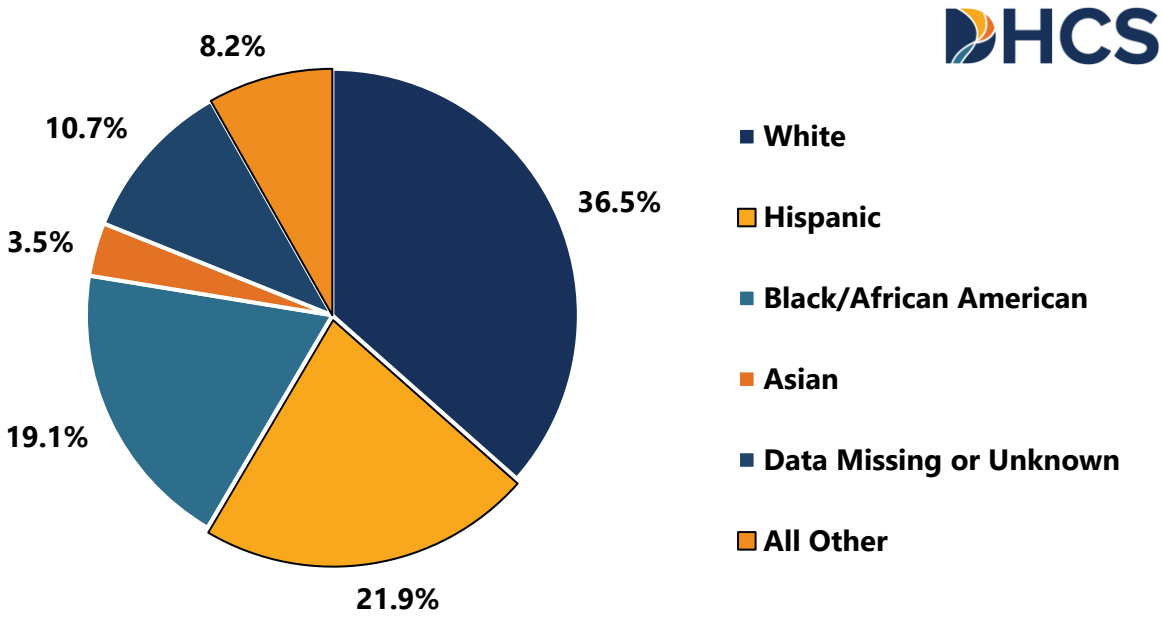
The source of CARE petitions has changed over the course of CARE implementation. This may reflect the increased training efforts to ensure system partners are aware of CARE and CARE eligibility criteria.

- The proportion of total CARE petitions by someone with a personal relationship to the participant (referred to as a personal petition) *decreased* from 66.7 percent of petitions during the first quarter of CARE Act implementation (Q4 2023) to 25.5 percent in the last quarter included in this report (Q2 2025).
- The proportion of total CARE petitions from system partners (defined as a hospital director, licensed BH professional treating the client, public guardian, or conservator) *increased* from 24.8 percent of petitions in Q4 2023 to 61.3 percent in Q2 2025.
- The proportion of total petitions from participants (self-petitioners) and petitions from first responders have not noticeably changed.

Socio-Demographic Characteristics of CARE Participants

Most of the 1,960 CARE participants sent to county BH agencies were 26–45 years old (60.2 percent) and male (64.9 percent). With regard to the race and ethnicity of CARE participants, over one-third (36.5 percent) identified as White, 21.9 percent identified as Hispanic, 19.1 percent identified as Black/African American, 3.5 percent identified as Asian, and 10.7 percent had missing or unknown data (**Figure E.S.2**). Most CARE participants (87.1 percent) reported English as their preferred language.

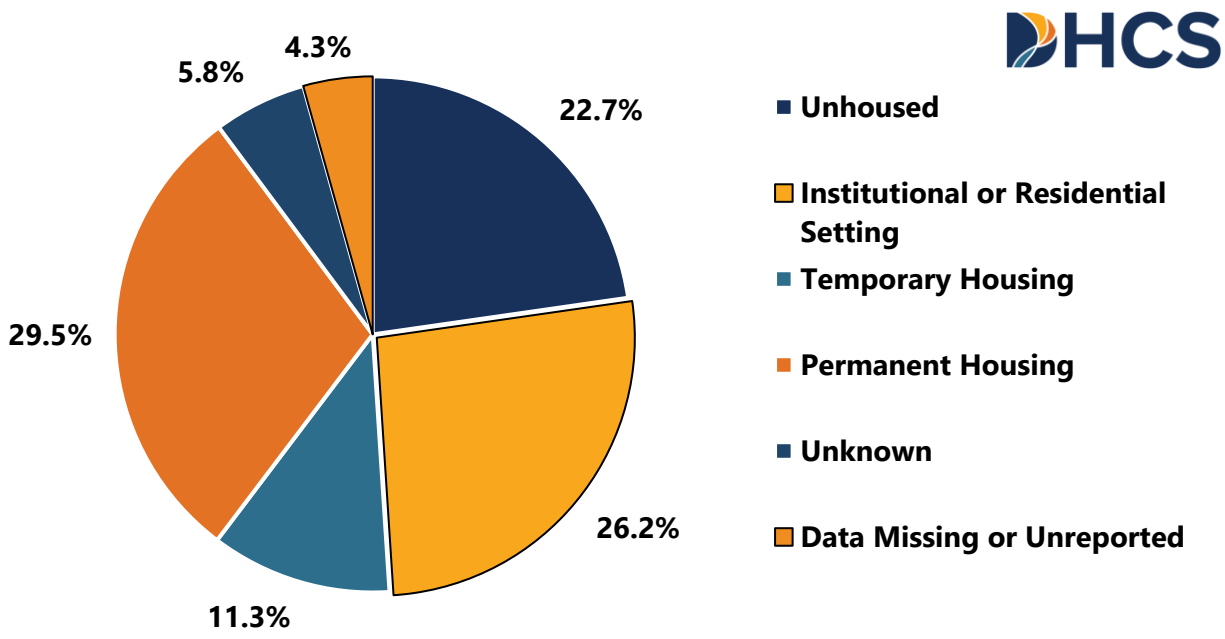
Figure E.S.2. Race and Ethnicity of CARE Participants (n=1,960)



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.*

At the time the petition was filed, 40.8 percent of the 1,960 CARE participants were living in permanent or temporary housing, and 22.7 percent were unhoused (**Figure E.S.3**). Additionally, 26.2 percent were in an institution or residential treatment program.

Figure E.S.3. Housing Status/Living Situation of CARE Participants at Time of Petitioning (n=1,960)



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.*

Health insurance information was documented for 78.0 percent of the 1,960 CARE participants (the remainder had unknown or missing information regarding health care coverage). Overall, 1,136 (58.0 percent) were reported to be Medi-Cal enrollees, 5.9 percent were Medicare beneficiaries, 1.6 percent were private pay, and 11.1 percent had more than one insurance.[6]

[6] See Table 6 for more detail, including where small numbers for some insurance types was suppressed to protect confidentiality of the individuals summarized in the data.

Time to Initial Disposition on CARE Petitions

Across the 1,206 CARE participants with an initial petition disposition,[7] the median number of days from petition to initial disposition was 76 calendar days, or approximately 11 weeks (Inter Quartile Range [IQR]:[8] 44–129 days).[9]

For 15.0 percent of CARE participants, an initial disposition was determined within 30 calendar days of the date the petition was filed. The proportion of initial dispositions that took 30 calendar days or fewer was highest among participants with an ordered CARE plan (35.3 percent) and lowest among dismissed participants who did not receive county services (9.1 percent).

Variation in median time to initial disposition was observed across counties (IQR: 40–85 days) and across counties with different population densities.[10] Dense counties reported the longest median times to first disposition (83 calendar days, IQR 49–139) followed by medium counties (67 calendar days, IQR 42–130). Rural and small counties reported the shortest median times to disposition, taking 48 (IQR 25–75) and 50 (IQR 23–71) calendar days, respectively.

Services and Supports Accessed Prior to an Initial Petition Disposition

Beginning in January of 2025, county BH agencies began to report on the services and supports that CARE participants accessed before the initial petition disposition.[11] County BH agencies reported missing or unknown services and supports data for 21.9 percent of the 1,328 participants before CARE petition disposition. Over half (57.2 percent) of participants accessed at least one service or support. Specifically, 44.4 percent received

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[7] An initial disposition is an outcome of a petition, which, in the CARE process, includes: a CARE agreement approved, a CARE plan ordered, or a CARE petition dismissed. These dispositions are the result of an order by a judicial officer and are documented in an official court record or document.

[8] IQR (interquartile range) represents the span between the 25th and 75th percentiles, indicating where the middle 50% of values fall. Here, half of petitions received a disposition between 44 and 129 days from filing.

[9] The CARE Act statutory framework (WIC § 5977.1) provides a timeline for various steps that support outreach and engagement to individuals petitioned to CARE and lays out sequential hearings before CARE agreements may be approved or CARE plans ordered.

[10] Counties are categorized into dense, medium, small and rural counties based on DHCS network adequacy standards Attachment A.

[11] "Access" is defined here as a CARE participant being enrolled in or having documented receipt of a service or support at some point during the Initiation Period.

mental health treatment services,[12] 22.5 percent received a stabilizing medication, and 14.2 percent accessed a housing service or support prior to an initial petition disposition.[13]

[12] Mental health treatment services include services such as targeted case management, crisis stabilization, psychosocial services, and peer support services. The list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.1 Mental Health Treatment Services Provided.

[13] CARE participants are counted as having housing service/support if they (a) accessed a housing support program (e.g., No Place Like Home, California Housing Accelerator) or (b) received a CalAIM community housing support service (i.e., Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization Housing, or Transitional Rent).

Outreach and Engagement to Petitioned Individuals

Outreach and engagement are critical components of CARE Act implementation. Yet they are often complicated by significant barriers, including features of the diagnosis that qualify individuals for CARE, historical distrust of public systems, challenges locating individuals, and varying interest levels in receiving treatment. CARE addresses these realities by allowing for administrative claiming of outreach and engagement activities to compensate for the time and effort required to conduct the sustained, relationship-based outreach that is critical to the success of CARE.

Between January 1 and June 30, 2025, 47 counties reported a **median of 7.7 (IQR: 2.5–15.5) total outreach and engagements per petitioned individuals who were involved in the CARE initiation period**, with wide variations. County BH agencies reported workflows that were still in development to systematically track outreach and engagement efforts; thus, these numbers likely represent a gross undercount of county outreach and engagement efforts.

Among counties that have developed robust workflows, the **San Diego County** BH CARE team highlights success factors, including strong coordination with their public defenders to contact and engage petitioned individuals. They emphasize evidence-informed motivational interviewing techniques and the use of incentives, such as offers to meet basic needs like food, housing, and connections to critical resources. These efforts prioritize relationship-based engagement and meeting individuals where they are to build trust and rapport.

CARE Participant Service Access and Housing Outcomes

Access to Services and Supports Among CARE Participants with CARE Agreements or CARE Plans

Among the 517 CARE participants with CARE agreements or CARE plans, the most common service type accessed was mental health treatment, with 88.6 percent of active CARE participants who had CARE agreements or CARE plans receiving at least one

mental health treatment service while participating.[14] Nearly two-thirds of participants who had CARE agreements or CARE plans received stabilizing medications (62.1 percent), with about half receiving a long-acting injectable. Wide variation across counties was observed in the number of participants who received stabilizing medication (33.8–100.0 percent).

Because engagement in evidence-based treatment is difficult when an individual is unhoused or unstably housed, a critical feature of the CARE Act is promoting access to a diverse range of housing services and supports.[15] In all, 26.7 percent of the 517 active CARE participants with a CARE agreement or CARE plan received a California Advancing and Innovating Medi-Cal (CalAIM) housing service or support (i.e., CalAIM enrollee benefit), and 42.2 percent received a housing service or support funded through county, state, and federal programs (e.g., The No Place Like Home Program, California Housing Accelerator, The Multifamily Housing Program) at some point during their enrollment in CARE.

Most CARE participants with CARE plans and CARE agreements (87.2 percent) were reportedly enrolled in a specialized program at some point during their time in the CARE process. The most accessed specialized program was Full-Service Partnership (FSP),[16,17] with 43.3 percent of active participants with a CARE agreement or CARE plan enrolled in FSP at some point during their Active Service Period. The second most

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[14] Mental health treatment services include targeted case management, crisis stabilization, psychosocial services, and peer support services, among others. The list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.1 Mental Health Treatment Services Provided.

[15] Gowda, G.S., Isaac, M.K. Models of Care of Schizophrenia in the Community—An International Perspective. *Curr Psychiatry Rep* 24, 195–202 (2022). https://doi.org/10.1007/s11920-022-01329-0

[16] FSP is a California-specific recovery-oriented, comprehensive service program aimed to assist individuals with serious mental illness and a history of criminal justice involvement or repeat hospital utilization, who are unhoused or at risk of becoming unhoused. During the time period assessed in this report, FSP was a core program within the largest of the five the Mental Health Services Act (MHSA) components: community services and supports (CSS). As of July 1, 2026, the Behavioral Health Services Act took effect in place of the MHSA, making FSP one of three primary, required BHSA components in all counties.

[17] Mental Health Services Oversight and Accountability Commission. Report to the Legislature on Full
Service Partnerships. January 2023. Report to the Legislature on Full Service Partnerships, January 2023.

accessed specialized program was Assertive Community Treatment (ACT), with a 26.7 percent participation rate.[18,19]

Trends in Access to Services and Supports Among CARE Participants with CARE Agreements or CARE Plans: First Five Months in CARE Process

At the time of reporting, many individuals with a CARE agreement or CARE plan were still progressing through the program, with a median duration of 4.5 months. To support stability of trends in access to services, descriptions of trends were restricted to the first five months of a CARE participant's involvement in the program. Over that timeframe, the proportion of participants with CARE plans and CARE agreements who accessed a mental health service,[20] social services and supports,[21] and stabilizing medications increased (see callout box below).

[18] ACT is an evidence-based comprehensive, time-unlimited psychosocial and community-based intervention and alternative to hospitalization for individuals with serious mental illness.
[19] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.
[20] Mental health treatment services include targeted case management, crisis stabilization, psychosocial services, and peer support services. The list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.1 Mental Health Treatment Services Provided.
[21] Social services and supports include Supplemental Security Income/State Supplementary Payment (SSI/SSP), CalWORKs, California Food Assistance Program, and education and/or employment services. The full list of available services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.17 Social Services and Supports.

Trends in County Services and Supports Over Time

Over the first five months* of a CARE participant's time in the Active Service Period, the most commonly accessed services were mental health, social services, and stabilizing medications, with an *increase* in trends observed among proportions of participants receiving these services.

- The proportion of participants who accessed a **mental health service** during the month increased by 10 percentage points, **from 77.0 percent during month one to 86.7 percent by month five**.
- The proportion of participants who received a **social service or support** increased by 14 percentage points, from **50.3 percent in month one to 63.9 percent by month five**.
- The proportion of CARE participants who received a **stabilizing medication** increased by 14 percentage points, from **47.0 percent to 61.4 percent from month one to five**.*

** Given the median length of time individuals with CARE plans or CARE agreements have engaged in CARE (4.5 months), data trends in this report are restricted to five months to support stability of trends.*

Trends in Reduction of Unsheltered Living Situations for CARE Participants

Although permanent housing is a long-term goal for CARE participants, it is commonly recognized that living situations will likely evolve over time, as they reflect the needs of individuals as they progress through the CARE process. Individuals may gain or maintain shelter/housing (temporary or permanent) or reside in an institutional or residential care setting.[22]

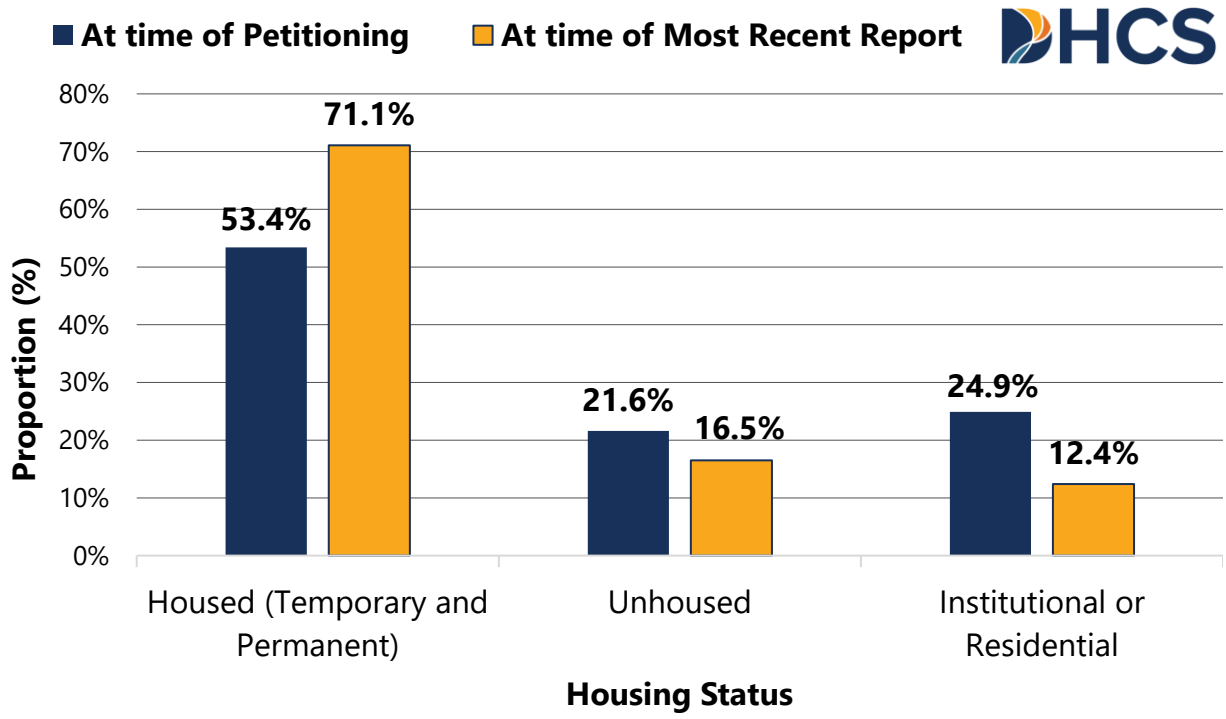
[22] Per the current CARE Act Data Dictionary 2.0, living situations are grouped into four primary categories in alignment with the U.S. Department of Housing and Urban Development (HUD) Data Standards: (1) Homeless (unhoused), (2) Institutional, (3) Temporary Housing, and (4) Permanent Housing. "Institutional [living] Situations" are defined as a: foster care home or foster care group home; hospital or other residential non-psychiatric medical facility; jail, prison, or juvenile detention facility; long-term care facility or nursing home; psychiatric hospital or other psychiatric facility; or substance abuse treatment facility or detox center. The full list of living situations is outlined in the CARE Act Data Dictionary 2.0, Appendix G: Living Situations Options List.

Among the 517 active participants with CARE agreements or CARE plans, 485 reported at least two months of data on their living situation—a baseline from their time of petitioning (Initiation Period) and at least one data point in their Active Service Period.

As **Figure E.S.4** shows, the proportion of CARE participants who were housed in either temporary or permanent housing grew from 53.4 percent at the time of their petitioning to 71.1 percent during their most recent month of data at the time of this report. The proportion of unhoused participants fell between these two time periods (from 21.6 percent to 16.5 percent), as did the proportion of participants residing in an institutional or residential setting (from 24.9 percent to 12.4 percent).

These early findings among CARE participants, many of whom are still progressing through the CARE process, highlight the complex nature of their living situations and the necessity to support the housing needs of CARE participants as they move through the CARE process over time.

Figure E.S.4. Living Situation at Time of Petitioning and At Most Recent Report (n=485)



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.*
Note: Among the 517 Active CARE participants with CARE agreements or CARE plans, 485 reported at least two months of housing status data: a baseline from their time of petitioning (Initiation Period) and at least one in their Active Service Period. At the time of petitioning 259 participants were housed, 121 participants resided in an institutional or residential setting, and 105 participants were unhoused.
Note*: Per the CARE Act Data Dictionary 2.0, living situations are categorized into four primary categories, in alignment with the U.S. Department of Housing and Urban Development (HUD) Data Standards: (1) Homeless (unhoused), (2) Institutional, (3) Temporary Housing, and (4) Permanent Housing. "Institutional [living] Situations" are defined as a: foster care home or foster care group home; hospital or other residential non-psychiatric medical facility; jail, prison, or juvenile detention facility; long-term care facility or nursing home; psychiatric hospital or other psychiatric facility; or substance abuse treatment facility or detox center. The full list of included living situations is outlined in the CARE Act Data Dictionary 2.0, Appendix G: Living Situations Options List.*

Access to Three Key Evidence-Based Components of Recovery for CARE Participants

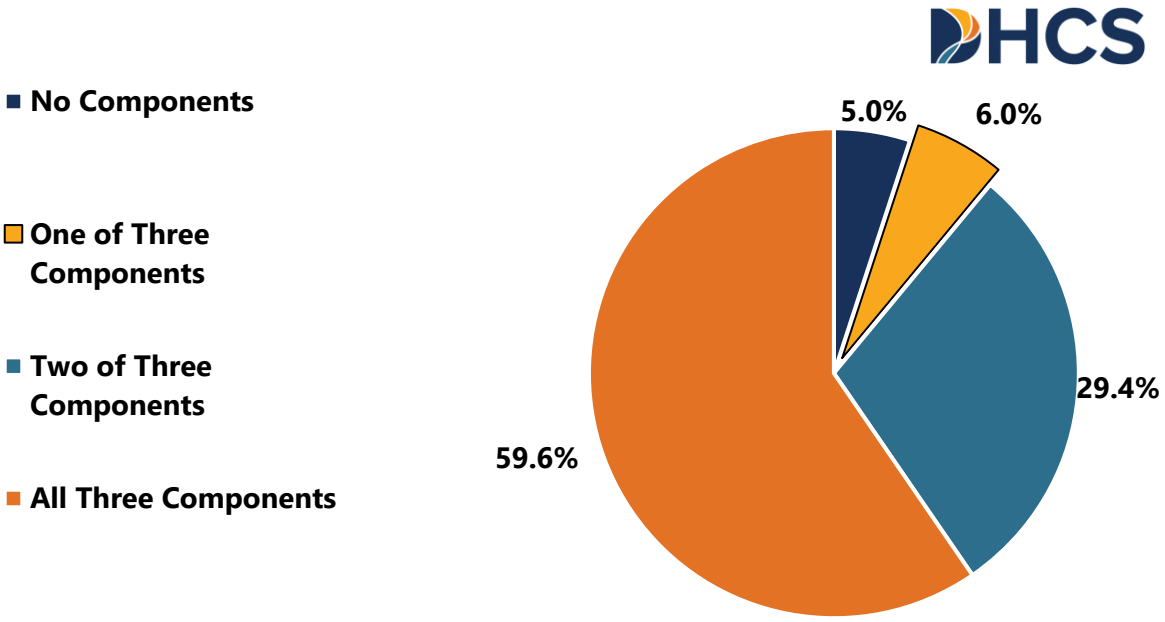
Collectively, three key evidence-based components of care form the foundational aspects of recovery for CARE participants: stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports.[23] Although data on access to each of these individual components are detailed elsewhere in this report, the receipt of these three services and supports serves as a useful metric for evaluating the impact of the CARE Act's implementation on service access.

As **Figure E.S.5** shows, 59.6 percent of the 517 CARE participants with CARE agreements or CARE plans were reported to have received all three key services and supports during their Active Service Period.[24] Of the individuals who received two of the three services and supports (29.4 percent), the most commonly observed combination was housing supports and psychosocial and community-based treatment.

[23] Keepers, G. A., Fochtmann, L. J., Anzia, J. M., Benjamin, S., Lyness, J. M., … Mojtabai, R. (2020). The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. *American Journal of Psychiatry*, *177*(9), 868–872. https://doi.org/10.1176/appi.ajp.2020.177901

[24] CARE participants are counted as having housing supports if they have: (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.

Figure E.S.5. CARE Participant Receipt of Three Evidence-Based Components± for Recovery (n=517)



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.*
± 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 participants are counted as having housing supports if they have: (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 housed in permanent, temporary, or institutional housing.

Elective Clients Receiving Services Outside of Court Jurisdiction

Over the course of CARE Act implementation (October 1, 2023, through June 30, 2025), 192 CARE participants became elective clients and received county services and supports outside of court jurisdiction. These participants did not appear to differ from participants with CARE agreements or CARE plans in terms of socio-demographic characteristics. County BH agencies have reported significant barriers with tracking elective clients who are no longer under court jurisdiction. Statewide, 19 counties reported data on elective clients; among them, a high proportion of missing and

unknown data was observed for reported services and supports (20.9–53.8 percent missing data).

Although the available data suggest possible care quality gaps for those served outside court jurisdiction, including fewer services accessed across all service types tracked by counties, this information should be considered unreliable and interpreted with caution. Efforts to improve the quality of data for those served outside court jurisdiction is critical to assess the value of court oversight.

CARE Inquiries and County Actions

In accordance with SB 1400, beginning in January 2025, county BH agencies were required to start reporting aggregate data on the number of contacts received about individuals eligible or likely to be eligible for the CARE process, including the outcome of contacts received about the CARE Act. These CARE inquiries, which include inquiries received by phone, warmlines, voicemail messages, emails, and in-person conversations or consultation, as well as the county actions associated with them, are an important window into CARE Act implementation and opportunities to connect individuals with significant mental health needs to necessary services. From January–June 30, 2025, a total of 53 counties reported 1,794 CARE inquiries.

Inquiries most frequently originated from family members, friends, or roommates (27.5 percent), followed by county BH or social service representatives (22.0 percent). Counties reported 710 follow-up actions related to these inquiries, the most common of which was connection to county mental health services (290 actions), social services and supports (105 actions), and to FSP (91 actions).

These data likely represent an undercount of county BH agency efforts because of ongoing barriers reported in establishing robust data flows that fully capture the myriad activities related to CARE Act implementation.

Statutory System Referrals

Beginning in January 2025, counties were also required to track and report individual-level data on statutory system referrals from LPS-designated facilities[25] and specific courts (Assisted Outpatient Treatment [AOT] Court, or from Incompetent to Stand Trial

[25] County LPS Designated Facilities are mental health treatment facilities that the county has designated and DHCS has approved to provide intensive treatment pursuant to the LPS Act. A designated facility may include a licensed psychiatric hospital, a licensed psychiatric health facility, and certified crisis stabilization units.

[IST] Court [both Misdemeanor and Felony]) sent to the county for investigation of CARE eligibility and appropriateness, in accordance with SB 1400. Overall, 443 statutory system referrals were reported by 56 counties between January and June 2025. These referrals primarily originated from Misdemeanor IST courts (53.7 percent) and LPS-designated facilities (35.7 percent).

Among the 332 statutory system referrals with known outcomes (74.9 percent of total statutory system referrals received), 30.7 percent were petitioned to CARE, 25.0 percent were not petitioned but connected to county services/supports and were pending enrollment confirmation, 8.4 percent were not petitioned but had accepted voluntary county services, and 35.8 percent were neither petitioned nor connected to county services. Conversion rates from referral to CARE petition varied widely across counties, indicating substantial variation in local referral practices, capacity, and system coordination.

Among the 230 statutory system referrals that were not petitioned to CARE, the most common reason reported by counties (more than one reason could be included) was that the individual was "unlikely to benefit from CARE" (39.6 percent). The group determined to be "unlikely to benefit from CARE" came from two referral sources: Misdemeanor IST courts (54.9 percent) and facilities (45.1 percent). Other commonly reported reasons for not petitioning to CARE included the individual lacking an appropriate CARE-eligible diagnosis (26.1 percent) and the individual requiring a higher level of care (24.3 percent).

Key Takeaways and Recommendations

Implementation of the CARE Act (October 2023–June 2025) has highlighted several key takeaways and opportunities, which can be summarized as follows.

Key Takeaways

Key takeaways and opportunities to leverage early findings are detailed in Section 9, with highlights below.

1. **Initial dispositions of CARE petitions took a median of 11 weeks but were highly variable with notable outliers. The middle 50 percent of petitions took six to 18 weeks to resolve. During the period between the filing of the petition and receiving an initial disposition, over half (57 percent) of petitioned CARE participants accessed services or supports.**

County BH agencies are expected to collaborate with courts and to investigate the appropriateness of CARE for petitioned individuals. The time involved until an initial petition disposition was ordered varied from person to person and was also highly variable across counties. Across the state, the time from CARE petitioning to initial disposition by the courts varied considerably, with a median of 76 calendar days (approximately 11 weeks, IQR 44-129 days). Considerable variations were also observed across counties, with dense counties taking a median of 83 calendar days, whereas rural counties took 48 calendar days to reach an initial disposition. For 15.0 percent of CARE participants with an initial disposition, this was determined within 30 calendar days from the date the petition was filed.

Prior to receiving an initial petition disposition, over half of CARE participants (57.2 percent) accessed a service or support—most commonly mental health treatment. Dense counties appeared to face greater barriers to providing CARE participants with services and supports compared to small and medium counties (numbers were too small to report in rural counties). Notably, services and supports data for one-fifth of individuals before disposition were missing or unknown.

2. A growing proportion of participants with CARE agreements or CARE plans are accessing mental health treatment services, social services, and stabilizing medications throughout their first five months in CARE.

Engaging individuals in an array of mental health services and supports can take time. The proportion of participants with CARE plans and CARE agreements who accessed a mental health service (e.g., targeted case management, psychosocial services) increased by nearly ten percentage points from month one in CARE to month five (77.0 percent to 86.7 percent).[26] This same pattern was seen among social services and supports (e.g., food assistance programs, CalFresh), which increased by nearly 14 percentage points (from 50.3 to 63.9 percent), and stabilizing medications, which also increased by 14 percentage points (from 47.0 to 61.4 percent). These findings suggest that time in CARE may help to facilitate a therapeutic alliance and increase access to and engagement in services and supports. Little change was observed for CARE participant access to

[26] Given the median length of time individuals with CARE plans or CARE agreements have engaged in CARE (4.5 months), data trends in this report are restricted to five months to support stability of trends. For context, 517 CARE participants with CARE agreements or CARE plans were included in the month one service/support access proportions and 285 at month five.

housing supports (e.g., housing transition navigation services, housing deposits),[27] substance use disorder (SUD) treatment, or CalAIM services (e.g., respite services, day habilitation programs, medically-supportive food/meals) over a CARE participant's first five months in CARE.

3. **Nearly two-thirds (59.6 percent) 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).**

Collectively, three evidence-based components of care form the foundation of recovery for CARE participants: stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports. Overall, 59.6 percent of the 517 CARE participants with CARE agreements or CARE plans were reported to have received all three key services and supports during their Active Service Period.[28] Of those who received two of the three services and supports (29.4 percent), the most commonly observed combination was housing supports and psychosocial and community-based treatment.

4. **Positive trends were observed among participants who gained or maintained housing during their time in CARE; suggesting the CARE Act may be aiding counties in promoting creative housing solutions.**

Among the 485 participants with a CARE agreement or CARE plan who had at least two months of data on their living situation, the proportion who were housed, in either temporary or permanent housing, grew from 53.4 percent (n=259) at the time of their petitioning to 71.1 percent (n= 345) during their most recent month of data. The proportion of unhoused participants fell between these two time periods, from 21.6 percent (n=105) to 16.5 percent (n=80). Finally, the proportion of participants residing in

[27] Note: County BH agencies separately collect and report data on housing supports accessed by CARE participants and participant's living situations. Both data points together are important for understanding how individuals are gaining and maintaining housing but are separately displayed and discussed in this report.

[28] 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.

an institutional or residential setting decreased from 24.9 percent (n=121) to 12.4 percent (n=60).

Since implementation, counties have developed creative and adaptive solutions to expand housing options, promote housing stability, and integrate supportive services that foster independence and reduce stigma for CARE participants. Examples include dedicating housing units in housing programs to CARE participants, repurposing and increasing available housing stock through hotel conversions, and expanding residential care programs and service-rich housing options. These models collectively demonstrate how flexible housing strategies can meet diverse needs while promoting dignity and community connection.

5. **The most common county-reported rationale for dismissal of CARE participants was CARE ineligibility, typically the individual lacking a qualifying diagnosis.**

The most commonly county-reported reasons for CARE petition dismissals (initial dispositions) included ineligibility for the program (22.7 percent), nonparticipation in the CARE process (13.4 percent), transition to a higher level of care (12.1 percent), and inability to locate a participant (12.4 percent).

The most commonly cited rationale for dismissal due to CARE ineligibility was that the individual did not have a qualifying diagnosis of schizophrenia spectrum and other psychotic disorder (47.0 percent), followed by the county reporting that it was unlikely that the individual would benefit from participation in a CARE plan or CARE agreement (23.5 percent).

These findings suggest an opportunity for targeted technical assistance and training to system partners, potential petitioners, and the public on both the expanded CARE Act eligibility criteria,[29] as well as emerging data highlighting the value of court jurisdiction over county accountability for services among eligible individuals with a CARE plan or CARE agreement.

6. **Nearly three-quarters of CARE participants dismissed without a CARE agreement or CARE plan (initial petition disposition) were not receiving**

[29] Note that effective January 1, 2026, SB 27 expanded eligible diagnosis to include bipolar I with psychotic features, because this Annual Report includes data through June 30, 2025, it reflects eligible diagnosis limited to schizophrenia spectrum or other psychotic disorders.

county services and supports at the time of dismissal, with small counties facing more barriers in connecting these individuals to services.

Of the 689 CARE participants dismissed by the courts at the time of their first petition disposition, 497 (72.1 percent) did not go on to receive any county BH services or supports. Among CARE participants who had their petitions dismissed and did not receive county services, the most common reasons included nonparticipation in the CARE process (17.1 percent), inability to locate the participant (16.1 percent), transition to a higher level of care (12.4 percent), and sentenced to long-term incarceration (6.7 percent). These common reasons highlight opportunities for county BH to collaborate with system partners to monitor individuals who were dismissed without ongoing county services and supports, to facilitate potential re-engagement, if possible.

7. **Education and training of system partners on the CARE Act appear to improve identification and referral of potentially eligible CARE participants.**

The source of CARE petitions has changed over the course of CARE implementation, with the proportion of total petitions from system partners (i.e., hospital directors, licensed BH professionals, public guardians, or conservators) increasing from 24.8 percent of petitions in 2023 to 61.3 percent in 2025, and the proportion of petitions by someone with a personal relationship to the participant decreasing over the same period (66.7 percent to 25.5 percent).[30]

County-reported data show that 42.9 percent of CARE petitions resulted in CARE agreements or CARE plans (517 out of 1,206 with an initial disposition). Differences were observed based on petitioner type. Nearly half (49.4 percent) of system-petitioned CARE participants and self-petitioned Individuals (47.9 percent) resulted in a CARE agreement or CARE plan approved, compared with 37.6 percent of those petitioned by someone who had a personal relationship with the participant (personal petition) and 32.9 percent of those petitioned by a first responder.

This variance suggests that system partners trained in CARE Act eligibility criteria may be more successful in identifying individuals who are good candidates for the CARE process. Given the relatively low number of petitioners among this group and the low rates of conversions from petitions to CARE agreements or plans, targeted trainings for specific types of petitioners—such as first responders—may be critical.

[30] This analysis compares data from the first quarter of reported CARE Act data (October 1–December 31, 2023, by the seven Cohort I counties and Los Angeles County) to the data reported as of June 20, 2025 (including full implementation of CARE in all counties).

8. **CARE participants do not mirror the communities in which they reside in terms of socio-demographic characteristics. However, they do reflect at-risk racial groups known to be underserved and over-represented among individuals with psychotic disorder diagnoses or in psychiatric hospitals and carceral settings.**

When comparing CARE participants with the California Census numbers, we found that the demographics of petitioned individuals differed from the communities in which they lived. Rather, the CARE population more closely reflected the composition of racial groups known to be underserved and over-represented among individuals with CARE-eligible diagnoses, unhoused populations, psychiatric hospitals, and carceral settings—the very populations the CARE Act is intended to help through a civil court process.[31,32,33,34,35]

CARE participants were found to be younger and disproportionately male (Details in Section 6.1.1 CARE Participant Socio-Demographic Characteristics and in **Appendix D**). With regard to race and ethnicity, Asian and Hispanic individuals were found to be underrepresented in the CARE population relative to the overall California (Census) population. Conversely, Black/African American individuals were over-represented in the CARE population. These trends were also seen at the county level.

9. **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.**

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[31] Young Ponder, K., Moore, T., Adhiningrat, S., Sakoda, R., Kushel, M. (2024). Toward Equity: Understanding Black Californians' Experiences of Homelessness in the California Statewide Study of People Experiencing Homelessness. Black CA Report 2024.pdf

[32] Sawyer, Wendy. (2023). Comparing California's Resident and Incarcerated Populations. Prison Policy Initiative. Comparing California's total population to its incarcerated population, by race | Prison Policy Initiative

[33] Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. *Psychiatric services (Washington, D.C.)*, *73*(12), 1322–1329. https://doi.org/10.1176/appi.ps.202100342

[34] Van der Ven, E., Olino, T. M., Diehl, K., *et al.* (2024). Ethnoracial risk variation across the psychosis continuum in the United States: A systematic review and metaanalysis. *JAMA Psychiatry, 81*(5), 447–455. https://doi.org/10.1001/jamapsychiatry.2023.5497

[35] Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of psychiatry*, *4*(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133

Asian and Hispanic individuals were more likely to be petitioned by people with whom they have personal relationships. Yet those petitions were more likely to be dismissed than those generated by system partners, which suggests opportunities to educate and raise awareness in Asian and Hispanic communities. Culturally aligned outreach and promotion, training and technical assistance to trusted community providers, and engagement with volunteer supporters may be key areas of opportunity.

10. Conversion rates from statutory system referral to CARE petition varied widely across counties, indicating substantial variation in local referral practices, capacity, and system coordination.

Between January 1 and June 30, 2025, 56 counties reported a total of 443 statutory referrals to county BH; 53.7 percent were from Misdemeanor IST courts and 35.7 percent were from LPS-designated facility referrals. Far fewer referrals came from Felony IST and AOT courts.

Of the statutory system referrals, 332 (74.9 percent) had a reported outcome. One-third of these referrals with a reported outcome (30.7 percent) were petitioned to CARE. Conversion rates from referral to CARE petition varied widely across counties, indicating substantial variation in local referral practices, capacity, and system coordination

1. BACKGROUND

1.1 CARE Act Implementation Timeline and Status

Senate Bill (SB) 1338 (Umberg, Chapter 319, Statutes of 2022) established the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health (BH) services and supports to Californians living with eligible diagnoses who meet certain health and safety criteria. The law allows certain individuals or entities to petition the court to begin proceedings that connect people with comprehensive wraparound treatment, services, and pathways to long-term recovery.

The CARE Act is a civil court process that jointly holds counties and individuals accountable for accessing and engaging in treatment and community services. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent avoidable psychiatric hospitalizations, incarcerations, and Lanterman-Petris-Short (LPS) conservatorships.

The CARE Act was implemented in two cohorts:

- Cohort I counties began implementation on October 1, 2023. Cohort I counties included: Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne counties, and the City and County of San Francisco. Los Angeles County, though technically a Cohort II county, opted to implement early, on December 1, 2023.
- Cohort II counties, which represent the remainder of California's 58 counties, began implementation on or before December 1, 2024.[36]

1.2 Scope and Objectives of the Annual Report

This Annual Report—produced in consultation with the Judicial Council (JC), county BH agencies, and state partners—covers the implementation of the CARE Act from October 1, 2023, through June 30, 2025. Pursuant to Welfare and Institutions (W&I) Code section 5985(e), the Annual Report includes process measures to examine the scope of impact and monitor the performance of CARE Act implementation. To meet this objective, this Annual Report examines key aspects of CARE Act implementation, including:

- Volume of CARE inquiries to county BH agencies and county actions taken

[36] San Mateo County began implementing CARE on July 1, 2024; Kern County on October 1, 2024; Mariposa County on November 1, 2024; and Napa County on November 25, 2024.

- Statutory referrals from specific courts and LPS-designated facilities and their outcomes
- Volume of CARE petitions through civil courts
- Flow of CARE participants sent to county BH agencies and efforts to engage them in services and supports
- Characteristics of CARE participants
- Services and supports accessed among CARE participants
- County BH agencies' capacity to meet CARE participants' needs
- Elective clients who receive county supports and services outside court jurisdiction

The Annual Report differs from the CARE Act Independent Evaluation. Pursuant to W&I Code section 5986, the Independent Evaluation (which is being conducted by an independent, research-based entity) will evaluate the effectiveness of the CARE Act. The preliminary report will be delivered to the legislature by December 31, 2026, and a final report will be delivered by December 31, 2028.

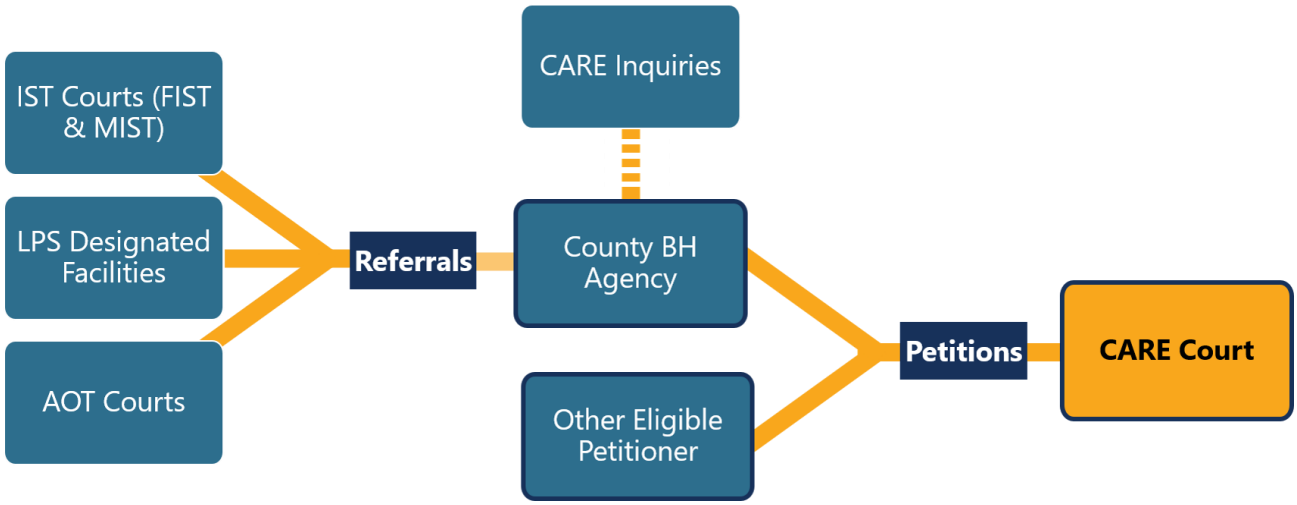
An independent report authored by the Legal Services Trust Fund Commission (LSTFC) at the State Bar of California can be found here. This report provides funding allocations, annual expenditures, and program outcomes from county public defender offices, qualified legal services projects, and support centers. The data contained within the LSTFC report originated from an independent source and were collected through a distinct methodology; therefore, variances or discrepancies in comparison with other datasets presented in this Department of Health Care Services (DHCS)-produced Annual Report may occur and should be interpreted accordingly.

1.3 The CARE Process: A High-Level Overview and Organization of this Report

1.3.1 Entry Points for the CARE Act Process: Petitions and System Referrals

All individuals enter the CARE process via petition; however, the source of the petition may vary. **Figure 1** shows these variable entry points for the CARE Act process.

Figure 1. Entry Points for the CARE Act Process



During the period covered in this report, a statutory system referral to county BH may originate from an LPS-designated facility, an Assisted Outpatient Treatment (AOT) Court, or an IST Court (both Misdemeanor [MIST] and Felony [FIST]). These referrals require county BH assessment of CARE eligibility as outlined in SB 1400.

An individual's referral period begins once county BH receives a documented request on behalf of an individual who meets or is likely to meet CARE criteria submitted to county BH from one of these entities. The referral period ends when the individual is either petitioned to CARE, accepts voluntary treatment, or when county BH determines that the agency will not be petitioning or referring the individual to county services and supports.

The CARE Act also authorizes a range of individuals, such as family members, health care or social service providers, and first responders, to file a petition with a civil court to initiate CARE Act proceedings.

CARE inquiries include general inquiries, contacts by phone, warmlines, voice messages, emails, and in-person conversations or consultations related to the CARE Act. CARE inquiries provide an important window into CARE Act implementation and opportunities to connect individuals with significant mental health needs to necessary services. These inquiries could result in a petition to CARE or connection to county behavioral health services.

Following petitioning, CARE participants (individuals who are the subject of the petition for the CARE process and met the prima facie standard) enter their CARE Process Initiation Period. This period begins when a petition is filed or when the court orders a

county to investigate and submit a report to determine whether the respondent meets, or is likely to meet, CARE eligibility criteria. The report will include outcomes of county BH's attempts to voluntarily engage the individual in behavioral health services and supports. An elective client is defined as an individual petitioned to CARE who was diverted to county services and supports (formerly referred to as voluntary county services and supports), resulting in the court's dismissal of the petition.

For individuals who are eligible for CARE, a court may approve a voluntary CARE agreement between the participant and the county BH agency that includes an individualized range of community-based services and supports. If a CARE agreement is not reached, the court may then order a CARE plan, which includes the same elements as a CARE agreement but is court-ordered.

The CARE Process Initiation Period concludes when the court orders an initial disposition (i.e., approves a CARE agreement, orders a CARE plan, or dismisses the petition). Following an initial court disposition, CARE participants and elective clients move into their Active Service Period, which begins at the conclusion of the CARE Process Initiation Period and continues through 12 months of services and supports provided through a CARE agreement, CARE plan, or elective county services outside CARE Act proceedings. A CARE participant with a CARE agreement or CARE plan may be reappointed to CARE for an additional 12 months, which would extend the Active Service Period for up to a total of 24 months.

1.3.2 CARE Inquiries

Counties receive inquiries related to the CARE Act via phone, warmlines, email, in-person conversations, or other methods and from a range of sources, including family members, community members, potential petitioners, and providers. These inquiries offer an important opportunity for county BH agencies to engage with the community and connect individuals to information, services, and supports. Beginning in January 2025, county BH agencies began reporting aggregate counts of all CARE inquiries received, including information on the source, the topical focus, and any county action following the CARE inquiry.

2. DESIGN AND METHODOLOGY

In accordance with W&I Code sections 5985(e) and 5986, JC and county BH agencies reported data to DHCS using measures and specifications set forth in the CARE Act Data Dictionary 1.0 (for data reported between October 1, 2023, and December 31, 2024) and the CARE Act Data Dictionary Version 2.0 (for data reported starting January 1, 2025).

The CARE Act Data Dictionary Version 2.0 includes extensive changes to county BH reporting requirements resulting from two legislative updates signed into law in late 2024 (SB 1400 and SB 42).[37] These changes included revised definitions of CARE participants and elective clients; expanded reporting on county BH efforts during the CARE petitioning process (i.e., outreach and engagement, county services and supports offered; county recommendations for petition dismissal and determination of ineligibility); and new requirements to track and report on individuals who receive county services and supports, regardless of CARE eligibility.

County BH agencies must also report on pre-petitioning efforts, including inquiries regarding the CARE Act and county actions taken on those inquiries, and on statutory system referrals from specified courts and facilities as well as the outcomes of these referrals. The CARE Act Data Dictionary Version 2.0 was released on February 2, 2025, following a public comment period. Counties were required to begin tracking and reporting on the expanded data points retrospectively to January 1, 2025.

To minimize the burden of data collection and reporting, the CARE Act Data Dictionaries were aligned, to the extent possible, with existing state and federal data requirements and industry standards. These data were used to produce this Annual Report.

- JC Data: Data submitted by JC include aggregated data from courts related to petition volume, CARE hearing counts, and petition dispositions.
- County BH Agency Data: Data submitted by county BH agencies includes individual-level data on CARE participants served by county BH agencies, individual-level data on statutory system referrals sent to county BH agencies, and aggregated county data on CARE inquiries.

[37] SB 1400 amended provisions of the Penal Code related to CARE referrals of individuals deemed incompetent to stand trial. Additionally, it amended provisions to expand county BH reporting requirements related to CARE inquiries, statutory system referrals (from specific courts and facilities), and petitioned individuals. SB 42 required these additional data elements be included in the CARE Act Annual Report, beginning in 2026.

Table 1 provides an overview of the county BH agency data used in the development of this report, including county contributions to each reporting quarter from October 1, 2023, to June 30, 2025. Data used in this report were exported from the cumulative CARE Act dataset for analysis on December 8, 2025, following a final review by both county BH agencies and JC.

Table 1. County BH Agency Data Included in the CARE Act Annual Report

Reporting Quarters (Qs)	Dates Covered	Data Dictionary (DD) Used	Included Counties
Q4 2023–Q4 2024	October 1, 2023–December 31, 2024	DD 1.0	Cohort I Counties and Los Angeles County began Q3, 2023; All Cohort II began by December 2024*
Q1 and Q2 2025	January 1–June 30, 2025	DD 2.0	All Counties

**Counties that opted into Cohort I began implementation on October 1, 2023. These Cohort I counties included: Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne counties, and the City and County of San Francisco. Los Angeles County, though technically a Cohort II county, elected to implement early, on December 1, 2023. Cohort II counties, which represent the remainder of California's 58 counties, began implementation on or before December 1, 2024. San Mateo County began implementing CARE on July 1, 2024, Kern County on October 1, 2024, Mariposa County on November 1, 2024, and Napa County on November 25, 2024.*

To contextualize the JC and county-reported quantitative data, this report considers and leverages several additional sources of information, including data quality assurance reports, field notes, and logs from technical assistance efforts. Input was also sought from state partners involved in the implementation of the CARE Act. No administrative claims data were used for this report.

2.1 Data Analysis

2.1.1 Quality Assurance Process

Prior to analysis, data were cleaned and validated according to a standard quality assurance process based on four key dimensions: Completeness, Accuracy, Reasonability, and Timeliness (C.A.R.T). Technical specifications on data validation processes and construction of key variables can be found in **Appendix A**. Efforts were made to reconcile discrepancies between JC-reported and county BH-reported CARE

agreements and CARE plans as part of the quality assurance process, including targeted supports to encourage improved coordination and alignment of submitted counts of CARE agreements and CARE plans.

2.1.2 Statewide County Representation

All 58 courts reported court data on CARE petitions to the JC, which are included in this report. Nine courts reported no petitions during the period covered in this report.

County BH agencies are required to report data on three separate modules: CARE petitions, CARE inquiries, and system referrals. **Figure 1** shows the proportion of counties that reported data that could be included by module.

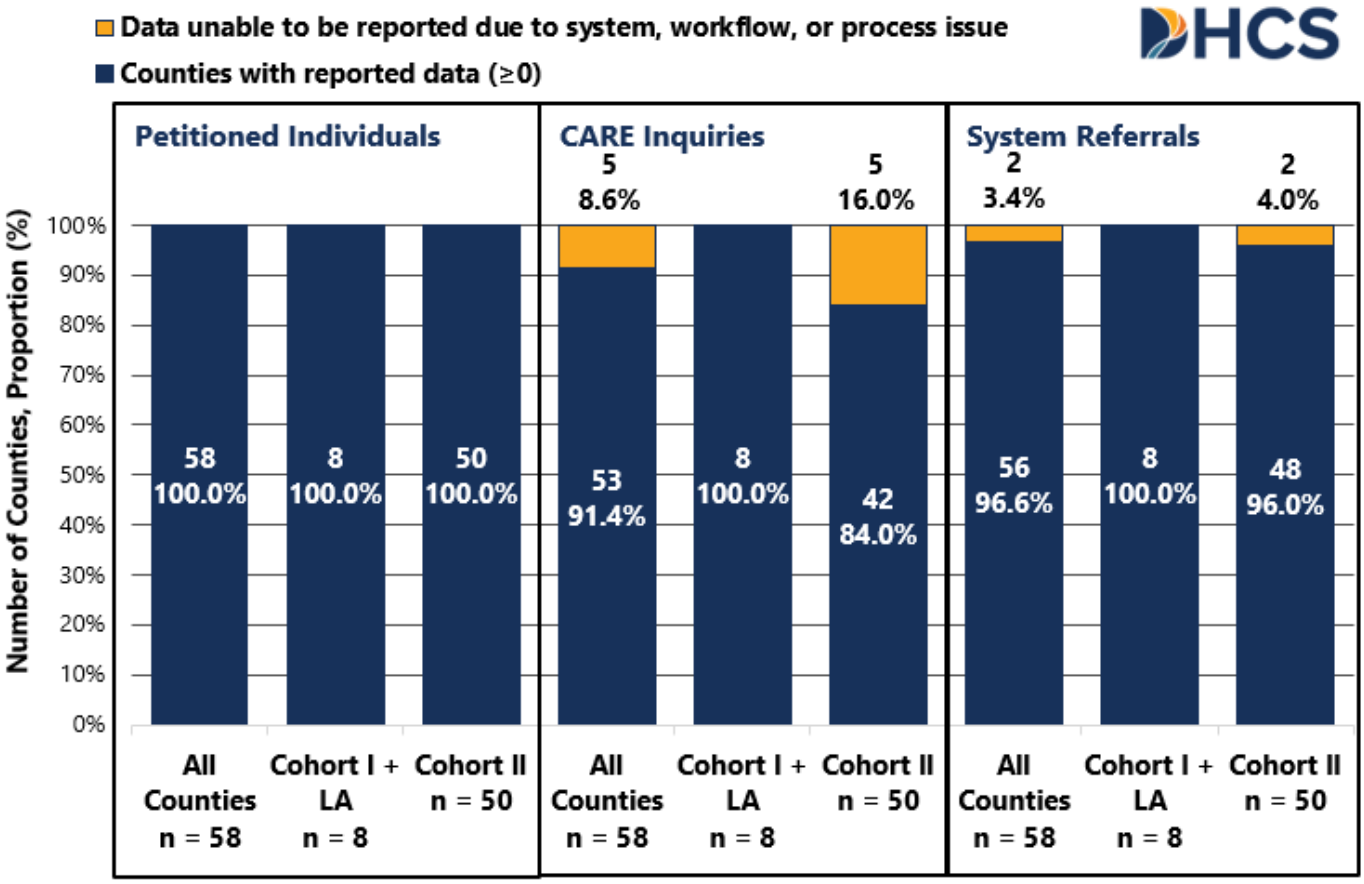
- **CARE petitions:** All counties reported data on CARE petitions. Nine counties[38] (15.5 percent) reported no petitions during the period covered by this report.
- **CARE inquiries:** Of the 58 counties, five (8.6 percent) were unable to report CARE inquiry data due to a system, process, or workflow issue; 18 counties reported no CARE inquiries for the period covered in this report.
- **Statutory system referrals to County BH:** Two counties (3.4 percent) were unable to report statutory system referral data because of system, process, or workflow issues. Another 25 counties (43.1 percent) reported no statutory system referrals to county BH for the period covered by this report.

County BH agencies reported system, process, or workflow issues that precluded their ability to report on the more recently added data reporting requirements related to CARE inquiries and statutory system referrals that took effect on January 1, 2025, pursuant to SB 1400.

Figure 2 summarizes and compares reporting status by cohort for each module of the CARE Act Data Dictionary for which county BH agencies are required to submit data: petitioned individuals, CARE inquiries, and system referrals. County BH that reported no petitions, no CARE inquiries, and no statutory system referrals, were disproportionately from Cohort II, perhaps indicative of differences in experience with CARE implementation and with data collection/submission. It may also reflect barriers some counties have had in establishing robust workflows for data collection, particularly on the new reporting requirements related to CARE inquiries and system referrals.

[38] Counties include Alpine, Colusa, Lassen, Mariposa, Mendocino, Plumas, San Benito. Sierra, and Trinity.

Figure 2. Counties Included in the CARE Act Annual Report, by Module (Statewide and by Cohort)



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.*

2.1.3 Missing and "Unknown" Data

As the CARE Act is being rolled out across two phases, county BH agencies are building their programs in response to evolving CARE legislation designed to improve ongoing implementation, including expanded reporting requirements. Incomplete data (missing or unknown) is thus expected as county BH agencies develop the necessary infrastructure.

Prior to development of the descriptive statistics presented in this report, bivariate analyses were conducted (specifically, tetrachoric correlation analyses) to assess the relationship of missing/unknown data between variables. This analysis of CARE Act data

revealed moderate to strong associations in some missing socio-demographic variables, with each other as well as with missing or unknown data in the outcome variables.

These observations collectively indicate that missing or unknown data are not random. Understanding non-random missing or unknown data is crucial from an implementation perspective, and as such, these are displayed or noted in tables throughout this report. Individuals with missing or unknown data are included in the denominators to avoid selection biases and distorted relationships between variables, including questionable conclusions about the CARE Act implementation or the population that CARE serves.

2.1.4 Analytic Methods

Descriptive statistics were generated to summarize CARE Act data. Generated statistics included means, medians, distributions, and standard deviations for continuous variables and frequency counts for categorical variables. Notably, county-level variations in CARE Act implementation are important considerations in interpreting the findings presented, as county court practices, delivery system capacity and local resources vary and may evolve over time and hence influence CARE pathway assignment and observed outcomes. When possible, descriptive statistics were stratified to highlight differences across CARE dispositions. To understand the potential role of court oversight, CARE implementation experience, and county population size, results were stratified by specific groups of CARE participants (those with CARE agreements or CARE plans and dismissed participants), CARE Act county cohorts (Cohort I and Cohort II counties), and county categories by population density (Rural, small, medium, dense, as defined in the DHCS Network Adequacy Standards and **Appendix B**). For some categorical data, variables were grouped into broader meaningful categories. Race and ethnicity data were transformed to align with Office of Management and Budget standards. Additional information on data stratifications and transformations can be found in **Appendix B**.[39]

For service provision and adverse events (e.g., jail days), variables were recoded into a binary format: "Yes, ever during the Active Service Period," and "No, never during the Active Service Period." Where relevant, variables with "other" response options were

[39] County level variation in CARE implementation, service and support availability, and resourcing is likely present and may impact the findings within this report. Future reports may include additional analyses to more closely examine differences in CARE implementation and outcomes across counties., where feasible.

reviewed and free text responses were recategorized (e.g., race/ethnicity; mental health services and supports; housing status/living situation).

2.1.5 Privacy Protection and Data Suppression Methods

Because of the distinctive CARE population data reported, participants may be identifiable. DHCS is committed to complying with federal and state laws pertaining to health information privacy and security. To protect participants' health information and privacy rights, some numbers for each of the specified outcomes cannot be publicly reported. In particular, the number of CARE plans statewide is very small (county BH agencies reported 17 CARE plans statewide). Hence, individuals with CARE plans and CARE agreements are reported together as a group to protect the privacy of these individuals. The display and visualization of all data was conducted in accordance with the DHCS Data De-identification Guidelines (DDG) v3.0. As a result, among other considerations, table cells representing fewer than 11 individuals have been suppressed throughout this report, and data are presented at a state aggregate level, rather than being county specific.

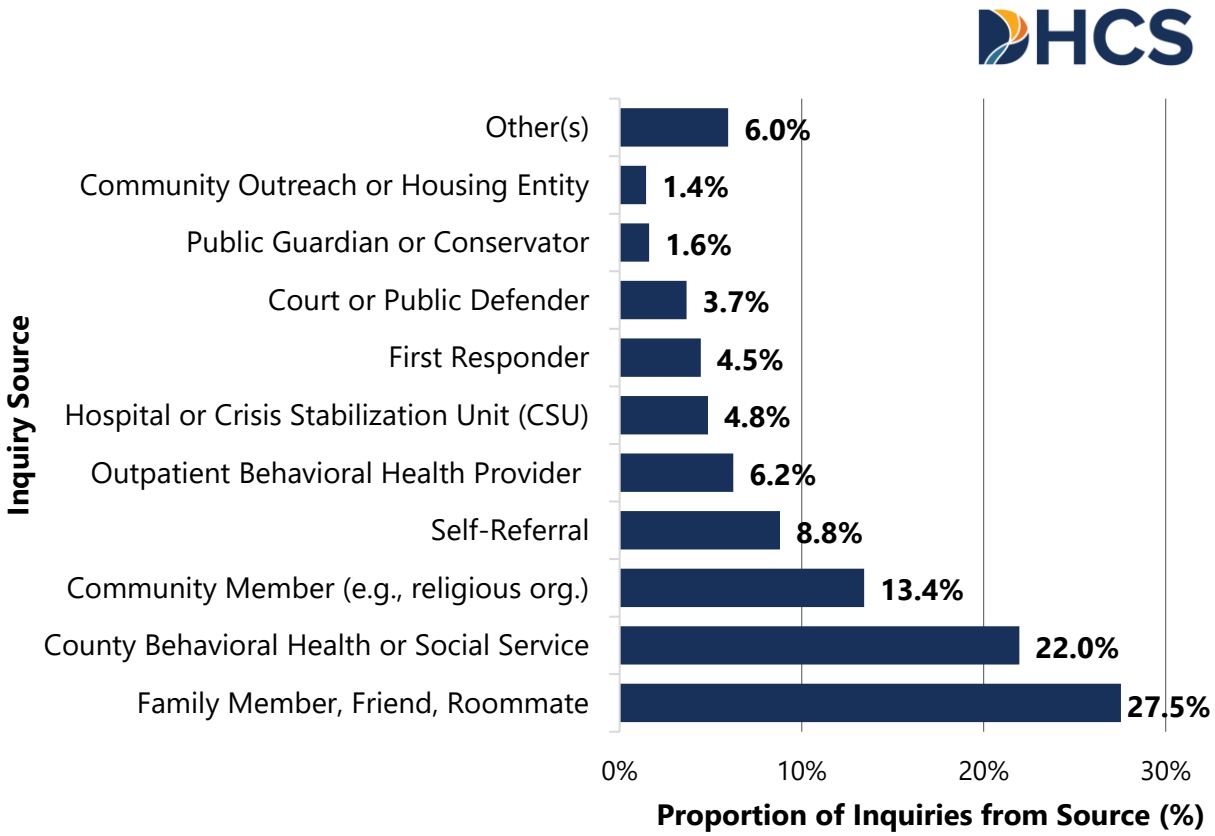
For CARE participants who were petitioned more than once in the first 21 months of implementation, only data associated with the last petition were included in the individual-level analysis. This approach, which is commonly used in quality measurement and monitoring efforts, was chosen to provide the most current view of an individual's interaction with the CARE process and to avoid CARE participant duplication.

3. FINDINGS: CARE INQUIRIES RECEIVED BY COUNTIES

CARE inquiries are an important opportunity for county BH agencies to connect individuals to services and supports. County actions associated with these inquiries highlight county efforts to connect individuals who have significant mental health needs with county services and supports. To capture such efforts, counties were required to report aggregate data on all inquiries received about the CARE Act beginning January 1, 2025, in accordance with SB 1400. CARE inquiries include general inquiries, contacts by phone, warmlines, voice messages, emails, and in-person conversations or consultations related to the CARE Act. County BH agencies are required to report monthly on the total number of CARE inquiries received by source type.

A total of 1,794 inquiries were made to 53 county BH agencies between January 1 and June 30, 2025. Los Angeles County and San Diego County reported the highest numbers of inquiries, accounting for 346 (19.3 percent) and 316 (17.6 percent) of the total, respectively. The largest source of CARE inquiries were family members, friends, or roommates (27.5 percent of all inquiries), followed by county BH or social service representatives (22.0 percent) (see **Figure 3**).

Figure 3. Source of CARE Inquiries Received (n=1,794)



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

County BH agencies are required to report the actions taken to connect individuals with services and supports following each CARE inquiry. Each CARE inquiry could be associated with multiple county actions. Of the 1,794 inquiries reported by county BH agencies, counties reported 710 actions. The most common connections made following a CARE inquiry were to county mental health services (290 actions), social services and supports (105 actions), and to Full-Service Partnership (FSP) (91 actions). Several counties, particularly very large counties and those that have yet to develop a single point of access for CARE participants, noted workflow challenges in collating inquiries and follow-through with inquiries across myriad county-wide sources.

4. FINDINGS: STATUTORY SYSTEM REFERRAL SOURCES AND OUTCOMES

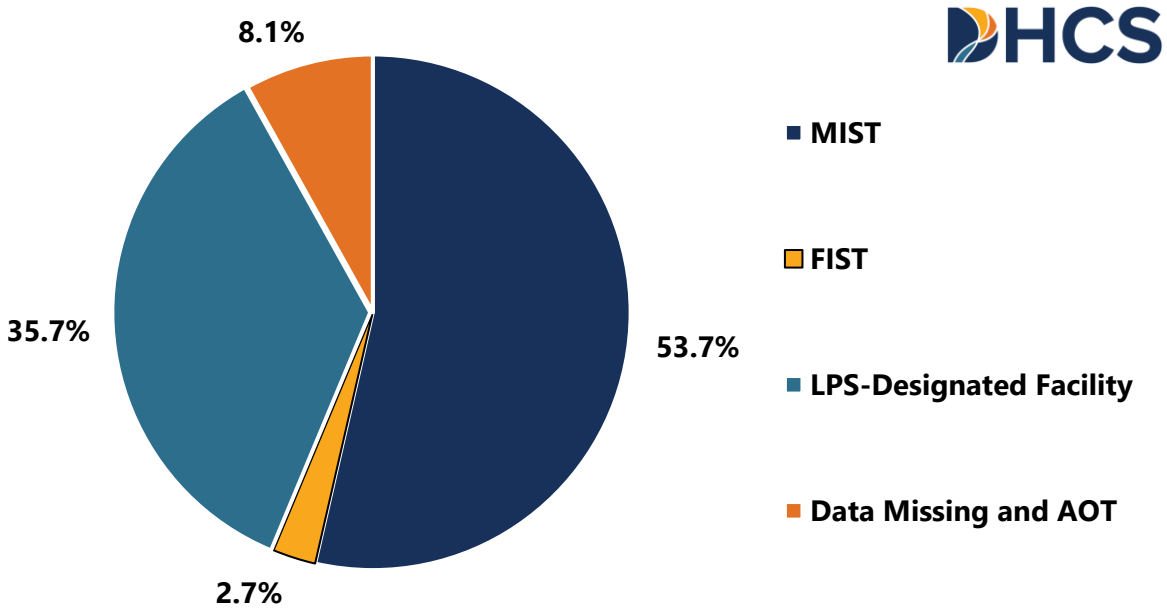
Since January 1, 2025, counties were required to track and report on statutory system referrals from LPS-designated facilities and specific courts (AOT Court or IST Courts [both Misdemeanor and Felony]) sent to the county BH agency for investigation of CARE eligibility and appropriateness, in accordance with SB 1400.

Counties report individual-level data on the source and outcome of the referral, including whether the referral resulted in a petition to CARE or whether county services or supports were provided or recommended. Counties also must report on outreach and engagement efforts for statutorily referred individuals.

4.1 Statutory System Referrals to County BH Agencies

Among the 56 counties that reported a cumulative 443 statutory system referrals between January 1 and June 30, 2025, Los Angeles County reported 120 (27.1 percent) and San Diego County reported 43 (9.7 percent). The largest source of statutory system referrals over this period was from MIST court proceedings (53.7 percent), followed by LPS-designated facility referrals (35.7 percent) (see **Figure 4**). FIST and AOT referrals were far fewer. Across both quarters, the number of counties reporting and the number of system referrals reported increased.

Figure 4. Source of Statutory System Referrals Received (n=443)



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

4.2 Statutory System Referral Outcomes

Of the 443 statutory system referrals, 332 had a reported outcome (74.9 percent) and the status of the other 111 (25.1 percent) was undetermined or missing during the first two quarters of 2025. As outlined in **Table 2**, among the 332 system referrals with an outcome:

- About one-third (n=102, 30.7 percent) were petitioned to CARE.
- 28 (8.4 percent) were not petitioned to CARE but had accepted voluntary treatment or enrolled in county services/supports.
- 83 (25.0 percent) were not petitioned but connected to county services/supports and were pending enrollment confirmation.
- About one-third (119, 35.8 percent) were neither connected to county services/supports nor petitioned to CARE.

The conversion rate from system referral to petition was highly variable, ranging from 1.7 percent to 100.0 percent among the 56 counties that reported receiving a system referral.

Table 2. Assigned Outcomes of Statutory System Referrals

Statutory System Referral Outcome	Number and Proportion of System Referrals with Assigned Outcomes (n=332)
Petitioned to CARE	102 (30.7%)
Not Petitioned - Connected to County BH Services/Supports	83 (25.0%)
Not Petitioned - Accepted Voluntary Treatment and Enrolled in Other County Service/Support	28 (8.4%)
Neither Petitioned nor Connected to County BH Services/Supports	119 (35.8%)

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

Among the 230 statutory system referrals that were not petitioned to CARE, the most common reason reported by county BH agencies (more than one reason could be reported) was that the individual was "unlikely to benefit from CARE" (39.6 percent). Other commonly reported reasons for not petitioning to CARE included the individual lacking a CARE-eligible diagnosis (26.1 percent) and the individual requiring a higher level of care (24.3 percent).

Building Effective Statutory System Partner Referral Pathways: Ventura County Key Takeaways

Ventura County Behavioral Health has built collaborative relationships across systems to create efficient referral pathways and ensure individuals are quickly connected to appropriate services, including CARE petitions. Between January 1 and June 30, 2025, all of Ventura county's system referrals had been assigned an outcome. Among system referrals with an outcome disposition, the conversion rate for system-referred individuals to CARE petitions in Ventura County was among the highest observed statewide (84.6% versus 30.7%). Below are some best practices that the county shared to explain its success:

- **Building relationships to drive results:** Strong, trust-based partnerships across behavioral health, hospitals, the justice system have enabled timely referrals and faster connections to services, including CARE petitions.
- **Regular coordination and information sharing:** Standing meetings and advance notice from system partners has allowed CARE teams to begin outreach immediately and prepare petitions before critical transition points. Data use agreements across system partners have facilitated timely sharing of relevant information on system-referred individuals.
- **Simplified CARE petitioning processes:** Referral pathways and forms are designed to minimize burden on partners, thereby increasing buy-in and consistent use across systems.
- **Integration and coordination to accelerate care transitions:** Co-located staff, shared record systems, and proactive communication with system partners support seamless referrals, eligibility review, and step-down from higher levels of care. The court, jail, and LPS facilities have processes in place with the county BH agency to support warm handoffs to appropriate county services and supports, ensuring safe and smooth transitions to the community and promoting the likelihood of successful post-release outcomes.

4.3 Outreach to and Engagement of Referred Individuals

With regard to outreach to and engagement of individuals who are the subject of a statutory system referral, county BH agencies reported considerable variations.

Thirty-one counties reported 443 statutory system referrals in the first six months of 2025.[40] Wide variations in reported data were observed, with 11 counties reporting no outreach or engagements with these individuals. Among the 443 system-referred individuals, 257 (58.0 percent) did not have any outreach or engagements reported (data not shown).

As shown in **Table 3**, a total of 492 outreach attempts (one-way, in-person, or virtual) and 414 engagements (two-way exchanges) were reported with a median of 3.0 outreach and engagement events per individual. Small counties reported a median of 4.4 outreach and engagement attempts per individual compared with dense counties, which reported less than one (data not shown).

Table 3. Outreach and Engagement of System-Referred Individuals

Outreach and Engagement	Statutory System Referrals January 1–June 30, 2025± (n=443)
Total Outreach Attempts	492
Median Number of Outreach Attempts per Individual	1.2 (IQR 0.0–2.8)
Total Engagement Events	414
Median Number of Engagement Events per Individual	1.2 (IQR 0.0–2.5)
Total Outreach and Engagement	906
Median Number of Outreach and Engagement Events per Individual	3.0 (IQR 0.0–5.0)

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

[40] While 56 counties reported data for the Statutory System Referral module of the Data Dictionary 2.0, only 31 reported non-zero values.

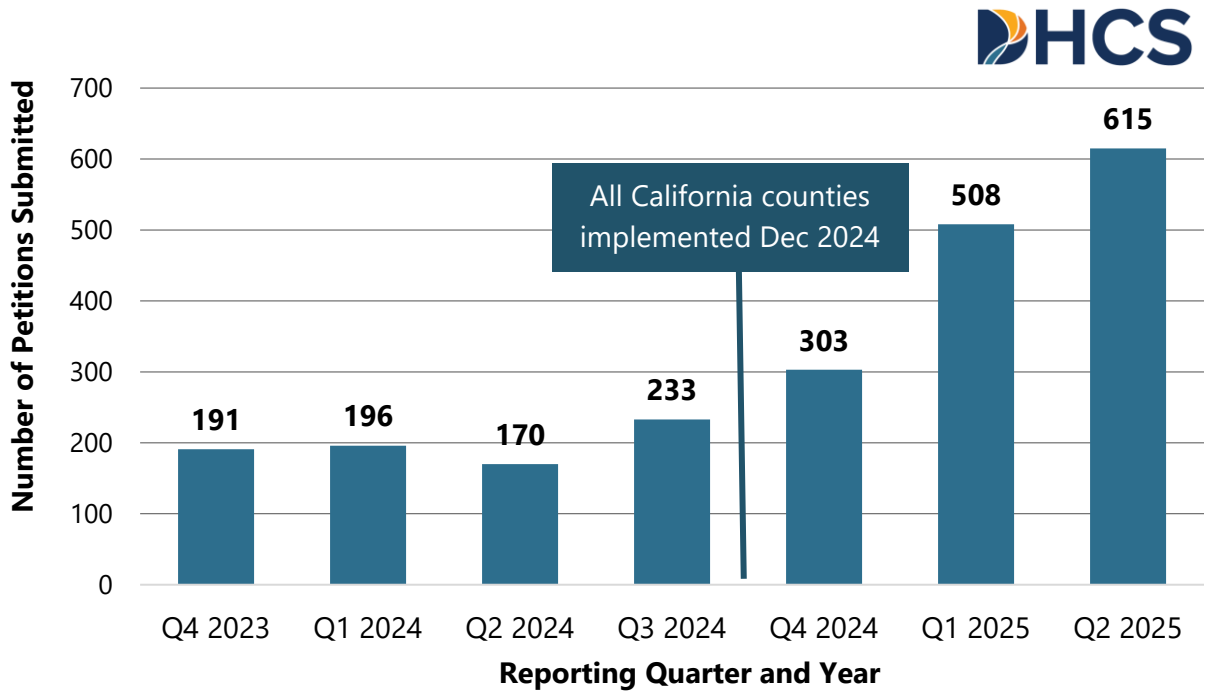
5. FINDINGS: COURT DATA

The required court hearings and activities of the CARE process are outlined in W&I Code sections 5970-5987. Using aggregated data from JC, this section describes the number of CARE petitions filed and their progression through the courts.

5.1 Petitions Submitted to the Courts

The CARE Act authorizes a range of individuals, such as family members, health care or social service providers, and first responders, to file a petition to initiate CARE Act proceedings. **Figure 5** below displays the number of petitions filed each quarter, with a total of 2,216 petitions filed between October 1, 2023–June 30, 2025.

Figure 5. CARE Petitions Submitted by Reporting Quarter and Year (n=2,216)

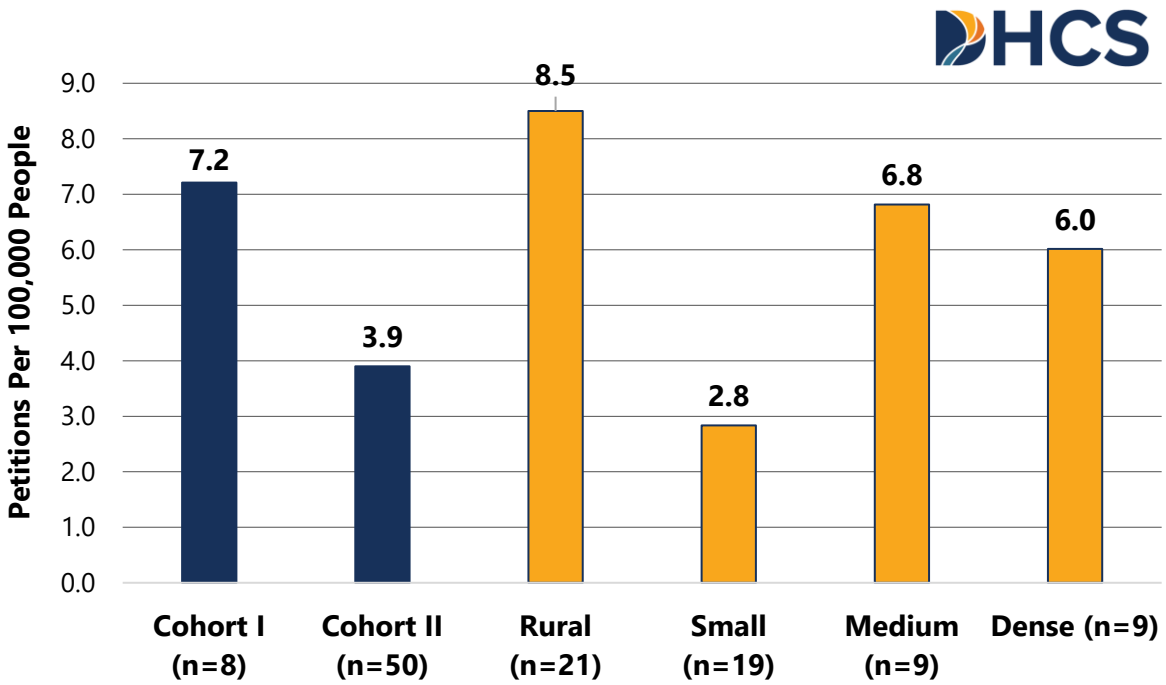


Data Source: *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
Note: *All Cohort I Counties, including Los Angeles County, began implementing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

As of June 30, 2025, 5.6 petitions had been filed per 100,000 residents across the state. To understand possible cohort effects and the potential role of county population density influencing per capita petition rates, **Figure 6** shows the number of petitions per

100,000 residents by county cohort and stratified by county population density. Cohort effects were observed, as shown on the left side of **Figure 6**. Higher per capita petition rates were observed among Cohort I counties (including Los Angeles County: 7.2 petitions per 100,000) than in Cohort II counties (3.9 petitions per 100,000), potentially reflecting maturity of CARE Act implementation among Cohort I counties. The right side of **Figure 6** shows per capita petition rates stratified by county population density. Rural counties, given their small population size, had the highest per capita rates of CARE petitions but few petitions. All small counties were part of Cohort II, and their per capita petition rates more closely resembled other Cohort II counties (see **Appendix C** for detailed information).

Figure 6. Total Petitions Per 100,000 by Cohort and County Population Density



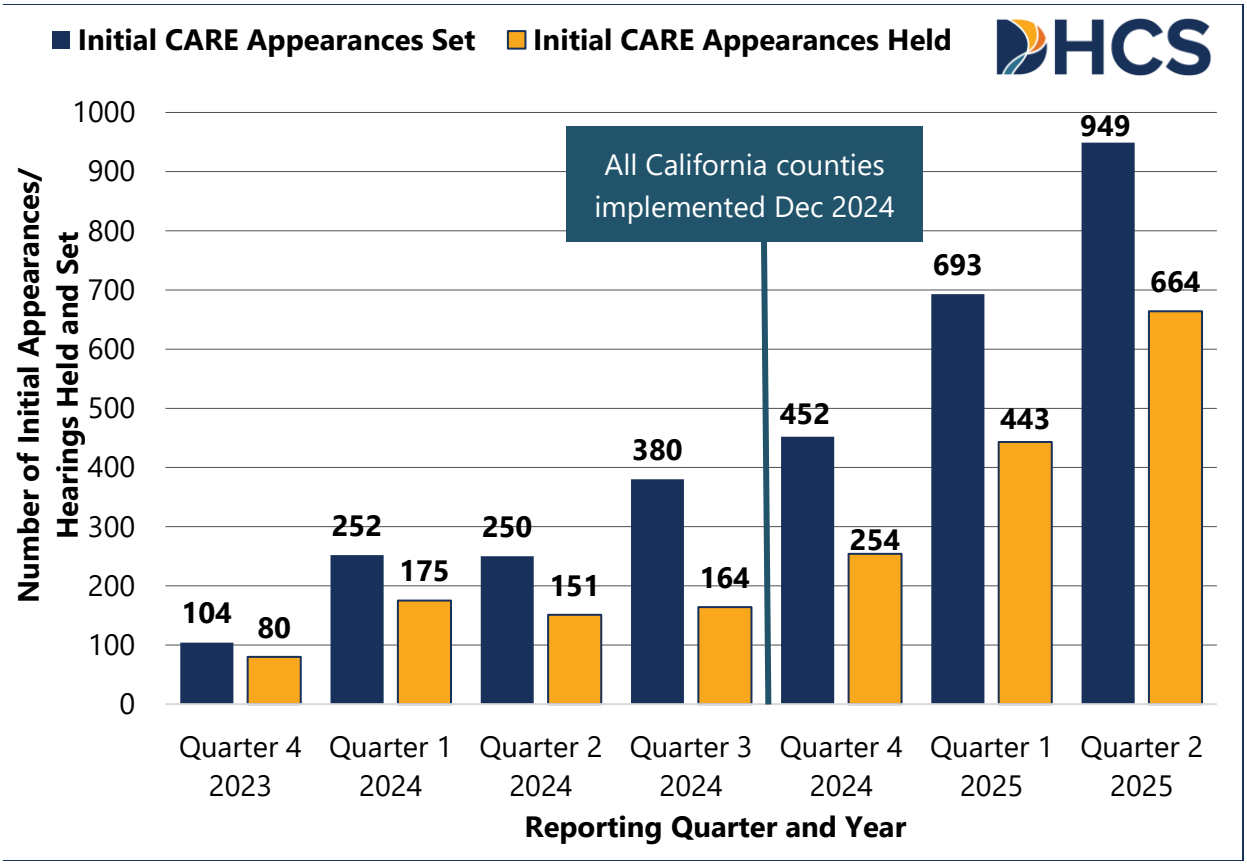
Data Source: *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
Note: *Cohort I does not include any small counties.*

5.2 Initial Appearances Set and Held by the Courts

Following the filing of a CARE petition, the court determines whether the petition shows that the individual meets, or may meet, eligibility criteria for CARE proceedings (i.e., prima facie showing). In instances where the petition is filed by an individual or entity other than the county BH agency, the court will order the agency to investigate and

make recommendations regarding the individual's eligibility for CARE. If the court determines that the petition and the county's report support a prima facie showing, the court sets an initial appearance hearing date, which may be combined with a hearing on the merits if all parties agree and the court approves (WIC section 5977(b)(7)(B)). As **Figure 7** demonstrates, 3,080 initial appearances were set and 1,931 initial CARE appearances took place between October 1, 2023, and June 30, 2025.[41] Each initial CARE appearance may be scheduled several times before it occurs.

Figure 7. Initial CARE Appearances Set (n=3,080) and Held (n=1,931), by Reporting Quarter



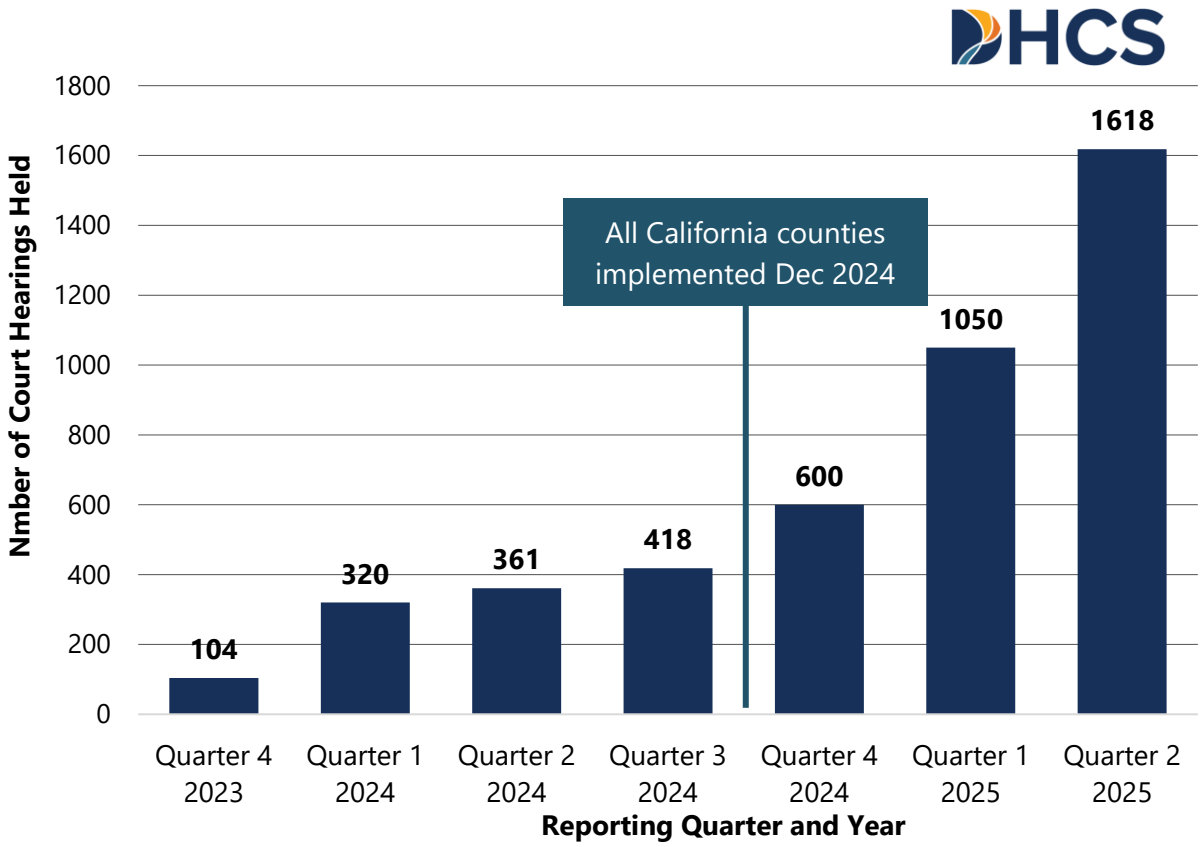
Data Source: *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
Note: *Cohort I Counties began implementing CARE in October 2023; Los Angeles County began implementing CARE in December 2023; all other counties implemented CARE by December 2024.*

[41] Initial hearings may be set, but not yet held, for multiple reasons, including the scheduled date not yet arriving or the hearing having been set and reset based on scheduling needs.

5.3 Total CARE Hearings Held by the Courts

As **Figure 8** shows, 4,471 total court hearings related to a CARE petition took place between October 1, 2023, and June 30, 2025. This total accounts for all hearings associated with a petition, including the initial appearance, hearing on the merits of the petition, case management, clinical evaluation review, CARE plan review, progress review(s), and status review(s).

Figure 8. Court Hearings Held Associated with CARE Petitions, by Reporting Quarter (n=4,471)



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.*
Note: *Cohort I Counties began implementing CARE in October 2023; Los Angeles County began implementing CARE in December 2023; all other counties implemented CARE by December 2024.*

5.4 CARE Petition Disposition

During the CARE Act process, the court determines the respondent's CARE eligibility and then makes an order that results in the initial disposition.[42] Of the 2,216 petitions filed between October 1, 2023, and June 30, 2025, courts reported 500 approved CARE agreements and 17 court-ordered CARE plans.[43]

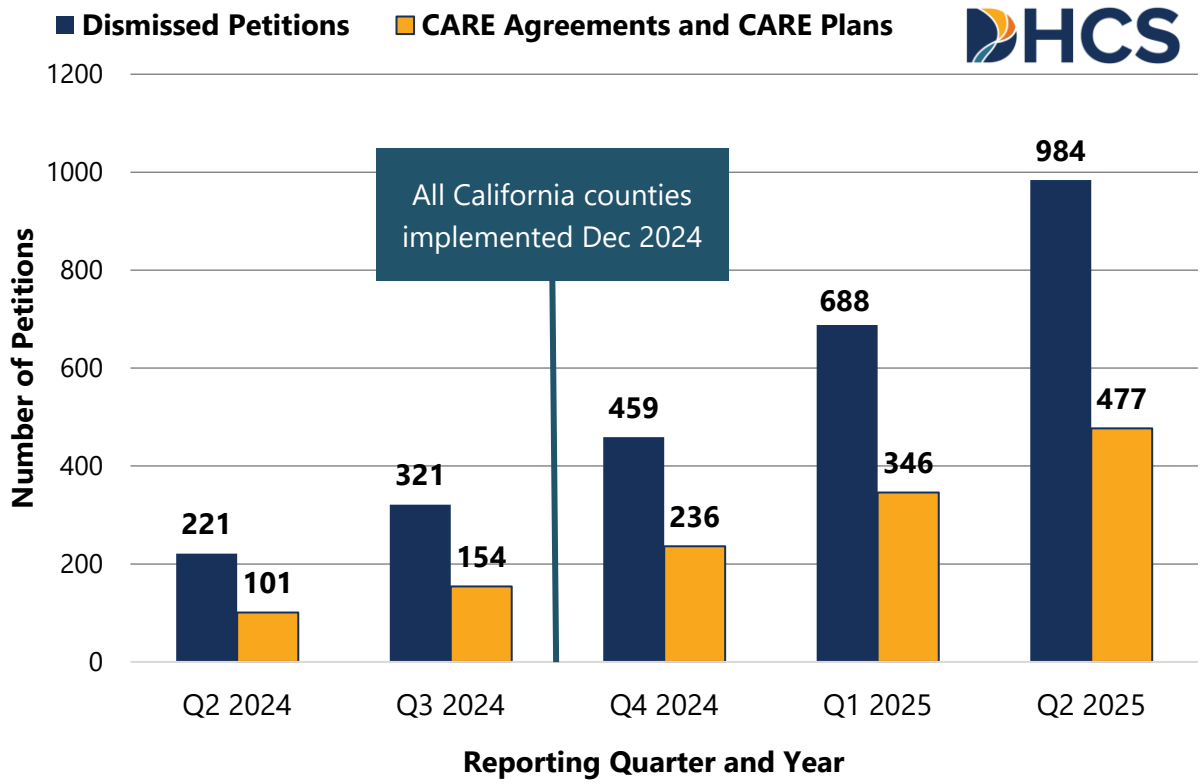
Importantly, the court may dismiss a petition at various points throughout the CARE Act process, including at the time of initial disposition, following the termination of a CARE agreement or CARE plan, or at the time of graduation.[44] By June 30, 2025, the courts had dismissed 984 petitions (see **Figure 9**).

[42] An initial disposition is an outcome of a petition, which, in the CARE process, includes: a CARE agreement approved, a CARE plan ordered, or a CARE petition dismissed (final resolution of petition). These dispositions are the result of an order by a judicial officer and are documented in an official court record or document.

[43] **CARE agreements** are voluntary agreements between a CARE respondent and a county BH agency after a court has found the respondent eligible for CARE. These agreements set forth an individualized range of community-based services and supports relevant to the CARE respondent. **CARE plans** include the same elements as a CARE agreement but are court-ordered.

[44] Although all petitions are ultimately dismissed at the conclusion of the CARE process, there are several reasons why a petition may be dismissed earlier, before a participant has had the opportunity to engage in services under court oversight, including not demonstrating a prima facie showing of eligibility, engagement in voluntary services outside of court jurisdiction, and not meeting CARE eligibility criteria after a county BH investigation.

Figure 9. Total Cumulative Count of CARE Petition Disposition by Quarter



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.*
Note: *Cohort I Counties began implementing CARE in October 2023; Los Angeles County began implementing CARE in December 2023; all other counties implemented CARE by December 2024.*
Note: *Data Values prior to Q2 2024 are not shown in this figure to protect confidentiality of the individuals summarized in the data.*

6. FINDINGS: COUNTY BEHAVIORAL HEALTH CARE PARTICIPANT DATA

Of the 2,216 CARE petitions submitted to the court, 2,008 petitions were reported by county BH agencies from the implementation of the CARE Act through June 30, 2025. This discrepancy exists because county BH agencies are only aware of and able to track CARE petitions they file themselves or that they are ordered by the courts to investigate.

6.1 CARE Participants Sent to County Behavioral Health Agencies

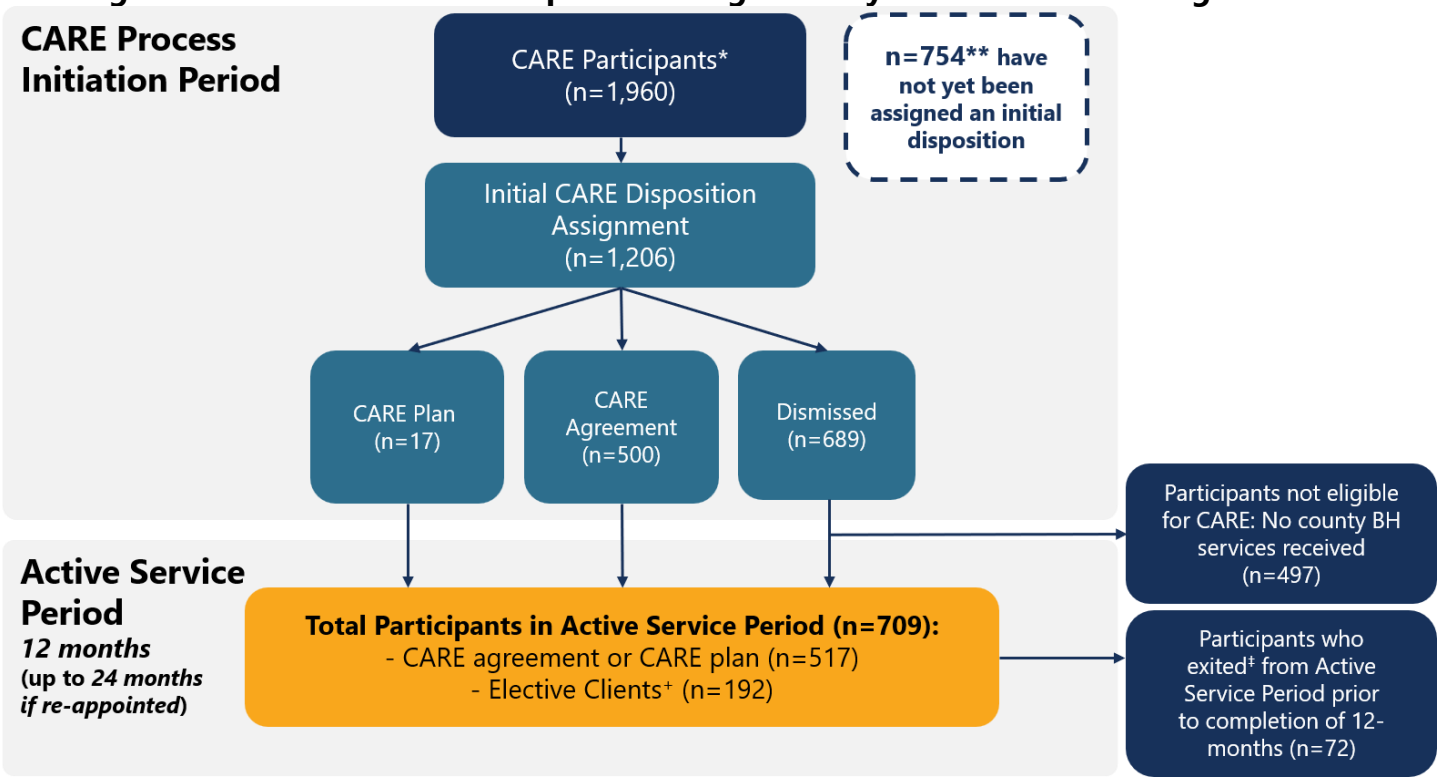
Figure 10 shows the flow of petitions from courts to county BH, including initial disposition by courts and county action.[45] These petitioned individuals (CARE participants) are in the CARE Process Initiation Period, which begins when a petition is filed or the court orders a county to file a written report. This period concludes when the court orders an initial disposition. Among the 2,008 CARE petitions that flowed to county BH agencies, they represent 1,960 unique CARE participants. [46,47]

[45] An initial disposition is an outcome of a petition, which, in the CARE process includes: a CARE agreement approved, a CARE plan ordered, or a CARE petition dismissed (final resolution of petition). These dispositions are the result of an order by a judicial officer and are documented in an official court record or document.

[46] CARE participants are unique within a county. A total of 47 individuals were petitioned more than once as of June 30, 2025, 12 were petitioned more than twice, and 11 were petitioned in more than one county. These transferred individuals are separately attributed to the county of residence for purposes of monitoring county BH agency accountability.

[47] As stated in the Design and Methodology Section of this report, for CARE participants who were petitioned more than once in the first 21 months of implementation, only data associated with the last petition were included in the individual-level analysis. This approach, which is commonly used in quality measurement and monitoring efforts, was chosen to provide the most current view of an individual's interaction with the CARE program and to avoid CARE participant duplication.

Figure 10. Flow of CARE Participants Through County Behavioral Health Agencies



**2,008 total CARE petitions, representing 1,960 unique CARE participants, were received by county BH agencies.*
***9 did not have a county-reported initial disposition but were later reported to be dismissed.*
+Of the 192 elective clients in the Initiation Period, DHCS only received Active Service Period data for 91: 15 CARE-eligible clients dismissed prior to January 1, 2025, and 76 clients dismissed between January 1 and June 30, 2025 who received county services/supports regardless of eligibility.
±Exited denotes dismissal or graduation before completion of the 12-month Active Service Period.

As of June 30, 2025, 1,206 CARE participants received by county BH agencies had an initial CARE disposition. Overall, 517 of 1,206 CARE participants with an initial disposition (42.9 percent) had either a CARE agreement approved (500) or a CARE plan ordered (17).[48] A total of 689 CARE participants with an initial disposition (57.1 percent) were

[48] JC and county BH agencies independently report on the number of CARE agreements and CARE plans. For this Annual Report, county BH agencies collectively reported 34 more CARE agreements and six more CARE plans than JC. Among the 29 counties with discrepant numbers of CARE agreements or CARE plans, most of the discrepancies were limited (one or two), with notable outliers among five counties with five or more discrepancies. Some of these variances may reflect differences in timing when courts and counties record a CARE agreement or CARE plan.

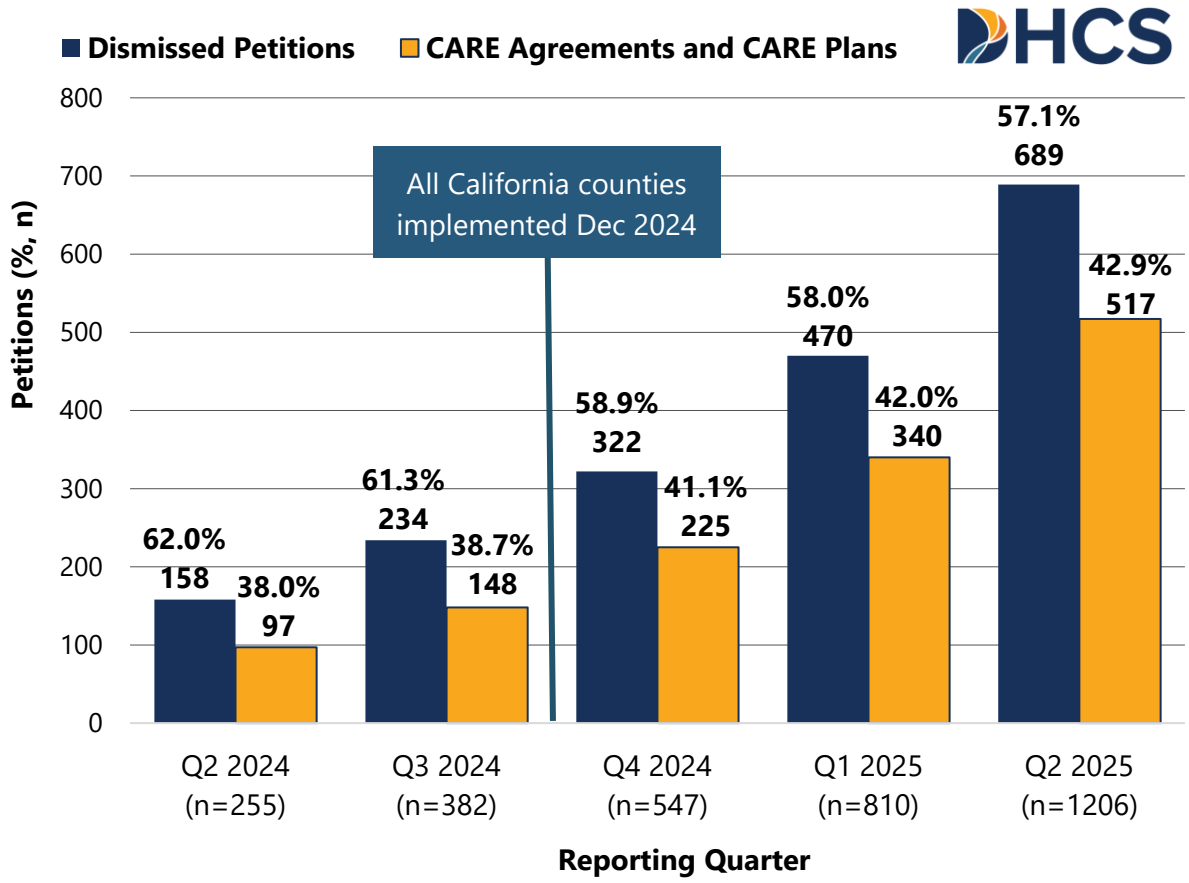
dismissed by the courts at the time of their first CARE petition disposition. The remainder of CARE participants received by county BH agencies (n=754) did not have a county-reported initial disposition at the time of reporting. **Figure 11** shows the proportion of CARE petitions with an initial disposition by quarter.

Among the 689 CARE participants dismissed by the CARE court as the initial CARE disposition:

- **497 were dismissed and did not receive any county BH services.** The most common reasons included: nonparticipation in the CARE process (17.1 percent); inability to locate the participant (16.1 percent); transition to a higher level of care (12.4 percent); and long-term incarceration (6.7 percent).
- **192 were dismissed and received county BH services** (also referred to as elective clients in this report and tracked similarly to those with a CARE agreement or CARE plan).[49]

[49] Beginning in January 2025, the definition of an elective client was revised to include CARE participants who receive services and supports outside of CARE court jurisdiction, regardless of whether they were found to be eligible for CARE. This may include receipt of services under AOT or LPS. Prior to January 2025, counties were responsible only for reporting on dismissed participants who were CARE-eligible and, rather than enter into a CARE agreement or CARE plan, chose to receive county services and supports as elective clients.

Figure 11. Proportion of CARE Petitions with Initial Disposition, by Disposition Type, Per Quarter



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.*
Note: *Cohort I Counties began implementing CARE in October 2023; Los Angeles County began implementing CARE in December 2023; all other counties implemented CARE by December 2024.*
Note: *Data Values prior to Q2 2024 are not shown in this figure to protect confidentiality of the individuals summarized in the data.*

As shown in **Table 4**, there were observable differences in petition dispositions across counties. Overall, the proportion of total CARE participants that the courts dismissed was higher in rural counties (70.0 percent) and dense counties (61.1 percent) than in medium counties (41.8 percent) and small counties (54.5 percent). Across the state, a greater proportion of dismissed CARE participants did not go on to receive county services and supports than those that did (i.e., became elective clients).

Table 4. CARE Participant Petition Dismissals During Initiation Period, by County Population Density

CARE Participants with Initial Disposition in Initiation Period	All Counties (n=1,206) n (%)	Rural Counties (n=40) n (%)	Small Counties (n=88) n (%)	Medium-Counties (n=237) n (%)	Dense Counties (n=841) n (%)
Dismissals: All	**689 (57.1%)**	**28 (70.0%)**	**48 (54.5%)**	**99 (41.8%)**	**514 (61.1%)**
Dismissals: Not Receiving County Services	497 (41.2%)	*	*	70 (29.5%)	370 (44.0%)
Dismissals: Receiving County Services (Elective Clients±)	192 (15.9%)	*	*	29 (12.2%)	144 (17.1%)

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.*
** Values are not shown to protect confidentiality of the individuals summarized in the data.*
± Of the 192 elective clients in the Initiation Period, DHCS only has Active Service Period CARE data for 91 (15 CARE-eligible clients dismissed prior to January 1, 2025, and 76 clients dismissed between January 1 and June 30, 2025, who received county services/supports regardless of eligibility).

Opportunity for Connection to Appropriate Services

Across the state, only 27.9 percent of the 689 dismissed CARE participants (initial CARE petition disposition) received county services and supports post-dismissal. **Los Angeles County** was notable in having 43.2 percent of its 162 dismissed CARE participants connected to services and supports post-dismissal. Courts in Los Angeles County make every effort not to dismiss CARE petitions until the appropriate linkages and connections have been made by the county BH agency. Voluntary connection to services in Los Angeles County post-CARE dismissal often includes connections to outpatient treatment and Full-Service Partnership programs.

6.1.1 CARE Participant Socio-Demographic Characteristics

Table 5 below summarizes the demographic characteristics of CARE participants. The data are displayed to highlight demographic differences by initial CARE disposition. While demographic data are primarily indicated by the participant (self-report), if a participant does not provide this information, counties can report this data using collateral and volunteer supporter reports as a source.

The majority of CARE participants were between the ages of 26 and 45 years (60.2 percent) and male (64.9 percent). With regard to the race and ethnicity of CARE participants, over a third (36.5 percent) identified as White, 21.9 percent identified as Hispanic, 19.1 percent identified as Black or African American, 3.5 percent identified as Asian, and 10.7 percent were missing or unknown. Most CARE participants reported English as their preferred language (87.1 percent).

Table 5. Demographics of CARE Participants, by Initial Disposition Type

Demographic Variable	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
Age				
18–25 years	171 (8.7%)	53 (10.3%)	*	42 (8.5%)
26–45 years	1,180 (60.2%)	309 (59.8%)	110 (57.3%)	293 (59.0%)
46–65 years	516 (26.3%)	132 (25.5%)	53 (27.6%)	130 (26.2%)
66+ years	*	23 (4.4%)	*	*
Data Missing or Unreported	*	0 (0.0%)	*	*
Sex				
Male	1,272 (64.9%)	330 (63.8%)	119 (62.0%)	310 (62.4%)
Female	621 (31.7%)	174 (33.7%)	*	151 (30.4%)
Other	*	*	*	*
Unknown	55 (2.8%)	*	*	*

Demographic Variable	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
Data Missing or Unreported	*	*	0 (0%)	*
Race/Ethnicity±				
White, Alone	716 (36.5%)	190 (36.8%)	75 (39.1%)	187 (37.6%)
Hispanic, Any Race	430 (21.9%)	130 (25.1%)	46 (24.0%)	85 (17.1%)
Black/African American, Alone	374 (19.1%)	94 (18.2%)	31 (16.1%)	75 (15.1%)
Asian (Excluding Pacific Islander), Alone	69 (3.5%)	22 (4.3%)	*	*
More than One Race	45 (2.3%)	14 (2.7%)	*	*
Native Hawaiian/ Pacific Islander	27 (1.4%)	*	*	*
American Indian/Alaskan Native, Alone	22 (1.1%)	*	*	*
Other, Single Race	68 (3.5%)	28 (5.4%)	*	*
Unknown	190 (9.7%)	23 (4.4%)	12 (6.3%)	79 (15.9%)
Data Missing or Unreported	19 (1.0%)	*	*	*
Gender Identity				
Male	984 (50.2%)	291 (56.3%)	87 (45.3%)	232 (46.7%)
Female	686 (35.0%)	181 (35.0%)	82 (42.7%)	156 (31.4%)

Demographic Variable	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
Unknown	262 (13.4%)	*	*	*
Other**	*	*	*	*
Data Missing or Unreported	*	*	0 (0.0%)	*
Preferred Language				
English	1,707 (87.1%)	485 (93.8%)	171 (89.1%)	404 (81.3%)
Spanish	42 (2.1%)	*	*	*
Other, Non-English or Spanish	*	*	*	*
Unknown	168 (8.6%)	*	*	67 (13.5%)
Data Missing or Unreported	*	0 (0.0%)	0 (0.0%)	*

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.*

**Values are not shown to protect confidentiality of the individuals summarized in the data. In some cases, data points or response options were removed to ensure calculation of small values cannot be computed. Data for several socio-demographic characteristics are not displayed in the table due to a high level of unknown or missing values: Sexual Orientation (47 percent unknown), Veteran Status (48 percent unknown), and Tribal Affiliation (77 percent unknown), and Disability (40 percent).*

*** The "Other" category for Gender Identity includes the following value options combined: Transgender: Male to Female, Transgender: Female to Male, Non-Binary, Another Gender Identity and Declined to State.*

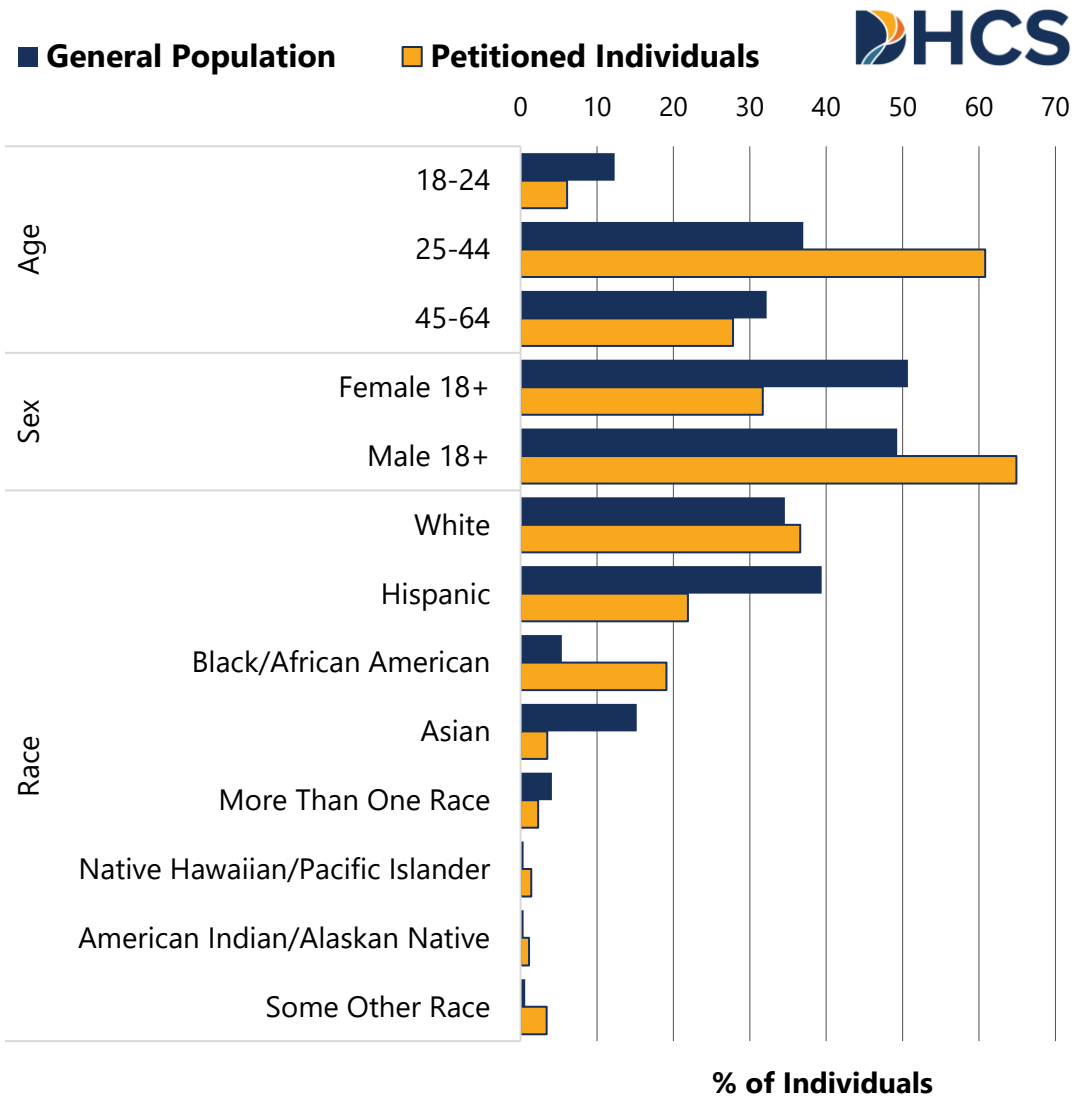
± Race/Ethnicity data were re-aligned to be consistent with the Office of Management and Budget's (OMB's) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, to the extent possible.

***Note**: Individuals of Hispanic ethnicity are categorized in this report as Hispanic, regardless of race, to preserve as much information as possible about the diversity of this ethnic group, per OMB guidance on presenting data. As such, Hispanics of different races were not classified within the broader category of "multiethnic or multiracial" which would create a loss of valuable detail about the Hispanic group, that have implications for CARE Act implementation.*

Census data was used as a comparator for this group. While this data is intended to capture the California population, it may not be an exact representation of individuals living with mental illness. In comparing CARE participants to the California Census, the population make-up of petitioned individuals was not found to mirror the communities in which petitioned individuals reside. Rather, the CARE population more closely reflects the make-up of racial groups known to be underserved and over-represented among individuals with CARE-eligible diagnoses, unhoused populations, psychiatric hospitals, and carceral settings—the very populations the CARE Act is intended to help through a civil court process.

CARE participants were found to be younger and disproportionately male (**Figure 12**, **Appendix D**). With regard to race and ethnicity, Asian and Hispanic individuals were found to be underrepresented in the CARE population relative to the overall California (Census) population. Conversely, Black and African American individuals were over-represented in the CARE population when compared to the overall California population. These trends were also seen at the individual county level. These findings, though preliminary, may suggest that CARE is identifying a population that may be at greater risk for avoidable psychiatric hospitalizations, incarcerations and LPS Mental Health conservatorships.

Figure 12. Demographic Comparison of CARE Participants (n=1,960) to General Population



Data Source (Petitioned Individuals): *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 Source (General Population Comparisons): *2020 Census State Redistricting Data (Public Law 94-171) Summary File Prepared by the U.S. Census Bureau, 2021.*
Note: *To protect confidentiality, the following values were suppressed - 1) Age 65+ and missing/unknown; 2) Sex Other 18+ and missing/unknown, 3) R/E missing/unknown*

Table 6 below provides an overview of key characteristics of CARE participants[50] by petition disposition type. Notable findings include:

- Of the 1,960 CARE participants, 1,136 (58.0 percent) were reported to be Medi-Cal enrollees, 116 (5.9 percent) were Medicare enrollees, and 32 (1.6 percent) were private pay. Because approximately one-fifth (22.0 percent) of CARE participants had unknown or missing data on health care coverage, these data should be carefully interpreted and used judiciously.
- Among the 1,960 CARE participants, 800 (40.8 percent) were housed (in permanent, or temporary housing), and 444 (22.7 percent) were homeless or unhoused at the time of petitioning. An additional 513 (26.2 percent) resided in an institution or residential treatment program at the time of petitioning.
- Nearly a third of employment status data was reported as unknown. Of the 1,960 unique CARE participants, 1.7 percent were reported to be in the paid workforce and 65.1 percent in the unpaid workforce (e.g., student, retired, looking for work). 1,054 (53.8 percent) were unemployed and not seeking work; 98 (5.0 percent) were unable to work due to disability or retirement; and 97 were actively looking for work (5.0 percent). Nineteen CARE participants reported that they were students (1.0 percent).

Table 6. Characteristics of CARE Participants, by Disposition Type

Characteristic	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
Health Care Coverage Status				
Medicaid (Medi-Cal)	1,136 (58.0%)	342 (66.2%)	105 (54.7%)	275 (55.3%)
Medicare	116 (5.9%)	28 (5.4%)	*	21 (4.2%)
Private Pay	32 (1.6%)	*	*	14 (2.8%)

[50] For the purposes of this analysis, the first available data during the CARE Process Initiation Period was used to describe housing status.

Characteristic	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
More than One Health Coverage	217 (11.1%)	111 (21.5%)	*	*
Unknown	421 (21.5%)	*	56 (29.2%)	144 (29.0%)
Other**	*	*	*	*
Data Missing or Unreported	*	0 (0.0%)	0 (0.0%)	*
Housing Status/Living Situation+				
Housed	800 (40.8%)	264 (51.1%)	100 (52.1%)	180 (36.2%)
Permanent	578 (29.5%)	198 (38.3%)	64 (33.3%)	146 (29.4%)
Temporary	222 (11.3%)	66 (12.8%)	36 (18.8%)	34 (6.8%)
Institutional or Residential Placement	513 (26.2%)	129 (25.0%)	40 (20.8%)	123 (24.8%)
Homeless (or unhoused)	444 (22.7%)	107 (20.7%)	39 (20.3%)	143 (28.8%)
Other or Unknown	118 (6.0%)	*	*	30 (6.0%)
Data Missing or Unreported	85 (4.3%)	*	*	21 (4.2%)
Employment Status				
Employed (Full- or Part-Time)	34 (1.7%)	*	*	*
Not in Paid Workforce	1,275 (65.1%)	408 (78.9%)	123 (64.1%)	311 (62.6%)
Not in Paid Workforce: Student	19 (1.0%)	*	*	*
Not in Paid Workforce: Actively Looking	97 (5.0%)	42 (8.1%)	*	29 (5.8%)

Characteristic	Total CARE Participants (n=1,960) n(%)	CARE Agreements and Plans (n=517) n(%)	Dismissed (Elective Clients) (n=192) n(%)	Dismissed (Not Receiving County Services) (n=497) n(%)
Not in Paid Workforce: Unable to Work Due to Disability or Retired	98 (5.0%)	29 (5.6%)	*	17 (3.4%)
Not in Paid Workforce: Unemployed/Not Seeking Work	1,054 (53.8%)	329 (63.6%)	110 (57.3%)	262 (52.7%)
Other	*	12 (2.3%)	*	*
Unknown	579 (29.5%)	85 (16.4%)	57 (29.7%)	166 (33.4%)
Data Missing or Unreported	*	*	0 (0.0%)	0 (0.0%)

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.*
Note: *A large proportion of data reported by counties on employment status and insurance coverage was missing or unknown.*
** Values are not shown to protect confidentiality of the individuals summarized in the data. In some cases, data points or response options were removed to ensure calculation of small values cannot be computed.*
*** The "Other" category for Health Care Coverage Status includes the following value options combined: Veterans Administration, Covered California, Uninsured, Other Health Insurance, and CHIP.*
+ First housing status reported for a participant during Initiation Period. Permanent housing generally includes staying or living with family, friends, or independently for a permanent tenure (including with a subsidy). Temporary housing generally includes staying with family, friends, or in transitional housing. Institutional housing includes settings such as jail, prison, juvenile detention, hospital (psychiatric or non-psychiatric), long-term care facility or nursing home, or a SUD treatment facility. More detailed definitions for each living situation type are included in the CARE Act Data Dictionary (derived from the U.S. Department of Housing and Urban Development FY 2024 HMIS Data Standards Data Dictionary).

6.1.2 CARE Petitioners

Table 7 shows that 896 of the 1,960 CARE participants (45.7 percent) were petitioned by a system partner (defined as a hospital director, licensed BH professional treating participant, public guardian, or conservator); 816 (41.6 percent) by someone with a personal relationship to the participant (referred to as a personal petition); 130 (6.6 percent) by a first responder, mobile crisis team, or outreach worker; and 72 (3.7 percent) by themselves. Among those with CARE agreements or CARE plans, a lower proportion (38.7 percent) came from personal petitions, compared to those from system partners (49.7 percent). Among the dismissed petitions that were diverted to elective services, 51.0 percent came from personal petitions and 34.4 percent from system partners. Among the dismissed petitions that were not connected to county services, 47.1 percent came from personal petitions and 39.6 percent from system partners.

Table 7. Origin of CARE Petitions, by Disposition Type

Origin of Petition	Total CARE Participants (n=1,960) n (%)	CARE Agreements and Plans (n=517) n (%)	Dismissed (Elective Clients) (n=192) n (%)	Dismissed (Not Receiving County Services) (n=497) n (%)
Personal Petition (e.g., spouse, domestic partner, or family member of participant; person who lives with participant)	**816 (41.6%)**	**200 (38.7%)**	**98 (51.0%)**	**234 (47.1%)**
A spouse or registered domestic partner, parent, sibling, child, or grandparent of the participant	706 (36.0%)	176 (34.0%)	81 (42.2%)	201 (40.4%)
A person who stands in the place of a parent to the participant	29 (1.5%)	*	*	*
A person who lives with the participant	81 (4.1%)	*	*	*

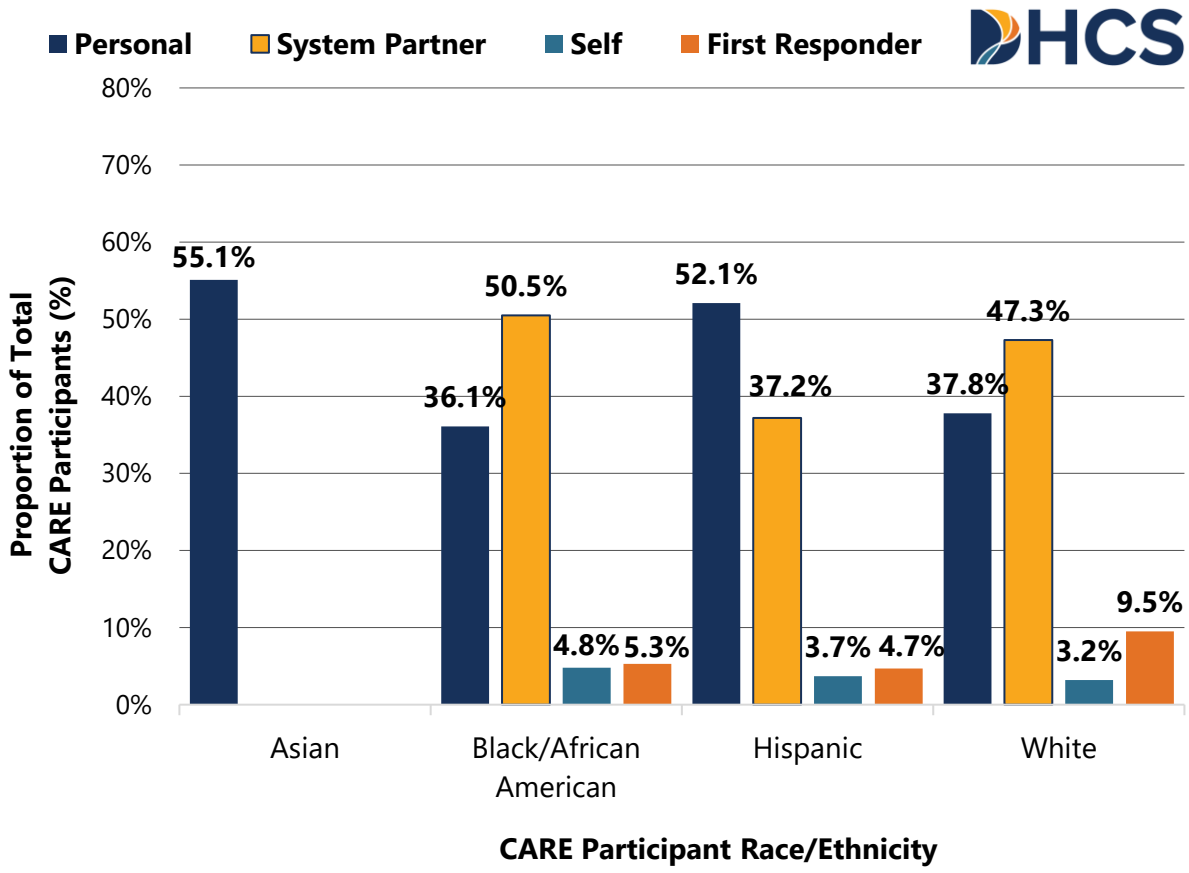
Origin of Petition	Total CARE Participants (n=1,960) n (%)	CARE Agreements and Plans (n=517) n (%)	Dismissed (Elective Clients) (n=192) n (%)	Dismissed (Not Receiving County Services) (n=497) n (%)
System Partner Petition (e.g., Director of hospital, licensed BH professional treating participant, public guardian, or conservator)	**896 (45.7%)**	**257 (49.7%)**	**66 (34.4%)**	**197 (39.6%)**
The public guardian or public conservator	141 (7.2%)	46 (8.9%)	*	*
The director of a public or charitable organization, agency, or home providing behavioral health services to the participant	44 (2.2%)	*	*	*
The director of a hospital in which the participant is hospitalized	138 (7.0%)	*	*	28 (5.6%)
The director of the county behavioral health agency	266 (13.6%)	116 (22.4%)	16 (8.3%)	53 (10.7%)
A licensed behavioral health professional who is or has been, within the reporting month, treating or supervising the treatment of the participant	307 (15.7%)	73 (14.1%)	25 (13.0%)	95 (19.1%)
Petition from first responder, mobile crisis team, outreach worker	**130 (6.6%)**	**28 (5.4%)**	**14 (7.3%)**	**43 (8.7%)**
Self-Petition by Participant	**72 (3.7%)**	**23 (4.4%)**	**12 (6.3%)**	**13 (2.6%)**
Data Missing or Unreported	**31 (1.6%)**	*	**0 (0.0%)**	*

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.*
** Values suppressed to protect confidentiality of the individuals summarized in the data. Data for the following petitioner types were too small to be displayed: Director of adult protective services, Director of a California Indian Health Services Program, and California Tribal Court Judge.*

Differences in the origin of CARE petitions were observed across CARE participants of different races/ethnicities (**Figure 13**).[51] Personal referrals were the largest source overall for CARE participants, especially for Asian (55.1 percent) and Hispanic (52.1 percent) participants. The converse was observed among Black/African American and White CARE participants, where system partner referrals were the dominant source for Black/African American participants (50.5 percent) and were also substantial for White participants (47.3 percent). Self-referrals and first responder referrals were consistently low across all groups, generally accounting fewer than 10 percent of participants regardless of race/ethnicity.

[51] Among the 10.7% of CARE petitions missing race/ethnicity data (n=209), the distribution of petitioners reflects that of the overall petitioned population: System partner (48.3%), personal (37.8%), first responder (6.2%), self (4.3%). Petitioners for those with missing or unknown race/ethnicity data were not included in the racial disparity analysis.

Figure 13. Origin of CARE Petitions, by CARE Participant Race/Ethnicity (n=1,960)



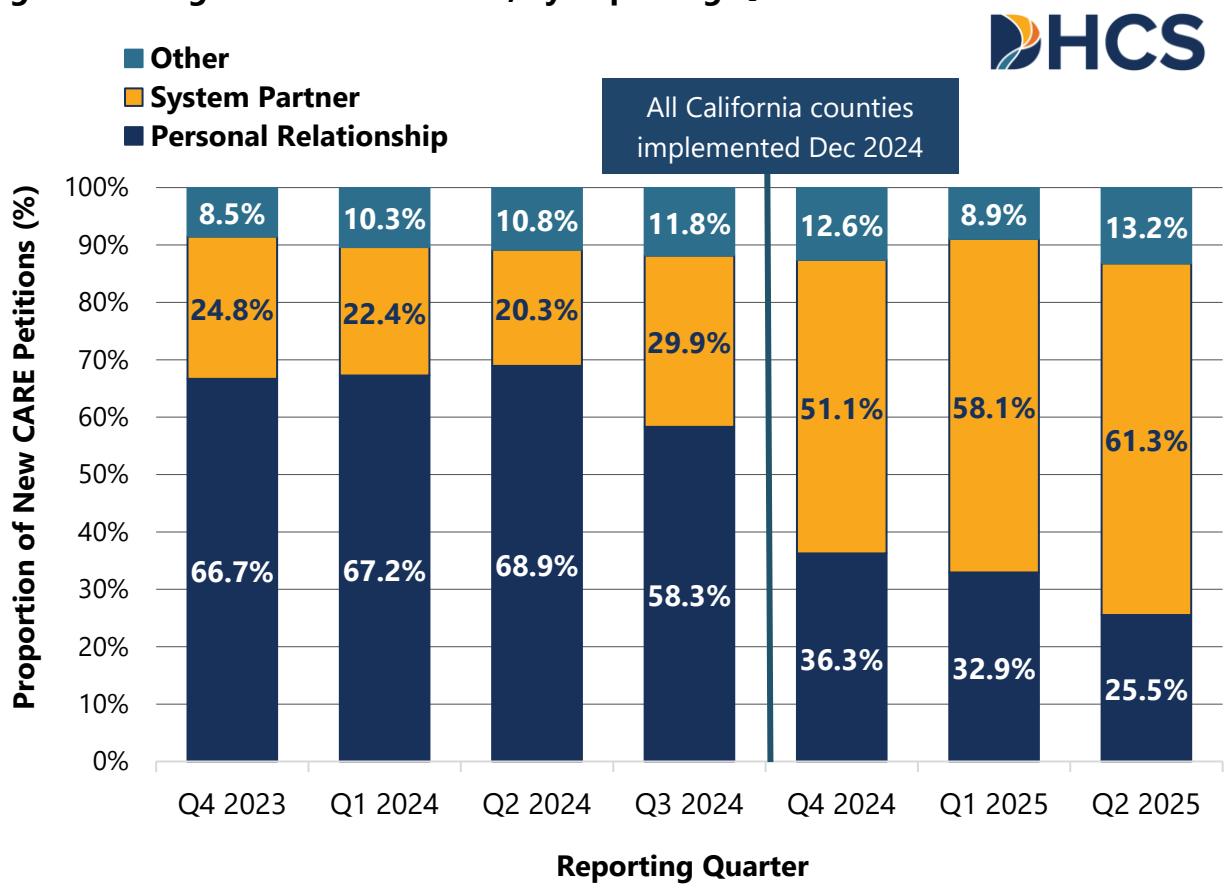
***Data Source**: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
***Note:** For Asian participants, data on system partner, self, and first responder petitions have been suppressed to protect confidentiality of the individuals summarized in the data.*

Figure 14 shows that the origin of CARE petitions has shifted since the CARE Act was implemented in 2023. Over the implementation period, the proportion of all petitions originating from a system partner has increased, from about a quarter of petitions (24.8 percent) in Q4 2023 to over half (61.3 percent) in Q2 2025.[52] In contrast, the proportion of all petitions originating from individuals with a personal relationship to the petitioner

[52] This analysis compares data from the first quarter of reported CARE Act data (October 1–December 31, 2023, by the seven Cohort I counties and Los Angeles County) to the data reported as of June 20, 2025 (including full implementation of CARE by all counties).

has decreased over time, from about two-thirds (66.7 percent) of all petitions in Q4 2023 to about a quarter of petitions (25.5 percent) in Q2 2025.

Figure 14. Origin of CARE Petitions, by Reporting Quarter



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.*
Note: *Cohort I Counties, began implementing CARE in October 2023; Los Angeles County began implementing CARE in December 2023; All other counties implemented CARE by December 2024.*

CARE Petitioners: Changing Landscape

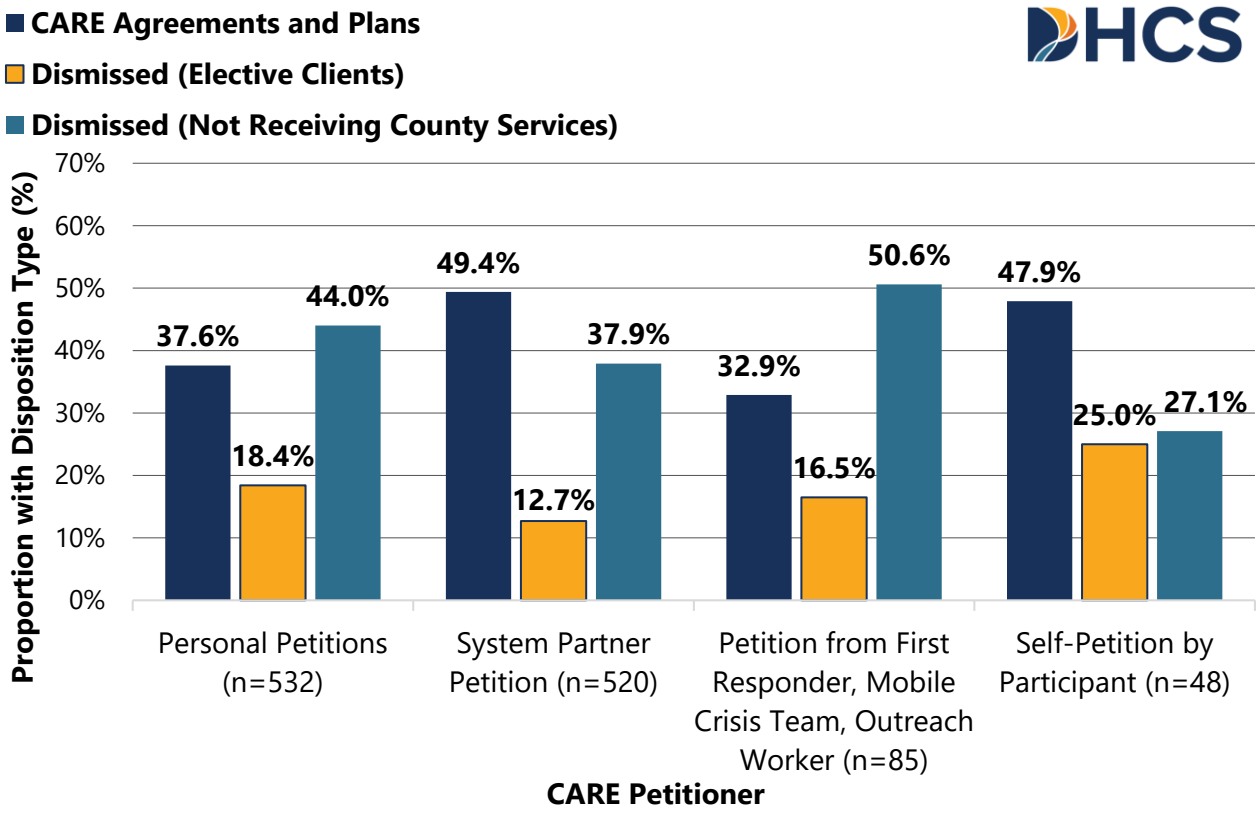
The source of CARE petitions has changed over the course of CARE implementation.

- **The proportion of total CARE petitions by someone with a personal relationship to the participant** (referred to as a personal petition) ***decreased*** **from 66.7 percent of petitions during the first quarter of CARE Act implementation to 25.5 percent in June of 2025 (last available quarter of data at the time of this report).**
- **The proportion of total CARE petitions from system partners** (defined as a hospital director, licensed behavioral health professional treating participant, public guardian, or conservator) ***increased*** **from 24.8 percent of petitions in December 2023 to 61.3 percent in June of 2025.**
- The proportion of total petitions from participants (self-petitions) and petitions from first responders have not noticeably changed.

As CARE implementation expanded statewide and evolved, petition initiation shifted from being primarily family-driven to system-driven, indicating increased engagement by system partners across counties.

Differences were observed in the initial CARE disposition ordered for CARE participants originating from different petitioners. Nearly half (49.4 percent) of system-petitioned CARE participants and self-petitioned individuals (47.9 percent) with an initial disposition had a CARE agreement or CARE plan approved at the time of their initial disposition, compared to 37.6 percent of those petitioned by someone with a personal relationship to the participant (personal petition) and 32.9 percent of those petitioned by a first responder. Half of CARE participants (50.6 percent) with an initial disposition petitioned by first responders were dismissed at the time of their initial disposition and not provided county services and supports, compared to 44.0 percent of participants petitioned by an individual with a personal relationship to the participant, 37.9 percent of participants petitioned by a system partner, and 27.1 percent of self-petitioned participants, as seen in **Figure 15**.

Figure 15. Initial Disposition Ordered for CARE Participants, by Original Petitioner Type



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.*

6.1.3 Median Time to Initial Disposition and CARE Eligibility Determinations

Table 8 shows that across the 1,206 CARE participants with an initial petition disposition, the median number of days from petition to initial disposition was 76 calendar days, or approximately 11 weeks (IQR[53] 44–129 days).[54] For 15.0 percent of

[53] IQR (interquartile range) represents the span between the 25th and 75th percentiles, indicating where the middle 50% of values fall. Here, half of petitions received a disposition between 44 and 129 days from filing.

[54] The CARE Act statutory framework (WIC § 5977.1) provides a timeline for various steps that support outreach and engagement to individuals petitioned to CARE and lays out sequential hearings before CARE agreements may be approved or CARE plans ordered.

CARE participants with an initial disposition, the disposition occurred within 30 calendar days from the date the petition was filed.

The median time to initial disposition was approximately two weeks shorter among those with a CARE agreement (62 calendar days, almost 9 weeks; IQR: 38–109) than those with a CARE plan (75 calendar days, almost 11 weeks; IQR: 25–106) and dismissed (elective) clients (76 days, almost 11 weeks; IQR: 49–128). The initial disposition process for CARE participants who were dismissed and did not receive county services and supports took the longest, with a median of 89 calendar days (almost 13 weeks; IQR 55-154).

County Exemplars: Time to Initial Disposition

Counties are expected to work together with courts to investigate the appropriateness of the CARE Act for petitioned individuals. Counties showed wide variation in the time taken to arrive at an initial disposition. **Accounting for outliers, counties ranged from 40 to 85 days for the middle 50 percent of petitions to reach an initial disposition.** 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.

The **San Diego County** Behavioral Health CARE team highlights success factors, including strong coordination with their public defenders to outreach and engage petitioned individuals. They emphasize evidence-informed motivational interviewing techniques and the use of incentives, such as offers to meet basic needs like food, housing, and connections to critical resources. These efforts prioritize relationship-based engagement and meeting individuals where they are to build trust and rapport. The CARE team also made efforts to develop CARE agreements with CARE participants, presenting these at the initial court hearing.

Table 8. Time from CARE Petition to Initial Disposition (Calendar Days)

Participant Group	Median	IQR
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

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.*

Wide variation was identified in median time to disposition across counties of different sizes. In dense counties, the median time to disposition was 83 calendar days (IQR: 49–139), compared to rural and small counties, which took a median of 48 calendar days (IQR: 25–75) and 50 calendar days (IQR: 23–71) respectively to reach a first disposition (data not shown).

6.2 Outreach and Engagement to CARE Participants Prior to Initial Disposition

During a CARE participant's Initiation Period, a range of activities can occur simultaneously, including outreach and engagement, service and support delivery, county investigation and information gathering for the purposes of court disposition , and trust building with the participant.

Beginning in January 2025, counties began to report information on outreach and engagement efforts to individuals, per SB 1400. Of the 1,960 CARE participants reported since the start of implementation, this additional data was available for 1,328 participants who were still in their Initiation Period, prior to their first disposition, between January 1, 2025 and June 30, 2025.

With regard to outreach to and engagement of CARE participants during their Initiation Period, there was considerable variation observed across counties. **Table 9** shows that a total of 4,427 one-way outreach attempts and 12,739 engagements (two-way interactions) were reported across the 47 county BH agencies with at least one CARE

participant in their Initiation Period between January 1 and June 30, 2025. Eight counties did not report any outreach or engagement events to CARE participants in their Initiation Period (data not shown).

Out of the 1,328 individuals still in the CARE Initiation Period, prior to an initial disposition, 345 (26.0 percent) did not have an outreach attempt or engagement effort reported. These 47 counties reported a median of 7.7 (IQR: 2.5-15.5) total outreach and engagements per individual, with wide variations.

Notably, medium counties reported the highest number of outreach and engagement efforts, with a median of 17.2 (IQR: 7.7-22.1) compared to 5.0 (IQR: 1.4-11.7) among small counties (data not shown). Dense counties reported a median of 11.0 (IQR: 0.8-12.0), and rural counties reported a median of 6.9 (IQR: 3.1-15.0) total outreach and engagements per individual (data not shown).

Table 9. Outreach and Engagement to Individuals Prior to Initial Disposition

Outreach and Engagement	Prior to Initial CARE Petition Disposition January 1–June 30, 2025± (n=1,328)
Total Outreach Attempts	4,427
Median Number of Outreach Attempts Per Participant	3.0 (IQR 0.7-6.6)
Total Engagement Events	12,739
Median Number of Engagement Events Per Participant	3.8 (IQR 1.0-8.4)
Total Outreach and Engagement	17,166
Median Number of Outreach and Engagement Events Per Participant	7.7 (IQR 2.5-15.5)

Data Source: *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: January–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
±Includes the 47 counties who reported one or more CARE participants in their Initiation Period.

County Exemplars: Relentless Outreach and Engagement

Engagement with the CARE population is critical, yet it is often complicated by significant barriers, including historical distrust of public systems, challenges locating individuals, and varying interest levels in receiving treatment. CARE addresses these realities by allowing for administrative claiming for outreach and engagement activities, which allows CARE teams to be compensated for the time and effort required to conduct sustained, relationship-based outreach.

Many counties are taking advantage of this component of CARE and are developing processes to engage CARE participants early in the CARE petition process. In **San Diego County**, the CARE team emphasizes an intensive, proactive approach focused on reaching individuals who have not historically been well served by the behavioral health system.

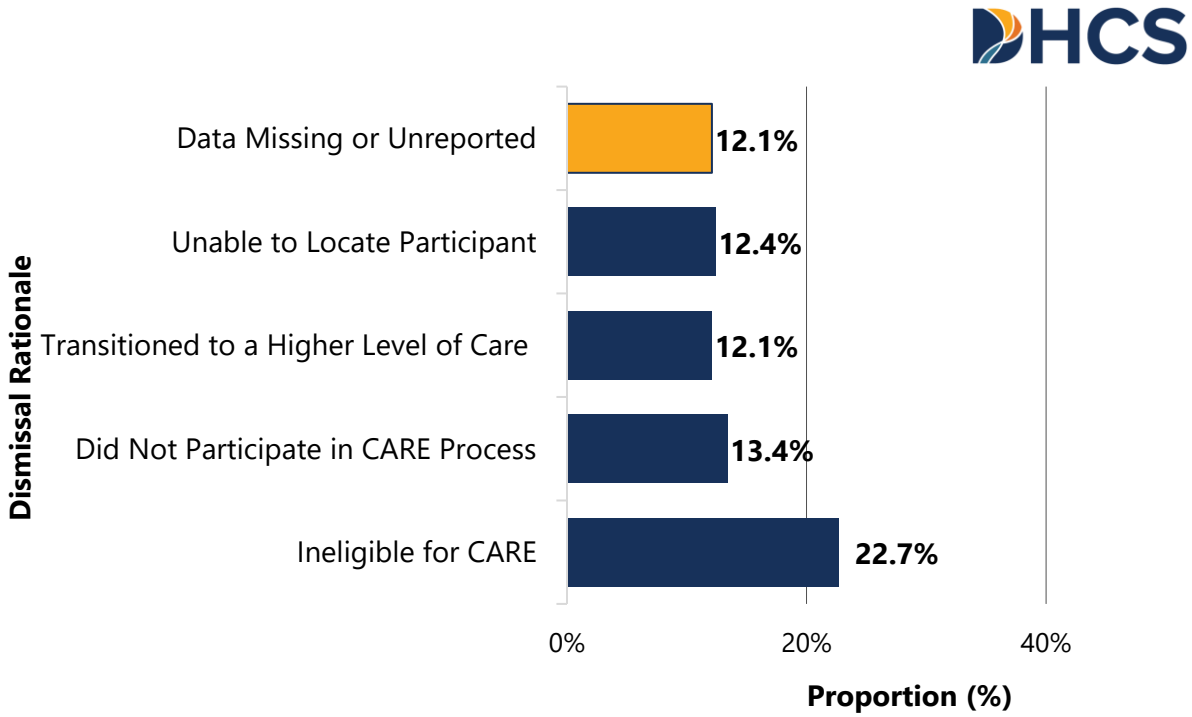
Effective strategies include:

- **Building personal and human connections with participants:** Outreach staff make concerted efforts to contact and meet with individuals one-on-one within two weeks of a petition being filed. These early interactions focus on understanding the individual's interests and personal goals and establishing a foundation of trust to support participation in CARE.
- **Strengthening coordination with family and supports:** Engagement strategies intentionally include family members and close contacts, supporting their participation in petitioning and supporter roles and reinforcing a more connected, supportive engagement process.

6.3 First Disposition Dismissals and Eligibility Determinations

Beginning in January 2025, county BH agencies began to report information on the rationale for an initial CARE petition disposition of dismissed, per SB 1400. Between January 1, 2025 and June 30, 2025, 387 CARE participants had an initial CARE petition disposition of dismissed, without a CARE agreement or CARE plan. **Figure 16** shows the most common reasons for dismissal among these individuals including participant ineligibility (22.7 percent), nonparticipation in CARE process (13.4 percent), transition to a higher level of care (12.1 percent), and inability to locate the participant (12.4 percent).

Figure 16. County-Reported Rationale for CARE Participants with Initial Disposition of Dismissed, without CARE Agreement or CARE Plan (Multi-Select Variable, n=387)



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.*
Note*: Data on the proportion of dismissals that did not meet clinical instability CARE eligibility requirements was not included to protect the confidentiality of the individuals summarized in the data.*

There were variations in reasons for CARE petition dismissals (initial dispositions) observed across counties of different sizes. Among rural counties, the most common reasons for these dismissals were participants not engaging in the CARE process or participants who could not be located. In contrast, dense counties reported CARE ineligibility as the most common reason for dismissal, followed by the individual voluntarily engaging in county services as an elective client (data not shown).

Of the 387 CARE participants who were dismissed between January 1 and June 30, 2025 without county services and supports, 299 (77.3 percent)[55] did not receive county services or supports. The most common reasons for dismissal among this group were similar to the overall dismissal rationale provided above.

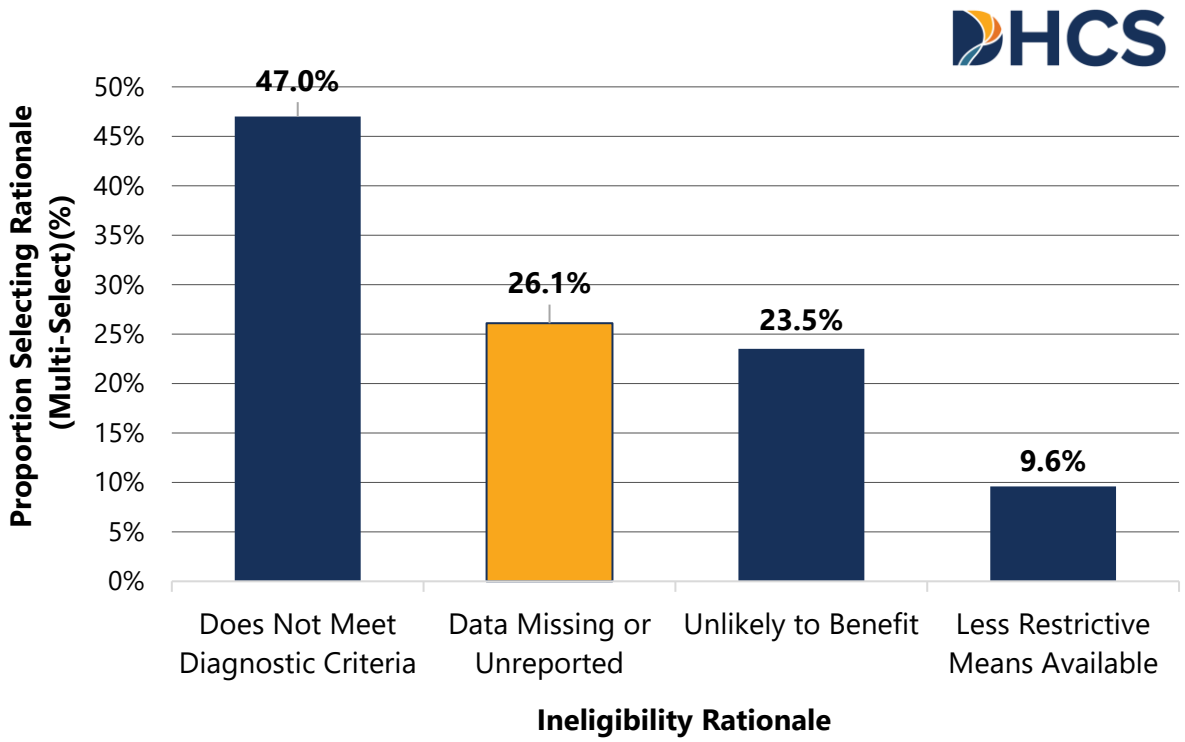
6.4 County Rationale for Determining CARE Ineligibility

Beginning in January 2025, counties were required to report on the rationale provided to courts on why they believed a CARE participant was ineligible for CARE, following county investigation. For the first two quarters of 2025, there were a total of 115 CARE participants dismissed by the courts due to ineligibility for CARE, with Los Angeles and San Diego counties contributing over half of these dismissed petitions.

Figure 17 shows that among the 115 CARE participants dismissed because of CARE ineligibility, the most commonly cited rationale was that the individual did not have a qualifying diagnosis of schizophrenia spectrum and other psychotic disorders (47.0 percent), followed by the county reporting that it was unlikely that the individual would benefit from participation in a CARE plan or CARE agreement (23.5 percent).

[55] This rate is slightly higher than the 72.1 percent of all 689 CARE participants dismissed by the courts between October 1, 2023, and June 30, 2025.

Figure 17. County Rationale for Recommending Initial CARE Petition Disposition of Dismissal Due to CARE Eligibility (n=115)



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.*
Note: *Data on the proportion of dismissals that did not meet clinical instability CARE eligibility requirements was not included to protect the confidentiality of the individuals summarized in the data.*

6.5 Services and Supports Provided to CARE Participants Prior to Initial Disposition on CARE Petition

Beginning in January 2025, counties began to report information on services and supports provided to CARE participants during their Initiation Period, prior to their initial CARE petition disposition, per SB 1400.

Table 10 below summarizes the number and proportion of CARE participants who accessed at least one service or support during their Initiation Period prior to their initial disposition. The term "access" is defined here as a CARE participant being enrolled in or having documented receipt of a service or support at some point during their Initiation Period. Of the 1,328 participants still in the CARE Initiation Period, within the first six months of 2025:

- 22.2 percent had missing or unknown data reported for services and supports accessed during their Initiation Period. This large proportion of missingness impacts how we interpret the data on services and supports that was reported.
- Over half (759, 57.2 percent) accessed a service or support. The most common service accessed was mental health treatment services, with 44.4 percent of CARE participants (590 participants) receiving at least one mental health treatment service (e.g., targeted case management, psychosocial supports) prior to first CARE petition disposition.
- 22.5 percent of CARE participants (299 participants) received stabilizing medications prior to first CARE petition disposition.
- 14.2 percent (188 participants) received a housing service or support (either through a CalAIM benefit or from a county, state, or federally funded program).
- Few CARE participants received SUD treatment (37, 2.8 percent) during this time period.

Of the 1,328 CARE participants before their initial CARE disposition during 2025, 180 (13.6 percent) were enrolled in FSP.

Table 10. Services and Supports Provided to Individuals Prior to Initial Disposition (January 1–June 30, 2025± (n=1,328))

Service or Support Category	Total with Service or Support (n (%))	Total Missing or Unreported (n(%))
Any Service or Support	759 (57.2%)	295 (22.2%)
Mental Health Treatment Service	590 (44.4%)	519 (39.1%)
Stabilizing Medication Prescription or Administration	299 (22.5%)	610 (45.9%)
Housing Service/Support	188 (14.2%)	304 (22.9%)
Specialized Program (Any)	180 (13.6%)	519 (39.1%)
Social Service or Support	60 (4.5%)	519 (39.1%)
SUD Treatment Service	37 (2.8%)	519 (39.1%)

CalAIM Community Support	13 (1.0%)	519 (39.1%)

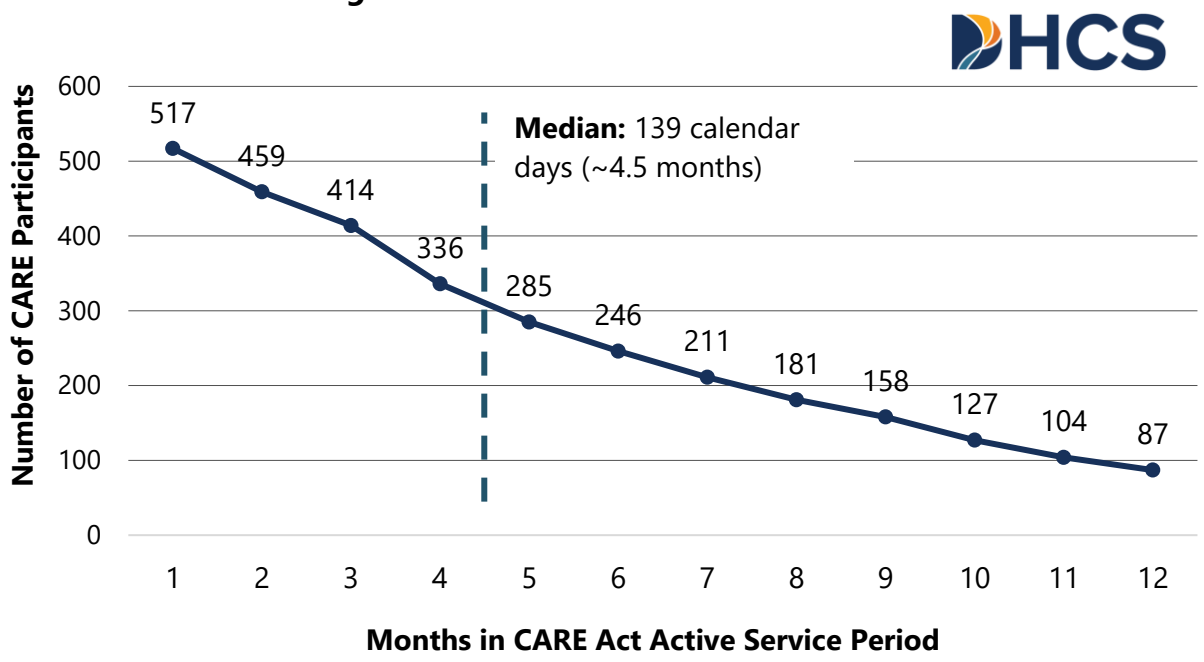
Data Source: *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023–June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*
Note*: About 21.9 percent of data on services and supports accessed by CARE participants in the CARE Initiation Period were missing or unknown. This data should be interpreted with caution.*
Note*: A CARE participant is counted as having housing service/support if they (a) accessed a housing support program (e.g., No Place Like Home, California Housing Accelerator), or (b) received a CalAIM community housing support service (i.e., Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization Housing, or Transitional Rent).*
± Of the 1,960 CARE participants reported since the start of the CARE Act implementation, data on services and supports is available only for the 1,328 participants who were still in the CARE Initiation Period between January 1, 2025 and June 30, 2025.

6.6 Services and Supports Among CARE Participants During Active Service Period

Following initial disposition, counties are responsible for reporting monthly data on services and supports accessed by CARE participants over the course of their Active Service Period (defined as the time from initial disposition to the last day of the reporting period used for this report). The Active Service Period continues for 12 months, or up to 24 months for those reappointed in a CARE agreement or CARE plan.

The median length of time a CARE participant with a CARE agreement or CARE plan was engaged in services and supports during their Active Service Period was 139 calendar days, or just over 4.5 months, with an IQR of 67–271 days. **Figure 18** highlights the number of active CARE participants and the number of months in CARE. Given the median length of time individuals with CARE plans or CARE agreements have engaged in CARE, data trends are restricted to five months to support stability of trends.

Figure 18. Number of Months Accrued in CARE by Active CARE Participants with CARE Plans and CARE Agreements



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.*
Note: *46 counties did not begin implementing CARE until December 1, 2024. For these counties, the maximum amount of time a CARE participant could have been in their CARE Active Service period is seven months.*

6.6.1 Access to Services and Supports Following Initial CARE Petition Disposition Among Participants with CARE Agreements or CARE Plans

For the purposes of this Annual Report, "access" is defined as a CARE participant being enrolled in or having documented receipt of a service or support at some point during their Active Service Period. **Table 11** below summarizes the number and proportion of CARE participants who accessed a service or support during their Active Service Period.

6.7 Accessing Services and Supports

The most common service type accessed by CARE participants with CARE plans or CARE agreements was mental health treatment,[56] with 458 of the 517 CARE participants who had CARE agreements or CARE plans (88.6 percent) receiving at least one mental health treatment service during their Active Service Period (**Table 11**). Participants residing in medium counties appeared to face fewer barriers to mental health treatment access than those living in dense or small counties, with 99.3 percent of participants in medium counties accessing at least one mental health treatment service, versus 85.0 percent and 82.5 percent, respectively, in dense and small counties (not shown in **Table 11**). Nearly two-thirds (321, 62.1 percent) of active participants with CARE agreements or CARE plans received stabilizing medications, with 50.5 percent of those with a stabilizing medication (162 out of 321) receiving a long-acting injectable. Wide county-level variation was observed in the number of participants who received stabilizing medication (33.8–100.0 percent, not shown in **Table 11**).

Most CARE participants with CARE plans and CARE agreements (451, 87.2 percent) were reportedly enrolled in a specialized program at some point during their Active Service Period, most commonly in either FSP[57,58] (224, 49.7 percent of those in a specialized program) or Assertive Community Treatment (ACT) (138, 30.6 percent of those in a specialized program).[59, 60] Few active participants with CARE agreements or CARE plans

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[56] Mental health treatment services include services such as targeted case management, crisis stabilization, psychosocial services, and peer support services. The list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.1 Mental Health Treatment Services Provided.

[57] FSP is a California-specific recovery-oriented, comprehensive service program aimed to assist individuals with serious mental illness and a history of criminal justice involvement or repeat hospital utilization, who are unhoused or at risk of becoming unhoused. During the time period assessed in this report, FSP was a core program within the largest of the five the Mental Health Services Act (MHSA) components: community services and supports (CSS). As of July 1, 2026, the Behavioral Health Services Act took effect in place of the MHSA, making FSP one of three primary, required BHSA components in all counties.

[58] Mental Health Services Oversight and Accountability Commission. Report to the Legislature on Full Service Partnerships. January 2023. Report to the Legislature on Full Service Partnerships, January 2023.

[59] ACT is an evidence-based comprehensive, time-unlimited psychosocial and community-based intervention and alternative to hospitalization for individuals with serious mental illness.

[60] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

were enrolled in Early Psychosis Intervention or Forensic ACT (FACT) during the Active Service Period. A smaller proportion of participants with CARE agreements or CARE plans were enrolled in specialized programs in small counties (57.5 percent) than in medium (92.8 percent) and dense (90.2 percent) counties, possibly reflecting variable availability of these programs.

Table 11. Number and Proportion of Active CARE Participants (n=517) Who Had a Service or Support Provided at Any Time in Active Service Period (ASP), by Category

Program, Service, or Support Category	One or More Service or Support During ASP n (%)	Total Data Missing or Unknown n (%)
Mental Health Treatment Service Targeted Case Management (n=417) Medication Support± (n=372)	458 (88.6%)	50 (9.7%)
Specialized Program (Any) Full-Service Partnership (FSP) (n=224) Assertive Community Treatment (ACT) (n=138)	451 (87.2%)	25 (4.8%)
Stabilizing Medication Prescription or Administration Long-Acting Injectable (n=162)	321 (62.1%)	62 (12.0%)
Social Service or Support SSI/SSP (n=223) CalFresh (n=217)	382 (73.9%)	37 (7.2%)
CalAIM Community Support Housing Transition Navigation Services (n=115) Housing Tenancy and Sustaining Services (n=40)	164 (31.7%)	42 (8.1%)

Program, Service, or Support Category	One or More Service or Support During ASP n (%)	Total Data Missing or Unknown n (%)
SUD Treatment Service	114 (22.1%)	168 (32.5%)*

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.*
Note*: Where possible, the top two most common services or supports within each service category have been included in this table.*
±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.
**For SUD Treatment Services, a large proportion of county-reported data on individual CARE participants was missing or unknown.*

6.8 Housing Services and Supports

Because engagement in evidence-based treatment is difficult when an individual is unhoused or unstably housed, a critical feature of the CARE Act is to promote access to a diverse range of housing services and supports.[61] In all, 26.7 percent of the 517 active CARE participants with a CARE agreement or CARE plan received a CalAIM housing service or support (i.e., CalAIM enrollee benefit), and 42.2 percent received a housing service or support funded through county, state, and federal programs at some point during their Active Service Period (e.g., The No Place Like Home Program, California Housing Accelerator, The Multifamily Housing Program) (**Table 12**). Differences in the proportion of CARE participants receiving housing services and supports were not observed across counties.

Table 12. Number and Proportion of Active CARE Participants (n=517) Who Had a Housing Service or Support Provided at Any Time in Active Service Period (ASP)

Housing Service or Support Category	One or More Service or Support During ASP n (%)	Total Data Missing or Unknown n (%)

[61] Gowda, G.S., Isaac, M.K. Models of Care of Schizophrenia in the Community—An International Perspective. *Curr Psychiatry Rep* 24, 195–202 (2022). https://doi.org/10.1007/s11920-022-01329-0

Any CalAIM Housing Support	138 (26.7%)	42 (8.1%)
Any County, State, or Federally Funded Housing Support (Not CalAIM)	218 (42.2%)	88 (17.0%)

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.*
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.*

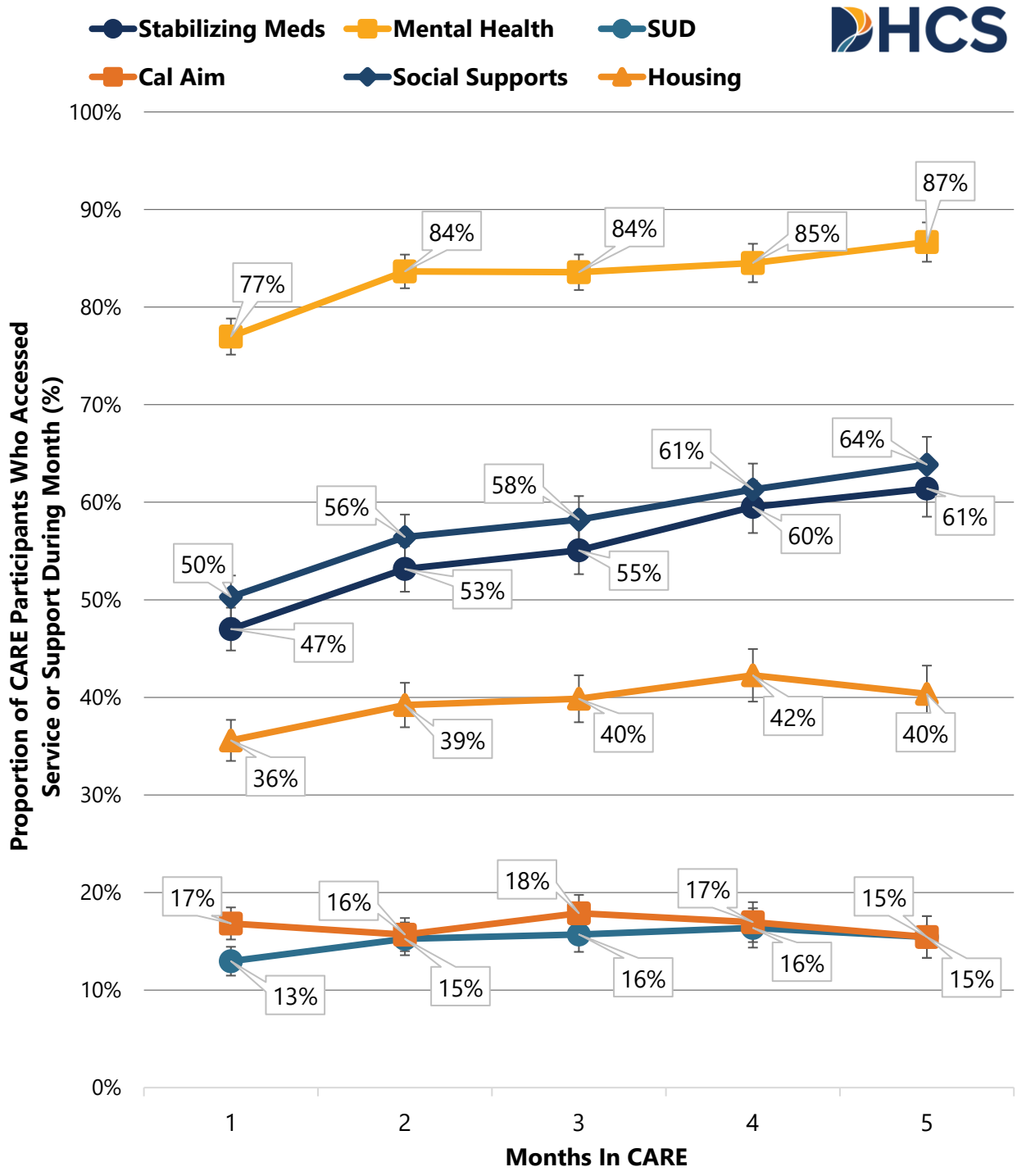
6.9 Trends in Service and Support Access Over a Participant's Time in CARE

Figure 19 shows trends in service and support access among participants with a CARE agreement or CARE plan over their first five months in the Active Service Period.[62] The proportion of participants with CARE plans and CARE agreements who accessed a mental health treatment service[63] increased by nearly ten percentage points from month one in CARE to month five (77.0 percent to 86.7 percent of participants). This same pattern was seen among social services and supports,[64] which increased by nearly 14 percentage points (from 50.3 to 63.9 percent of participants), and stabilizing

[62] Given the median length of time individuals with CARE plans or CARE agreements have engaged in CARE (4.5 months), data trends in this report are restricted to five months to support stability of trends. For this comparison, 517 CARE participants with CARE agreements or CARE plans were included in the month one service/support access proportions and 285 at month five.
[63] Mental health treatment services include targeted case management, crisis stabilization, psychosocial services, and peer support services, among others. The list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.1 Mental Health Treatment Services Provided.
[64] Social services and supports include Supplemental Security Income/State Supplementary Payment (SSI/SSP), CalWORKs, California Food Assistance Program, and education/employment services. The full list of included services is outlined in the CARE Act Data Dictionary 2.0, data point 3.5.17 Social Services and Supports.

medications, which also increased by 14 percentage points (from 47.0 to 61.4 percent of participants).

Figure 19. Services and Supports Provided to Active CARE Participants, CARE Agreements and CARE Plans Only



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.*
Note: *There were 517 CARE participants with CARE agreements or CARE plans included in the month 1 service/support access proportions and 285 at month 5. See Figure 9 of this report for denominators for each month.*
Note: *For SUD Treatment Services, a large proportion of county-reported data on individual CARE participants was missing or unknown. These data were not included in trend analyses.*

Trends in County Services and Supports Over Time

Over the first five months* of a CARE participant's time in the Active Service Period, the most accessed services were mental health, social services, and stabilizing medications, with an *increase* in trends for the receipt of the following key services and supports:

- The proportion of participants who accessed a **mental health service** during the month increased by nearly 10 percentage points, **from 77.0 percent during month one to 86.7 percent by month five** in CARE.
- The proportion of participants who received a **social service or support** increased by nearly 14 percentage points, from **50.3 percent in month one to 63.9 percent by month five** in CARE.
- The proportion of CARE participants who received a **stabilizing medication** increased by 14 percentage points, from **47.0 percent to 61.4 percent from month one to five** in CARE*

** The median length of time individuals with CARE plans or CARE agreements have engaged in CARE is 4.5 months. Data trends in this report are restricted to proportions of individuals during the first five months to support stability of trends.*

6.9.1 Access to Three Evidence-Based Foundations for Recovery

CARE participants are individuals who have severe and persistent symptoms related to serious mental health disorders and who may require additional supports to live safely and independently in the community. 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.[65] Although data on access to each of these individual components are detailed in the section above, the receipt of these three care components together serves as a useful metric for evaluating the impact of the CARE Act's implementation on service access. As **Figure 20** illustrates, 59.6 percent of the 517 CARE participants with CARE agreements or CARE plans were reported to have received all three key services and supports during their Active Service Period.[66] Of those who received two of the three services and supports (29.4 percent), the most commonly observed combination was housing supports and psychosocial and community-based treatment.

Access to Key Services and Supports among CARE Participants: Stabilizing Medication, Behavioral Health Supports, and Housing

Most active CARE participants received multiple key services and supports during their Active Service Period. Specifically, **59.6 percent of the 517 CARE participants with CARE agreements or CARE plans received all three key services—stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports—**and 29.4 percent received two of the three, most often a combination of housing supports and psychosocial treatment.

A few counties demonstrated greater success in providing the three key services and supports to CARE participants with CARE agreements or CARE plans.

- **Stanislaus County** reported that 88.9 percent of participants with CARE agreements or CARE plans received all three key services.
- **San Diego County** reported that 72.7 percent of participants with CARE agreements or CARE plans received all three key services.

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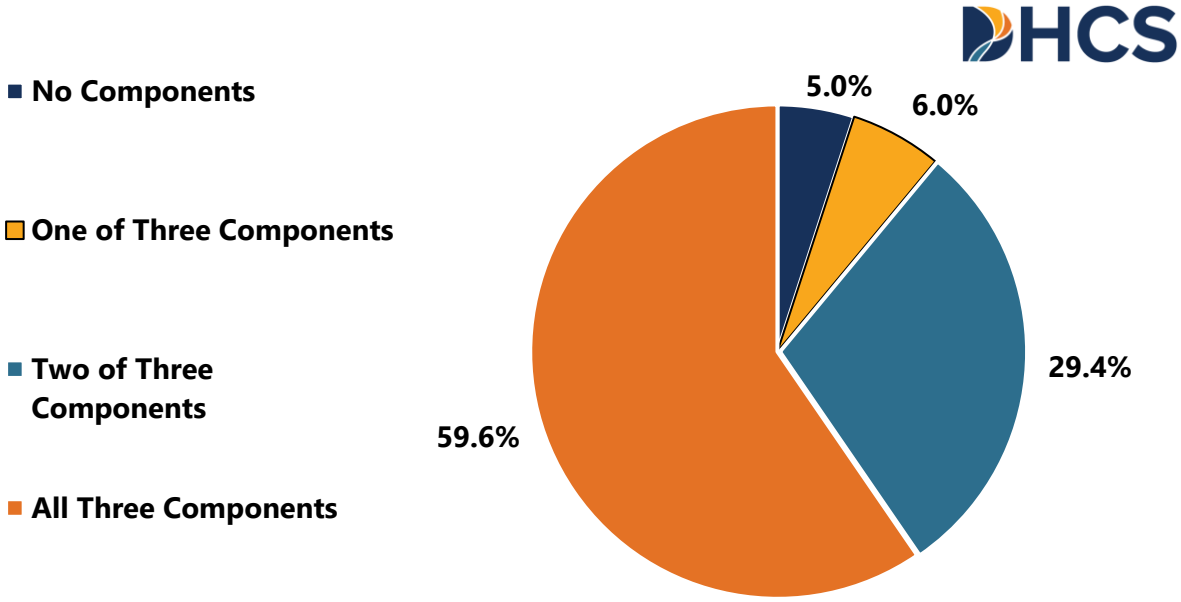
[65] Keepers, G. A., Fochtmann, L. J., Anzia, J. M., Benjamin, S., Lyness, J. M., … Mojtabai, R. (2020). The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. *American Journal of Psychiatry*, *177*(9), 868–872. https://doi.org/10.1176/appi.ajp.2020.177901

[66] 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.

Figure 20. Access to Three Evidence-Based Components± for Recovery Among CARE Participants with CARE Plans and Agreements (n=517)



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.*
± 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.

6.9.2 Most Frequently Ordered Services and Supports Not Provided

The most frequently ordered services and supports not provided at any time to participants with a CARE agreement or CARE plan include mental health treatment services and social services or supports. The most common reasons reported for not providing a mental health treatment service were because the client declined the service. For social services and supports, the most reported reasons were that the county BH agency declined the participant, followed by the participant declined the service. Participants may be denied services because of administrative delays in determining

eligibility or processing applications, as well as lack of available services within the county.

6.9.3 Psychiatric Advance Directives and Volunteer Supporters

The CARE Act emphasizes two key features to support person-centered care for CARE participants: psychiatric advance directives (PADs)[67] and volunteer supporters.[68]

Psychiatric Advance Directives

PADs can be a useful tool to ensure services are delivered to an individual in alignment with their preferences throughout court and beyond.[69,70] At the time of this report, too few PADs had been established for any CARE participant to include in this report. Because participants must have capacity to prepare a PAD, many participants may be unable to establish such a document early in the CARE process. Anecdotal reports from counties suggest that several intend to institute PADs as part of graduation planning.

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[67] A PAD is a legal document that documents and outlines a person's preferences and instructions for future mental health treatment. PADs can be used in supported decision-making processes and have been found to improve outcomes for individuals with SMI and to increase feelings of autonomy and dignity.

[68] Volunteer supporters, as outlined in W&I Code section 5981(a), are individuals who may accompany CARE participants in meetings, judicial proceedings, status hearings, or communications related to an evaluation, development of a CARE agreement or CARE plan, establishment of a PAD, or development of a graduation plan.

[69] Murray H, Wortzel HS. Psychiatric Advance Directives: Origins, Benefits, Challenges, and Future Directions. J Psychiatr Pract. 2019 Jul;25(4):303-307. doi: 10.1097/PRA.0000000000000401. PMID: 31291211. https://pubmed.ncbi.nlm.nih.gov/31291211/

[70] For more information on PADs and the CARE process: Psychiatric Advance Directives & the CARE Process: Toolkit & Checklist – CARE Act Resource Center.

Integrating Psychiatric Advance Directives into the CARE Process

Psychiatric Advance Directives (PADs) empower individuals with serious mental health conditions to document treatment preferences and support person-centered care across engagement, transition, and crisis. Though not yet a common feature of the CARE Act implementation, a few strategies to improve the creation of PADs are highlighted below:

- In **Riverside County**, behavioral health staff, peers, and therapists support individuals in completing PADs as part of ongoing care.
- In **Orange County**, Behavioral Health Services is piloting a digital PAD application while continuing to offer print options. PADs are incorporated into graduation planning and shared with service providers to support continuity after CARE-related involvement. Collaboration with public defenders and behavioral health teams, along with the digital pilot, can lead to improved accessibility, portability, and systemwide responsiveness.

Volunteer Supporters

Volunteer supporters are considered a key feature of person-centered care for CARE participants and may be identified by the CARE participant at any time during the CARE process. **Table 13** identifies the proportion of participants who had an approved volunteer supporter by service period. During the Initiation Period (following CARE petitioning but prior to initial disposition by the courts), 87 CARE participants (4.4 percent) identified their volunteer supporter. During the Active Service Period, 97 (18.8 percent) of 517 participants with a CARE agreement or CARE plan designated a volunteer supporter, which may suggest that active CARE participants are more likely to identify a volunteer supporter.

The median length of time from CARE petition to volunteer supporter identification was 51 calendar days (just over seven weeks) with an IQR of 27–98 calendar days (data not shown). This time span is shorter than the median number of days from petition to first disposition, which was 76 calendar days, or approximately nine weeks, suggesting volunteer supporters, if assigned, are often being identified and assigned in time to accompany CARE participants in initial meetings and proceedings, as directed by the CARE participant. Of the 97 participants with CARE agreements or CARE plans who had a volunteer supporter, the majority had selected a family member as their volunteer supporter (84 participants, 86.6 percent) (data not shown).

Table 13. Proportion of CARE Participants with Assigned Volunteer Supporter, by Service Period

Service Period	Proportion with Assigned Volunteer Supporter (n (%))
Total Participants in Initiation Period (n=1,960)	87 (4.4%)
Total Participants with Assigned Disposition in Active Service Period: CARE Plan or CARE Agreement (n=517)*	97 (18.8%)

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.*
** Volunteer Supporter data only collected for CARE participants with CARE plans and CARE agreements during the Active Service Period.*

The Role of the Volunteer Supporter in CARE

In the CARE process, each respondent may choose and designate a volunteer supporter to assist throughout the CARE process. The supporter should help the respondent understand, make, and communicate decisions and express preferences throughout CARE proceedings. These volunteer supporters may be anyone the CARE participant chooses, like a family member, friend, or community partner, and they are distinct from peer workers on behavioral health teams. Few CARE participants had designated a volunteer supporter during the CARE Initiation Period.

Several resources have been developed to support the uptake of the Volunteer Supporter role, including:

- A video that explains the role of the volunteer supporter in the CARE Act process. The accompanying discussion guide can help county BH staff facilitate conversations with CARE participants and potential volunteer supporters.
- A Volunteer Supporter Toolkit (available in 23 languages) that provides trainings, briefs, and other resources that can help both the volunteer supporter and respondent navigate the CARE process.

6.10 County Capacity to Meet CARE Participant Needs

6.10.1 Acute Medical, Psychiatric, or Law Enforcement-Related Events

Figure 21 below summarizes the proportion of active participants with CARE plans or CARE agreements who had an event that may signal a need that was not addressed within a community-based setting at some point during their Active Service Period. These events include criminal justice involvement, such as jail or prison encounters, arrests, citations, or bookings; LPS conservatorships; LPS holds; emergency department (ED) visits; hospitalizations; or death.[71]

Overall, 57.3 percent of the 517 participants with a CARE plan or CARE agreement had one or more of these events during their Active Service Period, the most reported of which was criminal justice events (38.3 percent had at least one episode). Notably, participants residing in dense counties had lower criminal justice involvement, by an average of 30 percentage points, than participants living in medium counties (data not shown).

Other experiences encountered by participants with a CARE plan or CARE agreement at some point in their Active Service Period included inpatient hospitalizations (20.9 percent), ED visits (20.5 percent), LPS holds (18.4 percent), and LPS conservatorship (3.5 percent).[72] The occurrence of these events did not appear to vary over the first several months that CARE participants were engaged in their Active Service Period, reflecting a need to develop and build strong cross-system partnerships (e.g., among BH, first responders, jails, hospitals, LPS facilities) to reduce negative encounters for this high-acuity population. These needs may be particularly urgent for counties that display high incidences of these events among their CARE participants.

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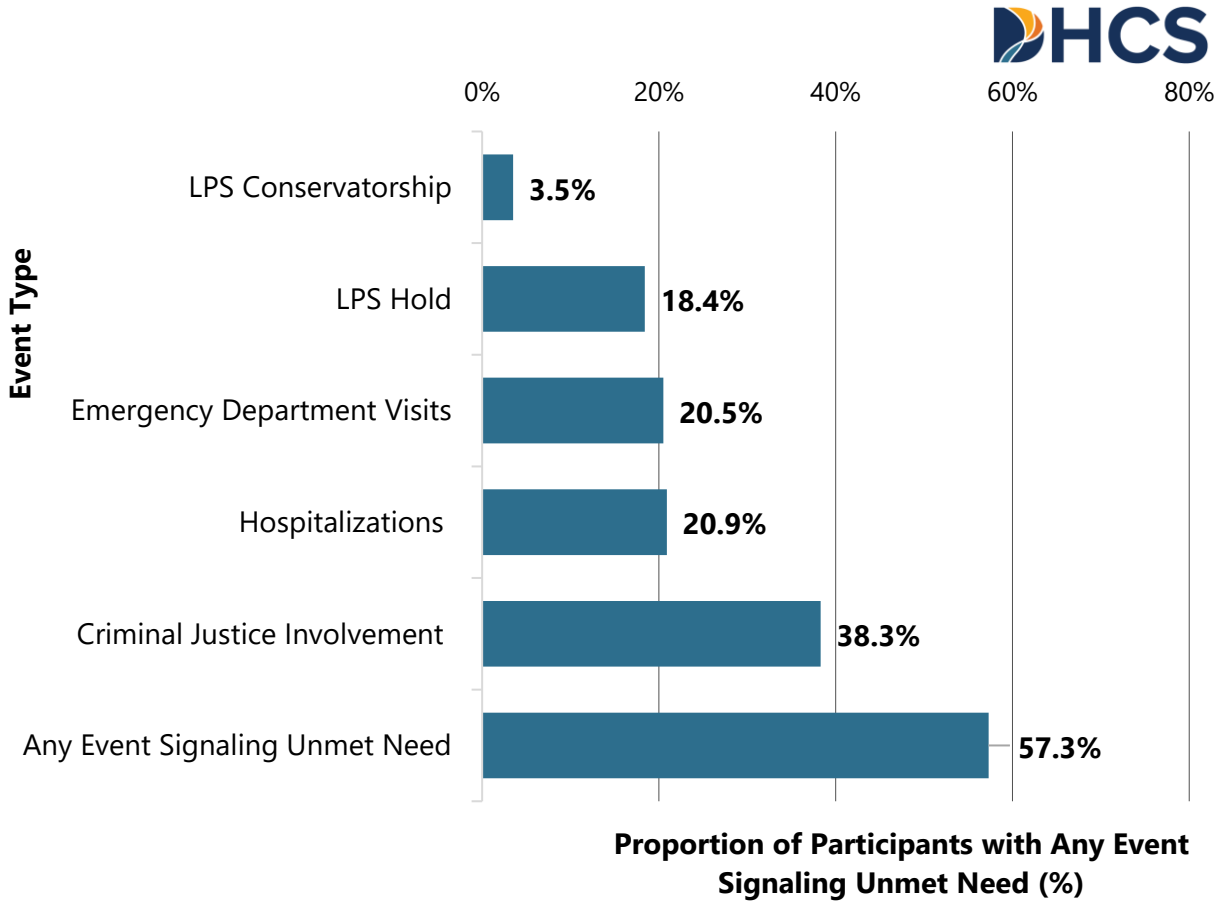
[71] County BH agencies reported known deaths among CARE participants during the period covered by this report. These numbers are too small to be included.

[72] Missing/unknown data varied across these variables. County BH agencies reported low rates of missing data on criminal justice involvement (5.0 percent) and LPS holds and LPS conservatorships (both at 6.2 percent). Higher missing/unknown data were observed for ED visits (11.2 percent missing/unknown) and hospitalizations (17.2 percent). Data on ED visits and hospitalizations should be interpreted with caution.

Figure 21. Proportion of Participants with CARE Agreement or CARE Plan with Any Event that May Signal Unmet Need within Active Service Period (n=517)



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.*
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.*

6.11 Housing/Living Situation

Although permanent housing is a long-term goal for CARE participants, it is commonly recognized that living situations will likely evolve over time, as they reflect the needs of individuals as they progress through the CARE process. Individuals may gain or maintain

shelter/housing (temporary or permanent) or reside in an institutional or residential care setting.[73]

Among the 517 active participants with CARE agreements or CARE plans, 485 (93.8 percent) reported at least two months of data on their living situation—a baseline from their time of petitioning (Initiation Period) and at least one in their Active Service Period. For this implementation report, the three living situation metrics of interest include:

1. Gaining or maintaining shelter/housing (temporary or permanent housing)
2. Placement in an institutional or residential care setting
3. Becoming unsheltered/unhoused

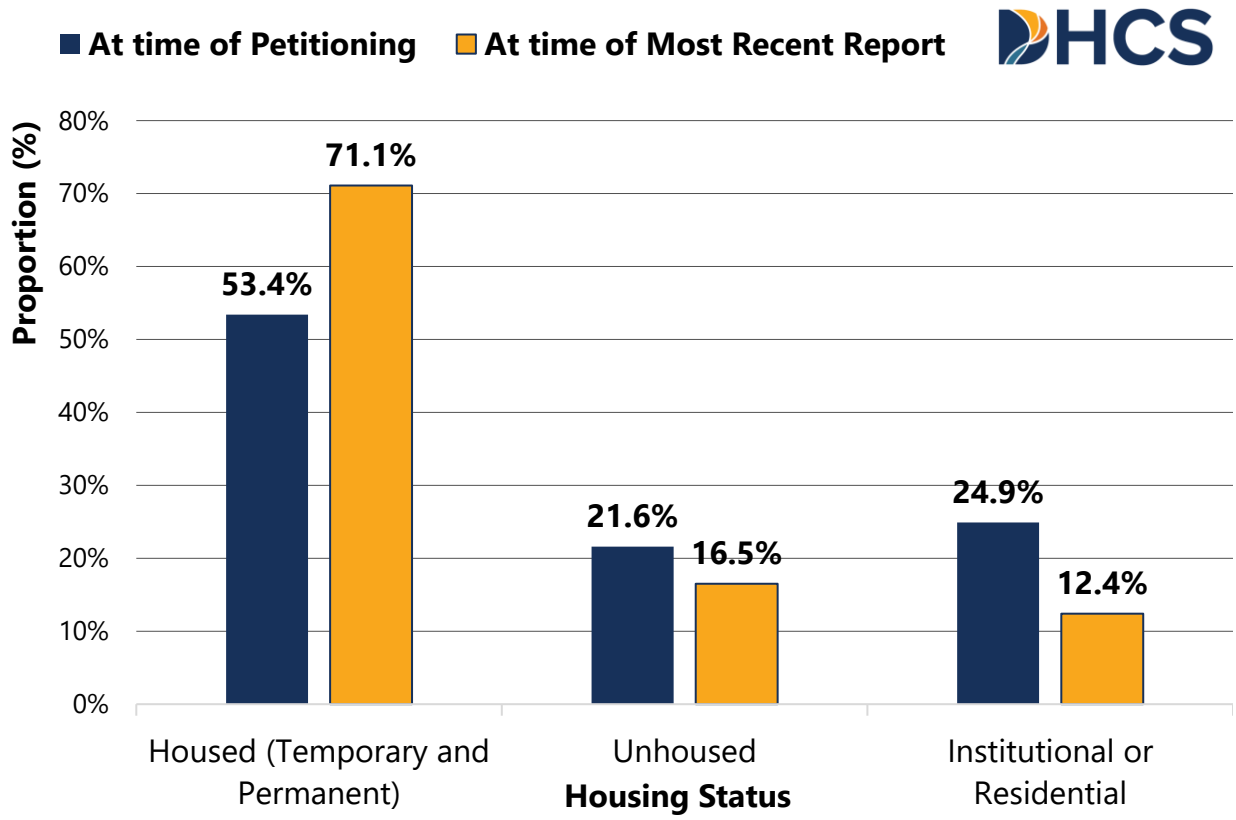
Overall, 485 participants with a CARE agreement or CARE plan reported at least two months of data on their living situation. As shown in **Figure 22**, the proportion of CARE participants who were housed in either temporary or permanent housing grew from 53.4 percent (n=259) at the time of their petitioning to 71.1 percent (n= 345) during their most recent month of data at the time of this report. The proportion of unhoused participants fell between these two time periods, from 21.6 percent (n=105) to 16.5 percent (n=80). Finally, the proportion of participants residing in an institutional or residential setting decreased from 24.9 percent (n=121) to 12.4 percent (n=60).

These early findings highlight the complex nature of the living situations among CARE participants and the ongoing need to support their housing needs. It is important to note that these data represent point-in-time living situations for CARE participants, many of whom are still progressing through the CARE process. These cross-sectional snapshots are limited but indicate living situations for these individuals may change frequently. These findings underscore the importance of continued coordination across county systems and sustained CARE team engagement to identify appropriate housing, adjust supports as needs change, and provide the ongoing assistance necessary to help

[73] Per the current CARE Act Data Dictionary 2.0, living situations are categorized into four primary classifications in alignment with the U.S. Department of Housing and Urban Development (HUD) Data Standards: (1) Homeless (unhoused), (2) Institutional, (3) Temporary Housing, and (4) Permanent Housing. "Institutional [living] Situations" are defined as: a foster care home or foster care group home; a hospital or other residential non-psychiatric medical facility; a jail, prison, or juvenile detention facility; a long-term care facility or nursing home; a psychiatric hospital or other psychiatric facility; or a substance abuse treatment facility or detox center. The full list of included living situations is outlined in the CARE Act Data Dictionary 2.0, Appendix G: Living Situations Options List.

participants obtain and maintain the most appropriate and safe living situations that align with their current needs.

Figure 22. Living Situation at Time of Petitioning and At Most Recent Report (n=485)



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.*

Note: *Among the 517 Active CARE participants with CARE agreements or CARE plans, 485 reported at least two months of housing status data: a baseline from their time of petitioning (Initiation Period) and at least one in their Active Service Period. At the time of petitioning 259 participants were housed, 121 participants resided in an institutional or residential setting, and 105 participants were unhoused.*

Note: *Per the CARE Act Data Dictionary 2.0, living situations are categorized into four primary categories, in alignment with the U.S. Department of Housing and Urban Development (HUD) Data Standards: (1) Homeless (unhoused), (2) Institutional, (3) Temporary Housing, and (4) Permanent Housing. "Institutional [living] Situations" are defined as a: foster care home or foster care group home; hospital or other residential non-psychiatric medical facility; jail, prison, or juvenile detention facility; long-term care facility or nursing home; psychiatric hospital or other psychiatric facility; or substance abuse treatment facility or detox center. The full list of included*

living situations is outlined in the CARE Act Data Dictionary 2.0, Appendix G: Living Situations Options List.

Early Findings: Living Situations Among CARE Participants

These early findings highlight the complex nature of the living situations among CARE participants and the ongoing need to support the housing support needs of CARE participants as they move through the CARE program.

- Among the **259 individuals housed at the time of petitioning, 214 (82.6 percent) were housed (temporary/permanent) during the last month of reporting**, while a small proportion (24 or 9.3 percent) resided in institutional or residential care settings or became unhoused (21 or 8.1 percent).
- Among the **121 participants who were in an institutional or residential placement setting at the time of petitioning, 84 (69.4 percent) had become housed (temporary or permanent) in a non-institutional setting during the last month of data reported** for their Active Service Period.
- Among the **105 participants who were unsheltered at the time of petitioning, 47 (44.8 percent) became sheltered or housed (temporarily or permanently), a small portion resided in an institutional or residential care setting by the most recent reporting month** of their Active Service Period.

Counties are implementing creative and adaptive housing solutions that expand options, promote stability, and integrate supportive services to foster independence and reduce stigma.

In **Siskiyou County**, the new Siskiyou Village tiny home shelter program includes dedicated units for CARE Act participants and continues to explore long-term housing pathways that enhance client stability and autonomy. Meanwhile, **Los Angeles County** is repurposing existing housing stock—such as converting hotels and expanding residential care programs—to create more inclusive, service-rich environments.

These models collectively demonstrate how flexible housing strategies can meet diverse needs while promoting dignity and community connection.

6.12 Exiting the CARE Process

6.12.1 Graduations from CARE and Re-Appointments to CARE

Per WIC 5977.3, the CARE court is required to hold a one-year status hearing for CARE participants with a CARE plan in the 11th month of the CARE process timeline.[74] In this hearing, CARE participants, their counsel or supporter, the judicial officer, and the county BH agency jointly review and discuss the CARE progress report submitted on behalf of the participant by the county BH agency. At this hearing, CARE participants may request graduation from the program and begin to develop a voluntary graduation plan with the county BH agency, or be reappointed for up to one year.

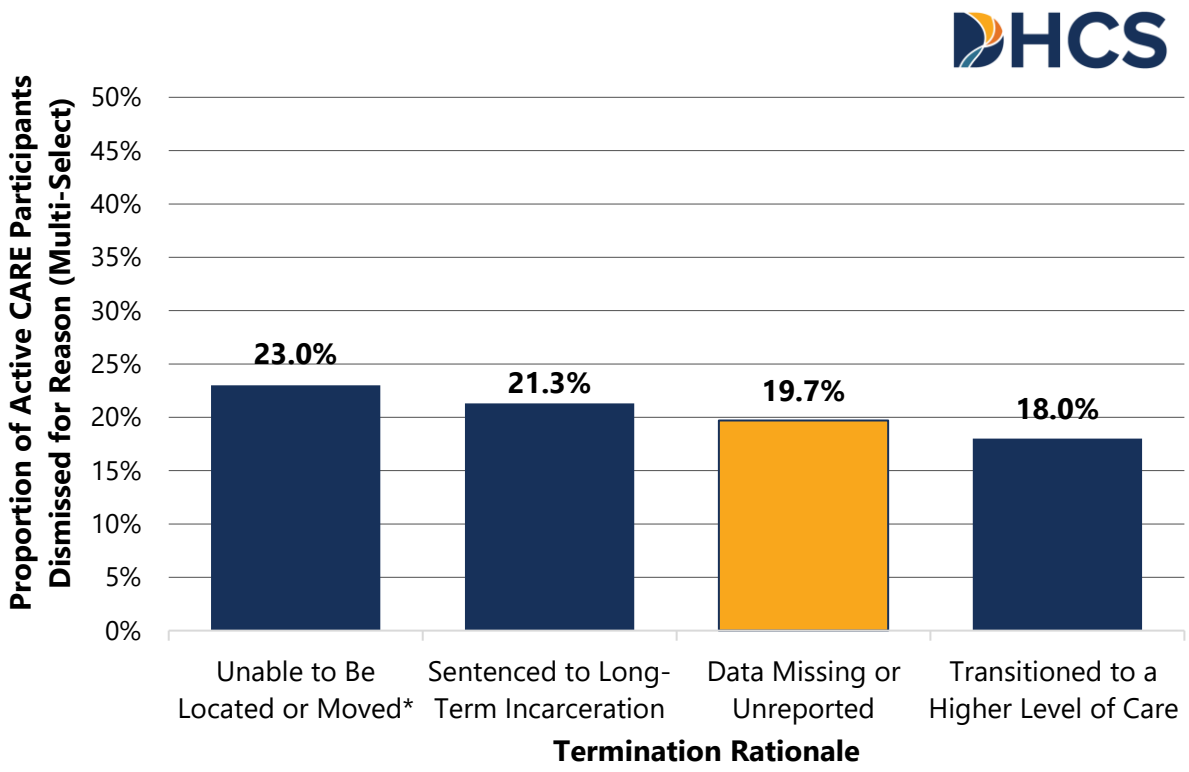
As of June 30, 2025, 32 CARE participants with CARE agreements or CARE plans had graduated from CARE. The median time spent on a CARE agreement or CARE plan among graduates was 13 months. In addition, 26 CARE participants were reappointed (mostly voluntarily) after 12 months on their CARE agreement or CARE plan.

6.12.2 Exit from a CARE Plan or CARE Agreement Prior to 12 Months of Active Service

A total of 61 CARE participants' cases were dismissed before graduating or completing 12 months on a CARE plan or CARE agreement. The median time spent on a CARE agreement or CARE plan among CARE participants with early exits was nearly six months (175 days, IQR 101-288 days). As **Figure 23** illustrates, the most common primary reasons for early exit included inability to locate the participant (23.0 percent), the participant being sentenced to long-term incarceration (21.3 percent), or transition to a higher level of care (18.0 percent).

[74] Although referred to as a "one-year status hearing," in practice, courts are holding these hearings and approving graduation plans for CARE participants prior to 12 months of Active Service in a CARE agreement or CARE plan.

Figure 23. County-Reported Rationale for Dismissals Prior to 12 Months of Active Service Among CARE Participants with CARE Plans or CARE Agreements (n=61)



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.*
**Unable to be located is used to describe CARE participants who were reported to have moved away, transferred to another county, or were unable to be located.*

7. COUNTY PROVISION OF SERVICES TO ELECTIVE CARE CLIENTS

The group of elective clients in this 2026 Annual Report includes a broader definition of CARE participants, who county BH agencies are required to track, regardless of CARE eligibility. Over the course of CARE Act implementation, 192 CARE participants became elective clients and received county services and supports outside of court jurisdiction. These 192 participants, who were reported by only 19 counties, appear similar to those with CARE agreements or CARE plans in terms of socio-demographic characteristics.

Elective Client Definition: Changes Over Time and Impact on CARE Data Collection and Analysis

Prior to January 2025, counties were only responsible for reporting on dismissed participants who were CARE-eligible and, rather than enter into a CARE agreement or CARE plan, chose to receive county services and supports as an elective client.

Beginning in January 2025, the definition of an elective client has broadened to include a CARE participant who receives services and supports outside CARE court jurisdiction, whether they were found to be eligible for CARE. This may include receipt of services under AOT or LPS.

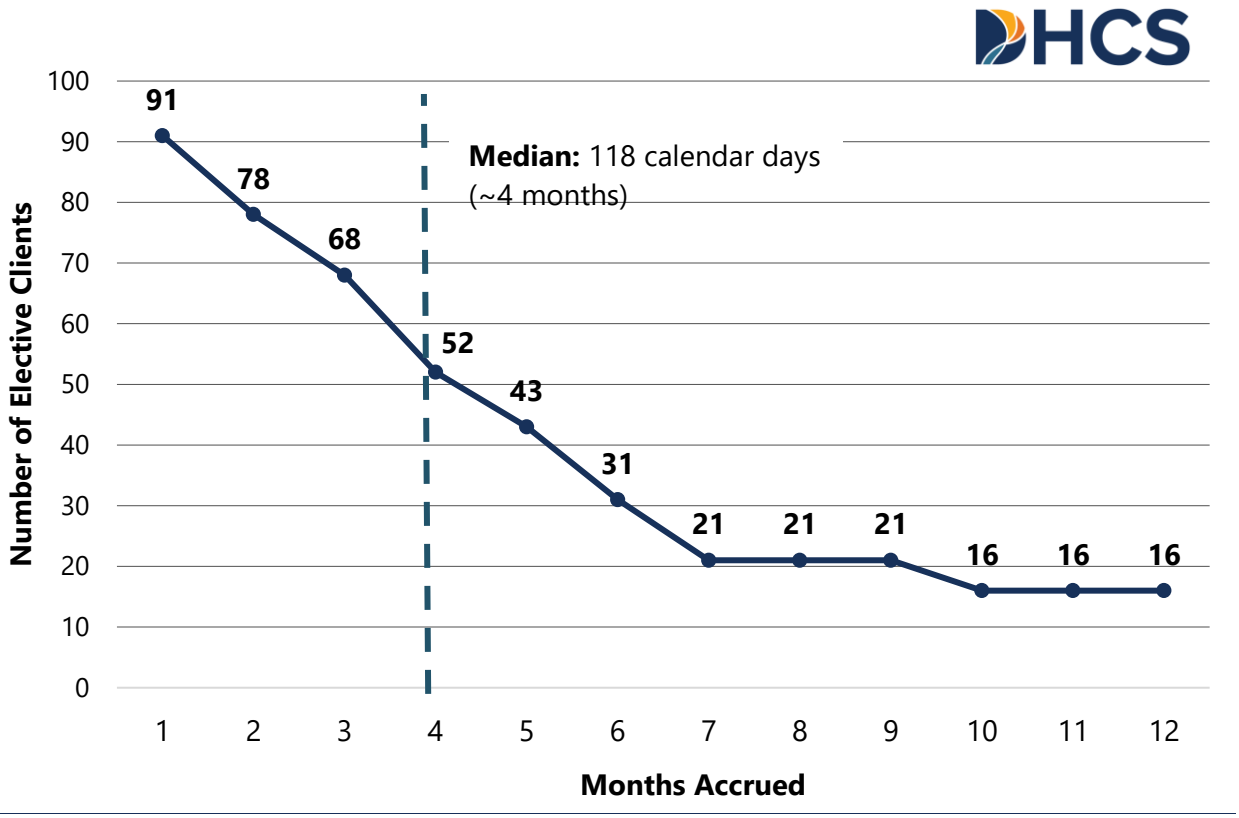
This change creates a trend break for elective client data pre- and post-January 2025. Throughout this report, the authors have noted when the broader definition of elective client went into effect and where it may impact interpretation of data.

Because of a change in county BH reporting requirements, which began January 1, 2025, Active Service Period CARE data are available for only 91 elective clients. Overall, counties have reported significant barriers with tracking elective clients who are no longer under court jurisdiction, as evidenced by the high proportion of missing and unknown data that counties submitted for these clients, compared with data submitted for CARE participants with CARE plans or CARE agreements. The findings for this group of individuals should be interpreted with caution.

Among those with available data, the median length of time that an elective client was engaged in services and supports after dismissal from CARE proceedings was 118 calendar days, or approximately four months. This is about three weeks less than the 4.5 months for participants with CARE plans or CARE agreements. **Figure 24** highlights the

number of months of services and supports elective clients have accrued in their Active Service Period.

Figure 24. Number of Months Accrued in Active Service Period by Elective Clients



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.*
Note: *Of the 192 elective clients in the Initiation Period, DHCS only has Active Service Period CARE data for 91 (15 CARE-eligible clients dismissed prior to January 1, 2025 and 76 clients dismissed between January 1 and June 30, 2025 who received county services/supports regardless of eligibility).*
Note: *46 counties did not begin implementing CARE until December 1, 2024. For these counties, the maximum amount of time a CARE participant could have been in their CARE Active Service period is seven months.*

7.1 Elective Client Access to Services and Supports

As **Table 14** indicates, among 91 elective clients with available data, a high proportion of missing and unknown data were observed for reported services and supports accessed by elective clients (21–54 percent missing data).

The available data suggests care quality gaps for individuals served outside court jurisdiction. Fewer than 59.3 percent of reported elective clients had known access to any mental health treatment services (54 clients) or specialized programs (49 clients) and 25.3 percent (23 clients) were reported to have known access to stabilizing medications. Given the county-expressed barriers in tracking these elective clients without court oversight, the findings should be considered unreliable and interpreted with caution. County efforts to more closely monitor these clients and improve the quality of data for people served outside of court jurisdiction is critical to understand care gaps.

Table 14. Number and Proportion of Elective Clients (n=91) Who Had a Service or Support Provided at Any Time in Active Service Period, by Category

Service or Support Category	One or More Service or Support n (%)	Total Data Missing or Unknown n (%)
Specialized Program (Any) Assertive Community Treatment (ACT) (n=14) Full-Service Partnership (FSP) (n=27)	49 (53.8%)	31 (34.1%)
Mental Health Treatment Service	54 (59.3%)	27 (29.7%)
Stabilizing Medication	23 (25.3%)	49 (53.8%)
Social Service or Support	17 (18.7%)	46 (50.5%)
CalAIM Community Support	*	19 (20.9%)
SUD Treatment Service	*	44 (48.4%)

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.*
Note: *Of the 192 elective clients in the Initiation Period, DHCS only has Active Service Period CARE data for 91 (15 CARE-eligible clients dismissed prior to January 1, 2025 and 76 clients dismissed between January 1 and June 30, 2025 who received county services/supports regardless of eligibility).*
Note: *A large proportion of data reported by counties on access to services and supports among elective clients was missing or unknown.*

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

7.2 Acute Medical, Psychiatric, or Law Enforcement-Related Events

For elective clients, as with CARE participants with CARE agreements or plans, county BH agencies are required to report data on criminal justice involvement, such as jail or prison encounters, arrests, citations, or bookings; LPS conservatorships; LPS holds; ED visits; hospitalizations; and death. A large proportion of the reported data on these types of events for elective clients, between 30.8 and 39.6 percent, were missing or unknown (compared with 5.0–17.2 percent for participants with CARE agreements or CARE plans). Given the quantity of incomplete data and potential for misinterpretation, findings related to these events have been omitted from this report.

8. DATA LIMITATIONS

Large-scale behavioral health programs typically require multi-year investments in planning, training, and operational rollout. Given the staggered statewide rollout of the CARE Act, Cohort I counties have only implemented the CARE Act for 21 months (with 19 months of implementation for Los Angeles County) and Cohort II counties for approximately seven months.

As is common among new state initiatives, county data systems are being developed in real time in response to evolving CARE legislation, which impacts definitions of the CARE population and data reporting requirements. Because of data lags and the time required to collect, submit, and process data on county implementation, **this report does not reflect current-day implementation and continuous quality improvement efforts by county BH agencies and their stakeholders.** Missing or unknown data remain significant for some variables, particularly newer measures (e.g., pre-petition activities such as outreach and engagement) and for CARE participants no longer under court jurisdiction, though data quality has improved over time.

Several limitations affect the reliable interpretation of data reported by entities involved in CARE Act implementation. They are as follows.

8.1 Discrepancies in CARE Agreements and CARE Plans Reported

JC and county BH agencies submit data independently to DHCS. Discrepancies were found between JC-reported and county BH-reported numbers of CARE plans ordered and CARE agreements approved during the study period—October 1, 2023, to June 30, 2025. Among the 29 counties where discrepancies exist, most variances involved small differences in the number of CARE plans and CARE agreements, which may reflect court and county BH differences in data processing and reporting cycles. This report includes all available data on individuals with county-reported CARE agreements and CARE plans.

8.2 Data Completeness

County BH agencies acknowledged barriers in establishing data flows, and hence in their ability to report on the new data elements as required by statutory amendments. The substantial revisions and late release of the expanded CARE Act Data Dictionary Version 2.0 meant that county BH agencies had a limited runway to adjust their data infrastructure to accommodate these updates and retrospectively report on required data elements, including the addition of reporting on pre-petition efforts.

8.3 Missing and Unknown Data

Data completeness varied across cohorts and improved over time, reflecting the barriers inherent in establishing reporting infrastructure during the early implementation of a new statewide initiative. These limitations should be considered when interpreting trends presented in this report.

Cohort I counties, which began implementation in December 2023, experienced the most significant data gaps during the initial months of the rollout. Early missing data in this cohort likely reflects the concurrent development of data collection systems, staff onboarding, and reporting protocols rather than absence of program activity. As implementation matured, data completeness improved meaningfully, and later-period observations for Cohort I counties are more reliable for trend interpretation than those from the earliest months.

Cohort II counties began implementation by December 2024 and contributed a more limited observation window to this report. As a result, fewer Cohort II participants contributed to data trends. It is expected that Cohort II counties will follow a similar trajectory of improving data completeness as reporting infrastructure stabilizes, consistent with the pattern observed in Cohort I.

Across both cohorts, two categories of data limitation were observed. First, missing data, where values were expected but not submitted, occurred most frequently in early implementation months and decreased over time. Second, unknown data, where it could not be determined whether a value existed, was not collected, or was inapplicable, reflects gaps in data collection protocols that were refined over the course of implementation. These two categories are analytically distinct; missing data reduces precision but may be recoverable in future reporting cycles, while unknown data represents a more fundamental constraint on what can be concluded from the available records.

Because this report is descriptive, no imputation or statistical correction for missing data was applied. Trends reflect observed values among individuals with sufficient program exposure within the analytic window. In periods or subgroups where data completeness was lower, reported trends may underrepresent program activity or reflect a more selected subset of participants. Thus, early findings described in this report should be interpreted with caution.

The observed improvement in reporting over time is encouraging and suggests that data quality will continue to strengthen as both cohorts advance through

implementation. Future reports will benefit from a more complete record and will be better positioned to characterize program trends with greater confidence.

8.4 Data Lags

Because of the time required to collect, submit, and process data on county implementation, the findings in this report will be outdated and will not reflect current implementation and continuous quality improvement efforts by county BH agencies and their stakeholders. As part of CARE Act implementation, DHCS supports ongoing training and technical assistance to counties collaborating extensively with key stakeholders such as the JC, the California Department of Health and Human Services, and CARE Act working groups (which includes representation from county BH agencies, family members, individuals with lived experience, and other system partners).

8.5 Analytic Limitations

It is important to consider the narrow timeframe of this report when interpreting these analyses. Given the staggered rollout of the CARE Act, this report represents 21 months of CARE Act implementation for the eight Cohort I counties (with 19 months of implementation for Los Angeles County) and approximately seven months of implementation for the Cohort II counties.

The result of this staggered implementation timeline is that data in this report are skewed toward Cohort I and Los Angeles County, as they have had longer to implement data collection and reporting workflows and to contribute data. While stratifications of the data throughout this report by county population density are valuable and provide useful insights for program implementation, they too should be interpreted with caution, as Cohort II counties are over-represented among rural and small counties.

Another limitation of this implementation report is the potential presence of survivorship bias. In this Annual Report, data was used to trend access to services and supports over a CARE participant's time in the CARE process, as well as to compare outcomes of interest (e.g., housing status and time of petition compared with the latest month in the Active Service Period).

Because a CARE participant's case may be dismissed prior to 12 months in Active Service, outcomes of interest may be biased toward participants who remain in the program longer. To partially mitigate against survivorship bias, we restricted trend analysis to the first five months of exposure to the CARE process to optimize sample size. However, due to diminishing sample sizes over time (reflecting both rolling enrollment and early exits) the trends over the five-month period reflect a smaller

subset of participants (e.g., 517 individuals included in month one and 285 by month five). Trends describe observed values of subsets of participants during this specific window and cannot be used to infer CARE process impact, as they may include program completers, those who are still in progress, or early exits.

Considerable county-level variation in CARE implementation processes likely influence observed outcomes of interest. Future reporting will strive to include more granular county-level variations where feasible. Local practices and resources may influence both CARE pathway assignment and observed outcomes, including differences in implementation maturity that inform evolving court practice and coordination across system partners, service availability, housing capacity, outreach intensity, and data completeness. In independent evaluations of the statewide impact of CARE Act, such county-level variations must be considered as key implementation context and potential sources of confounds or effect modification.

9. KEY TAKEAWAYS AND RECOMMENDATIONS TO LEVERAGE CARE ACT DATA

Implementation of the CARE Act (October 2023 through June 2025) has highlighted several key takeaways and opportunities.

1. **Initial dispositions of CARE petitions took a median of 11 weeks but were highly variable with notable outliers. The middle 50 percent of petitions took six to 18 weeks to resolve. During the period between the filing of the petition and receiving an initial disposition, over half (57.2 percent) of petitioned CARE participants accessed services or supports.**

County BH agencies are expected to collaborate with courts and to investigate the appropriateness of CARE for Petitioned Individuals. The time involved until an initial petition disposition is ordered appears to vary person to person and is highly variable across counties. Across the state, the time from CARE petitioning to initial disposition assignment by the courts took a median of 76 calendar days (approximately 11 weeks [IQR: 44–129 days]) with variation across counties of different sizes (e.g., dense counties took a median of 83 calendar days while rural counties took a median of 48 calendar days to reach a first disposition). Overall, for 15.0 percent of CARE participants with an initial disposition, the disposition came within 30 calendar days from the date the petition was filed.

Prior to receiving an initial petition disposition, over half of CARE participants (57.2 percent) accessed a service or support (most commonly mental health treatment). Dense counties appeared to face greater barriers to providing CARE participants with services and supports than small and medium counties (numbers too small to report in rural counties). Notably, about one-fifth of data reported on services and supports that this group accessed were missing or unknown, limiting the reliability of this information.

- **Opportunities to Leverage Findings:** Counties that are more efficient have highlighted successful outreach and engagement strategies for supporting the connection to and delivery of key services to CARE participants prior to an initial CARE disposition. These strategies could be documented as best practices to support county efforts in outreaching to those who may require time and trust to engage.
    - **Leveraging existing peer support networks to assist with outreach and engagement for individuals entering CARE.** Many counties have

reported that integrating peer workers is key to effective engagement. For example, **Madera County** has incorporated a Peer Support Specialist to support and reinforce client engagement and participation in services and treatment plans.

- CARE teams in **Placer** have emphasized outreach and engagement by deploying peer workers to connect with individuals in the community, explain the CARE process, and encourage participation in services. These efforts reduce barriers and foster trust before formal involvement begins.
- **Using funds to meet the social and basic needs of CARE participants can build engagement during the Initiation Period.** Counties have found that offering basic necessities (e.g., survival kits, gift cards for essential items, or food) without requiring participation in CARE or mental health services helps build rapport and trust. Offering these basic needs often leads to later engagement in services, both within the CARE process and through voluntary engagement.
- **Starting CARE agreement development during the Initiation Period leads to more rapid petition resolutions and fewer hearings.** Some counties have reported success using the Initiation Period to begin developing CARE agreements with individuals through evidence-based motivational interviewing. Having a CARE agreement ready for court approval at the first hearing has led to more rapid court dispositions in fewer court hearings and more rapid service engagements.

2. A growing proportion of participants with CARE agreements or CARE plans are accessing mental health treatment services, social services, and stabilizing medications throughout their first five months in CARE.

Engaging individuals in an array of mental health services and supports can take time. The proportion of participants with CARE plans and CARE agreements who accessed a mental health service (e.g., targeted case management, psychosocial services) increased by nearly 10 percentage points from month one in CARE to month five (77.0 percent to 86.7 percent).[75] This same pattern was evident among social services and supports (e.g.,

[75] Given the median length of time individuals with CARE plans or CARE agreements have engaged in CARE (4.5 months), data trends in this report are restricted to five months to support stability of trends. For context, there were 517 CARE participants with CARE agreements or CARE plans included in the month one service/support access proportions and 285 at month five.

food assistance programs, CalFresh), which increased by nearly 14 percentage points (from 50.3 to 63.9 percent), and stabilizing medications, which also increased by 14 percentage points (from 47.0 to 61.4 percent). These findings suggest that time in CARE may help to facilitate a therapeutic alliance and increase access to and engagement in services and supports. Little change was observed for CARE participant access to housing supports, SUD treatment, or CalAIM services over a CARE participant's first five months in CARE.

A few counties, including **San Diego County** and **Stanislaus County,** demonstrated enormous success in ensuring participants with CARE agreements and CARE plans accessed ordered stabilizing medications, with 85.7 percent and 90.7 percent of participants in these counties, respectively, accessing an indicated medication during their Active Service Period.

- **Opportunities to Leverage Findings:** CARE participants have experienced service gaps, especially in access to housing supports, SUD treatment, and CalAIM services. These services may be particularly challenging to access as they often require significant collaboration from other provider agencies and partners. Several counties have reported targeted efforts to promote the connection of participants to these ordered or recommended services and supports, including:
  - **Strengthening cross-system case conferencing.** Many counties have implemented standard procedures for case conferencing and coordination among behavioral health and housing programs to create a placement "fit" pathway that matches CARE participant needs to available housing and supports (e.g., interim, permanent, scattered site, congregate, on-site services) and have revisited placement decisions as needs change.
  - **Implementing protocols for integrated screening and warm handoffs to physical health and SUD providers.** Counties can implement protocols to screen and provide warm handoffs to an array of services, such as managed care supported Enhanced Care Management (ECM) services; community supports; and SUD services, which remain largely unintegrated with mental health services in many counties.
  - **Developing standardized coordination tools between county agencies and managed care organizations.** Counties could create checklists or similar tools to support more seamless coordination for CARE participants with complex mental health, SUD, and physical health needs. These tools

could help ensure key components of care delivery and management are addressed—such as ECM and Community Supports eligibility verification, managed care plan coordination, referral templates, and required documentation—and that responsibility for follow-through is clearly assigned.

3. **Nearly two-thirds (59.6 percent) of active participants with CARE agreements or CARE plans received all three evidence-based foundational components that promote recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatments, and housing supports).**

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. Overall, 59.6 percent of the 517 CARE participants with CARE agreements or CARE plans were reported to have received all three key services and supports during their Active Service Period.[76] Of those who received two of the three services and supports (29.4 percent), the most commonly observed combination was housing supports and psychosocial and community-based treatment.

- **Opportunities to Leverage Findings:** Although engagement in stabilizing medications appears a significant challenge, several counties, including **Stanislaus** and **San Diego** counties have reported considerable success in providing access to all three key services and supports to CARE participants with CARE agreements or CARE plans (88.9 percent and 72.7 percent, respectively). Strategies employed by these counties could be codified as best practices to support county efforts statewide.

4. **Positive trends were observed among participants who gained or maintained housing during their time in CARE; suggesting the CARE Act may be aiding counties in promoting creative housing solutions.**

Among the 485 participants with a CARE agreement or CARE plan who had at least two months of data on their living situation, the proportion who were housed, in either

[76] 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.

temporary or permanent housing, grew from 53.4 percent (n=259) at the time of their petitioning to 71.1 percent (n= 345) during their most recent month of data. The proportion of unhoused participants fell between these two time periods, from 21.6 percent (n=105) to 16.5 percent (n=80). Finally, the proportion of participants residing in an institutional or residential setting decreased from 24.9 percent (n=121) to 12.4 percent (n=60).

Accessing stable housing for the CARE population is challenging given their complex needs. Early findings indicate that CARE participants' housing journey may not be linear and can often change over time as their needs evolve. Since implementation, counties have promoted creative and adaptive housing solutions that are working to expand housing options, promote housing stability, and integrate supportive services to foster independence and reduce stigma for CARE participants. Leveraging the BH Continuum Infrastructure Program (BHCIP[77]) grant initiative, counties have acquired or renovated real estate to expand various housing options for those with BH needs. Examples include dedicating housing units in housing programs to CARE participants, repurposing and increasing available housing stock through hotel conversions, and expanding residential care programs and service-rich housing options.

- **Opportunities to Leverage Findings:** Housing is a critical component of CARE and an individual's path to recovery, as finding stability and staying connected to treatment is difficult when a person is experiencing the stressors associated with being unstably housed. Counties can consider housing models and funding sources for persons with serious mental illness who are experiencing housing instability (see resources on the CARE Resource Hub: Practical Approaches to Housing for the CARE Act, Lessons Learned and Best Practices for Housing the CARE Population, and the Housing and Community Supports Technical Assistance Activities).

5. The most common county-reported rationale for dismissal of CARE participants was CARE ineligibility. The most reported CARE ineligibility factor was lack of a qualifying diagnosis.

The most common county-reported reasons for CARE petition dismissals (initial dispositions) included participant ineligibility (22.7 percent), the participant not participating in the CARE process (13.4 percent), the participant transitioning to a higher level of care (12.1 percent), and inability to locate a participant (12.4 percent).

[77] https://www.dhcs.ca.gov/BHCIP/Pages/BHCIP-Home.aspx

The most frequently cited rationale for dismissal due to CARE ineligibility was that the individual did not have a qualifying diagnosis of schizophrenia spectrum/other psychotic disorders (47.0 percent), followed by the county reporting that it was unlikely that the individual would benefit from participation in a CARE plan or CARE agreement (23.5 percent).

- **Opportunities to Leverage Findings:** These findings suggest an opportunity for targeted technical assistance and training to system partners, potential petitioners, and the public on the expanded CARE Act eligibility criteria.[78] This technical assistance should help reduce the number of petitioned individuals who do not meet criteria and increase the success of petitioning individuals who may benefit from the CARE process.

6. Nearly three-quarters of CARE participants dismissed without a CARE agreement or CARE plan (initial petition disposition) were not receiving county services and supports at the time of dismissal, with small counties facing particular barriers in connecting these individuals to services.

Of the 689 CARE participants who were dismissed by the courts at the time of their initial petition disposition, 497 (72.1 percent) did not go on to receive any county BH services or supports. Among CARE participants whose CARE petitions were dismissed and did not receive voluntary county services, the most common reasons included: nonparticipation in the CARE process (17.1 percent); inability to locate the participant (16.1 percent); transition to a higher level of care (12.4 percent); and long-term incarceration (6.7 percent). These reasons shed light on why many individuals are not connected to county services at the point of dismissal and reflect circumstances that often limit opportunities for county follow-up.

- **Opportunities to Leverage Findings:** These findings suggest an opportunity to engage individuals whose cases are dismissed but may still benefit from county supports and services. Of note, due to the expanded CARE Act eligibility criteria,[79] data on dismissal rationale will be important to monitor in future

[78] Note that effective January 1, 2026, SB 27 expanded eligible diagnosis to include bipolar I with psychotic features. Because this Annual Report includes data through June 30, 2025, it reflects eligible diagnosis limited to schizophrenia spectrum or other psychotic disorders.
[79] Note that effective January 1, 2026, SB 27 expanded eligible diagnosis to include bipolar I with psychotic features. Because this Annual Report includes data through June 30, 2025, it reflects eligible diagnosis limited to schizophrenia spectrum or other psychotic disorders.

Annual Reports. Opportunities to engage CARE participants after dismissal include:

- **Developing dismissal-specific transition protocols.** Some counties have reported early success with developing and implementing protocols for connecting CARE-ineligible participants with significant behavioral health needs to appropriate services and supports post-dismissal. For individuals unwilling to engage in services, some counties report collaborating with other system partners, such as first responders and mobile outreach teams, to locate and monitor difficult-to-find or difficult-to-engage individuals, even after dismissal.

7. Education and training of system partners on the CARE Act appear to improve identification and referral of potentially eligible CARE participants.

The source of CARE petitions has changed over the course of CARE implementation, with the proportion of total CARE petitions from system partners (i.e., hospital directors, licensed BH professionals, public guardians, or conservators) increasing from 24.8 percent of petitions in 2023 to 61.3 percent in 2025, and the proportion of petitions by someone with a personal relationship to the participant decreasing over the same time period (66.7 percent to 25.5 percent).

County-reported data show that the conversion rate of CARE petitions to CARE agreements or CARE plans is 42.9 percent (517 out of 1,206 with an initial disposition), suggesting there may be opportunities for improving the yield of petitions. There were also differences observed in initial petition disposition by petitioner type. Nearly half (49.4 percent) of system-petitioned CARE participants and self-petitioned individuals (47.9 percent) had a CARE agreement or CARE plan approved, compared to 37.6 percent of those petitioned by someone with a personal relationship to the participant (personal petition) and 32.9 percent of those petitioned by a first responder. This suggests that system partners trained in CARE Act eligibility criteria may be more successful in identifying individuals who are good candidates for the CARE process. Targeted trainings for specific types of petitioners, such as first responders, may be critical, particularly given the relatively low numbers of petitioners among this group and the low rates of conversions from petitions to CARE agreements or CARE plans.

- **Opportunities to Leverage Findings**: These findings suggest that ongoing state technical assistance and training efforts to provide education to system partners about the CARE Act are effective tools for engaging CARE-eligible individuals. Successful strategies included in these training efforts include:

- **Strengthening system partner engagement and petitioning practices.** Counties have identified continued outreach, training, and coordination with system partners as key to strengthening the quality and consistency of CARE petitions. This includes establishing ongoing coordination touchpoints, providing targeted education and training, clarifying eligible petitioner roles and expectations, and increasing awareness and use of available petitioning resources. These approaches are detailed in the technical assistance resource Engaging with System Partner Petitioners at the County Level.
- **Assigning CARE liaisons with system partners can improve collaboration and reduce burdens for county BH and system partners.** Several counties have CARE Liaison roles or standing meetings for county staff to engage with system partners to reduce barriers and burden to CARE petitioning. Liaisons have been assigned—at times co-located within LPS facilities, hospitals, jails, and other facilities—to support seamless handoffs to county BH for continued engagement with the CARE Act process. This ongoing communication allows system partners to ask questions and flag any incoming petitions, and it helps county BH with timely engagement and to improve the quality and success of petitions.

8. **CARE participants do not mirror the socio-demographic characteristics of the communities in which they live. However, they do reflect at-risk racial groups known to be underserved and over-represented among individuals with psychotic disorder diagnoses or in psychiatric hospitals and carceral settings.**

A comparison of CARE participants with the California Census shows that the population characteristics of petitioned individuals differed from the communities in which they live. Rather, the CARE population more closely reflects the composition of racial groups known to be underserved as well as groups that are over-represented among individuals with CARE-eligible diagnoses, unhoused populations, psychiatric hospitals, and carceral

settings—the very populations the CARE Act is intended to help through a civil court process.[80,81,82,83,84]

CARE participants were found to be younger and disproportionately male (details in Section 6.1.1 CARE Participant Socio-Demographic Characteristics and in **Appendix D**) than the overall California Census population. With regard to race and ethnicity, Asian and Hispanic individuals were found to be underrepresented in the CARE population relative to the overall California Census population. Conversely, Black and African American individuals were over-represented in the CARE population compared to the overall California population. These trends were also seen at the individual county level.

- **Opportunities to Leverage Findings:** Findings around the underrepresentation of particular groups (i.e., Asian and Hispanic communities) may indicate opportunities for targeted outreach and education about CARE. These opportunities may include targeted trainings and technical assistance to system partners on engagement of individuals in Asian and Hispanic communities to build trust and engage potential CARE-eligible individuals.

9. **Future analyses conducted by the Independent Evaluation team may benefit from the examination of potential drivers of this underrepresentation, including language access, referral source, county variation, trust in the county BH agency or state, diagnostic pathways, service access, and petitioner support. Differences among petitioner types within racial groups highlight**

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[80] Young Ponder, K., Moore, T., Adhiningrat, S., Sakoda, R., Kushel, M. (2024). Toward Equity: Understanding Black Californians' Experiences of Homelessness in the California Statewide Study of People Experiencing Homelessness. Black CA Report 2024.pdf

[81] Sawyer, Wendy. (2023). Comparing California's Resident and Incarcerated Populations. Prison Policy Initiative. Comparing California's total population to its incarcerated population, by race | Prison Policy Initiative

[82] Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. *Psychiatric services (Washington, D.C.)*, *73*(12), 1322–1329. https://doi.org/10.1176/appi.ps.202100342

[83] Van der Ven, E., Olino, T. M., Diehl, K., *et al.* (2024). Ethnoracial risk variation across the psychosis continuum in the United States: A systematic review and metaanalysis. *JAMA Psychiatry, 81*(5), 447–455. https://doi.org/10.1001/jamapsychiatry.2023.5497

[84] Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of psychiatry*, *4*(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133

opportunities for targeted outreach, engagement, and education to raise awareness of the CARE Act, especially among underserved communities.

Asian and Hispanic individuals were more likely to be petitioned by people with whom they have personal relationships, yet those petitions were more likely to be dismissed than those generated by system partners. These data suggest there may be opportunities to educate and raise awareness in Asian and Hispanic communities about the CARE Act, CARE eligibility and the CARE petitioning process. They may also suggest potential gaps in system-partner referral pathways, language access, petition navigation support, and trusted provider engagement.

- **Opportunities to Leverage Findings:** Ensure the use of culturally sensitive and person-centered language in public-facing CARE Act information. Outreach and engagement processes and procedures, and training and technical assistance may help raise awareness about CARE across different communities. Such efforts may benefit from targeted work through trusted community organizers, leaders, and organizations in those communities. Future analyses conducted by the Independent Evaluation team may benefit from the examination of potential drivers of differences in petitioner types among CARE participants.

10. **Conversion rates from statutory system referral to CARE petition varied widely across counties, indicating substantial variation in local referral practices, capacity, and system coordination.**

Between January 1 and June 30, 2025, 31 counties reported a total of 443 statutory referrals to county BH; 53.7 percent were from MIST courts and 35.7 percent were from LPS-designated facilities. Far fewer referrals came from FIST and AOT courts.

Of the 443 statutory system referrals, 332 (74.9 percent) had a reported outcome. Fewer than one-third of these referrals with a reported outcome (30.7 percent) were petitioned to CARE (referred to as a conversion rate), with wide variation across counties, indicating substantial variation in local referral practices, capacity, and system coordination.

One-third of the 332 statutory system referrals with an outcome were diverted from CARE court and were either enrolled in county services/supports (8.4 percent) or had been connected to county services/supports and were pending enrollment (25.0 percent). One-third (35.8 percent) were neither referred nor petitioned to CARE. The most common reasons counties provided for not petitioning a statutorily system-referred individual to CARE included the individual being "unlikely to benefit" from CARE (39.6 percent), the individual not having a qualifying diagnosis (26.1 percent), and the individual requiring a higher level of care (24.3 percent).

- **Opportunities to Leverage Findings:** High variability was observed in system referral conversion rates to petitions. Counties that have designed and built intentional relationships across systems to create efficient referral pathways have been more successful in converting such referrals to petitions and appropriate services. Counties have found success in developing formalized protocols and referral pathways or workflows between courts, LPS-designated facilities, and county BH agencies. Important components of these protocols include delineation of responsibility for required information to facilitate referrals, clear roles for involved individuals, timeline expectations, and specific points of contact. Some counties have also established CARE liaisons specifically tasked with discussing and triaging cases to determine the most appropriate path to services for a referred individual.

10. APPENDICES

10.1 Appendix A. Quality Assurance Processes

Data were validated according to a standard quality assurance process based on four key dimensions: Completeness, Accuracy, Reasonability, and Timeliness (C.A.R.T) as detailed in **Table A.1** below. JC and counties were provided quality assurance reports and opportunities to correct data deficiencies prior to data analysis.

Missing, inaccurate, incomplete, or implausible data points were omitted from the analysis. For CARE participants petitioned multiple times, only data from the final petition were included for individual-level analysis.

Table A.1. Dimensions (C.A.R.T. Metrics) and Descriptions

Dimension	Description
Completeness	Data is assessed for both missingness, as well as for duplication.
Accuracy	Data is assessed for valid text values that adhere to value codes defined in the CARE Data Dictionary, with particular attention to key linkage variables to support data linkage to prior or administrative records. County BH and JC data are cross-validated to ensure corresponding numbers of CARE plans and CARE agreements during a reporting month.
Reasonability	Data are assessed to ensure they are structured appropriately; have the right data elements and data points based on the CARE status; contain values that are allowed for the required data elements/data points and pass basic audits (i.e., valid data); and are plausible when taken as a whole (i.e., data conforms to expectations).
Timeliness	Data must be submitted in accordance with a specified timeline. Data are due within 60 days after the last day of the reporting quarter, and corrections of data deficiencies are due 15 days after the issuing of the Quality Assurance report.

In addition to quarterly reviews of data against C.A.R.T metrics, analyses are conducted to identify identifier anomalies—defined cases in which identifying variables are not unique across records. Specific inconsistencies are identified, including shared Social Security Numbers (SSNs) across individuals, multiple SSNs assigned to one individual,

shared or multiple petition case numbers (without evidence of closure), shared or multiple Medi-Cal numbers, and conflicting or multiple values for birth date or sex.

To determine whether multiple identifiers belong to the same individual, unique persons are first identified using first and last names, with verification against other identifiers. Identification may be hindered by misspellings or alternate name forms. To address this, fuzzy matching is applied to names and validated against SSN, date of birth, and sex, where available. When these variables are unavailable, stricter matching criteria are used. Prior to matching, names are standardized by capitalization, removal of special characters, and truncation to the first word, if applicable. Names are then transformed using the Metaphone phonetic algorithm.

Although these methods address some misspellings and variations, certain diminutives (e.g., “Bob” vs. “Robert”) may not be matched, which required manual review of potential false positives, such as shared SSNs across individuals.

A supplemental report is generated and distributed to counties for review and correction. Manual correction by CARE data analysts is not typically performed. Instead, counties are provided with a summary of inconsistencies and are responsible for correcting identified issues prior to resubmission.

10.2 Appendix B. Data Stratification and Transformation

Table B.1. County Size Categories by Population Used in Data Stratification, DHCS Network Adequacy Standards

Size Category	Population Density	# of Counties	Counties
Rural	Less than or equal to 50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 599 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	Greater than or equal to 600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

Data Source: *California Department of Health Care Services Network Adequacy Standards | Attachment A*

Table B.2. Mapping of Race Categories Specified in the CARE Data Dictionary (Data Dictionary 2.0) to Mutually Exclusive Census Categories

Race/Ethnicity Category		Variable	Value
Hispanic	Hispanic, any race	3.4.2 Race/Ethnicity - Hispanic	2
Non-Hispanic	White, alone	3.4.2 Race/Ethnicity - White	1
	Black/African American, alone	3.4.2 Race/Ethnicity - Black	3
	Alaskan Native or American Indian/African American, alone	3.4.2 Race/Ethnicity - Alaskan Native or American Indian	5
	Asian, alone	3.4.2 Race/Ethnicity - Chinese	C

Race/Ethnicity Category		Variable	Value
		3.4.2 Race/Ethnicity - Asian Indian	N
		3.4.2 Race/Ethnicity - Filipino	6
		3.4.2 Race/Ethnicity - Vietnamese	V
		3.4.2 Race/Ethnicity - Korean	K
		3.4.2 Race/Ethnicity - Japanese	J
		3.4.2 Race/Ethnicity - Cambodian	H
		3.4.2 Race/Ethnicity - Laotian	T
	Native Hawaiian/Pacific Islander, Alone	3.4.2 Race/Ethnicity - Hawaiian	P
		3.4.2 Race/Ethnicity - Guamanian	R
		3.4.2 Race/Ethnicity - Samoan	M
		3.4.2 Race/Ethnicity - Other Asian or Pacific Islander	4
	Other, single race	3.4.2 Race/Ethnicity - Middle Eastern or North African	W
		3.4.2 Race/Ethnicity - Other	99903
	Data Missing or Unknown	3.4.2 Race/Ethnicity - Client declined to state	99900
		3.4.2 Race/Ethnicity - Unknown	99999
		All race variables are NULL	
	More than one race	3.4.2 Race/Ethnicity - Amerasian	A
		Any case where multiple races (Hispanic excluded) are marked	

Data Source: *United States Census Bureau | Updates to Race/Ethnicity Standards for Our Nation | Page last revised: December 20, 2025*

10.3 Appendix C. Total Petitions Per Capita, by County Population and CARE Cohort I and II

Table C.1. Total Petitions by Population, All Counties, by Cohort and County Population Density

Population	Total Contributed Counties	Total Petitions	Total County Population	Total Petitions Per 100,000
Statewide	**58**	**2,216**	**39,529,101**	**5.6**
CARE Implementation Cohort				
Statewide Cohort I	8	1,468	20,359,535	7.2
Statewide Cohort II	50	748	19,169,566	3.9
County Population Density Grouping*				
Rural	21	91	1,067,046	8.5
Small	19	215	7,582,944	2.8
Medium	9	447	6,558,659	6.8
Dense	9	1,463	24,320,452	6.0

Data Source (CARE Act Data): *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 Source (Population Estimates): *Data prepared by Demographic Research Unit, California Department of Finance | Report E-4: Population Estimates for Cities, Counties, and the State, 2021-2025, with 2020 Benchmark | Released May 1, 2025.*
**See Appendix B: Data Stratification and Transformation for list of counties within each of the county size groupings.*

10.4 Appendix D. CARE Participant Demographic Characteristics, Compared to Statewide Census Data

Methodology for Sub-Analysis

This sub-analysis compared the racial distribution among CARE participants to the general population at the state and county levels using the Census 2020 redistricting data[85] for California. The data for CARE participants is from Q3 2023 through Q2 2025. Consistent with the OMB's Statistical Policy Directive No. 15 (published March 2024), the CARE Data Dictionary supports collection of race and ethnicity as a single construct, with the option for participants to identify in as many categories as applicable. However, for this analysis, we used a transformation of those granular, multi-selection categories into mutually exclusive groups. This is the same transformation used by the U.S. Census Bureau Population Division when calculating diversity indices.[86] The mutually exclusive groups used for diversity index calculation are: American Indian/Alaskan Native, alone; Asian, alone; Black/African American, alone; Hispanic (any race); Native Hawaiian/Pacific Islander, alone; White, alone; Some other race, alone; or More than one race. **Table B.2 in Appendix B** summarizes the processing of CARE race data to create the Census categories prior to comparing distributions between petitioned individuals and the general population.

Note that this sub-analysis focuses on individuals, not petitions. Summaries of race are based on the most recent observation for each individual. Individuals with unknown values for race, age, or sex were included in this analysis to maintain consistency with counts and percentages presented for CARE participants elsewhere in this report. However, the Census data do not have missing categories, so individuals with unknown race are not shown in the summary. Just under 11 percent of all CARE participants have an unknown race. Given the magnitude of the differences in representation for certain race categories between the petitioned individuals and the general population, the inclusion of CARE participants with unknown race is unlikely to explain the findings.

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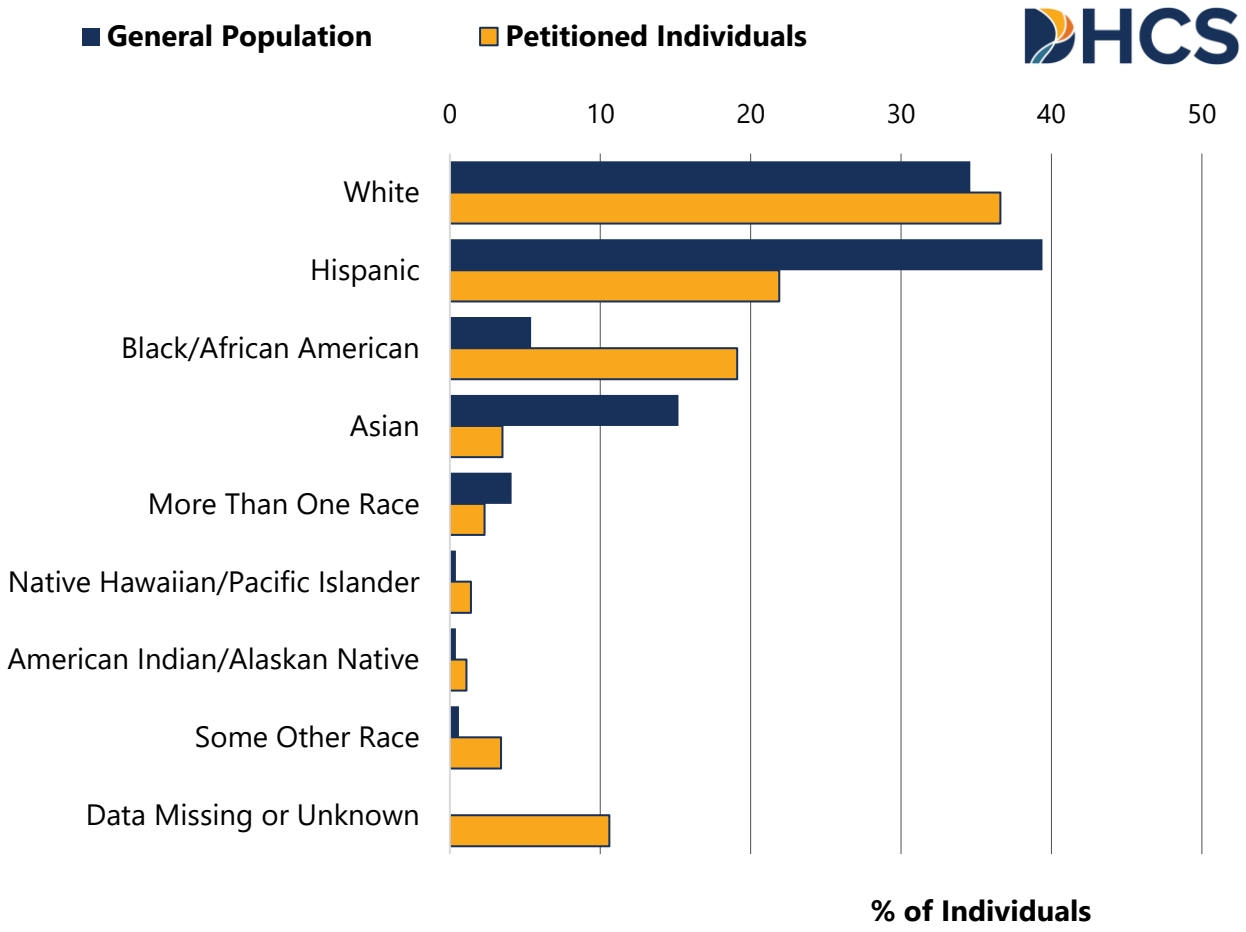
[85] 2020 Census State Redistricting Data (Public Law 94-171) Summary File Prepared by the U.S. Census Bureau, 2021.

[86] U.S. Census Bureau, "2020 U.S. Population More Racially, Ethnically Diverse Than in 2010," August 12, 2021, <2020 U.S. Population More Racially, Ethnically Diverse Than in 2010>, accessed on December 7, 2025.

Findings

Figure D.1 summarizes the state-level distributions for race between the general population (blue) and CARE participants (orange). We continue to see that Asian and Hispanic individuals are underrepresented among petitioned individuals (4 percent and 22 percent, respectively) relative to the general population (15 percent and 39 percent). Conversely, Black/African American individuals are over-represented among petitioned individuals (19 percent) compared to the general population (5 percent). These findings, though they varied in their specific magnitude of difference as well as statistical significance, tended to follow the same pattern across all counties.

Figure D.1. Comparison of Race/Ethnicity Distributions Between CARE Participants and the California General Population

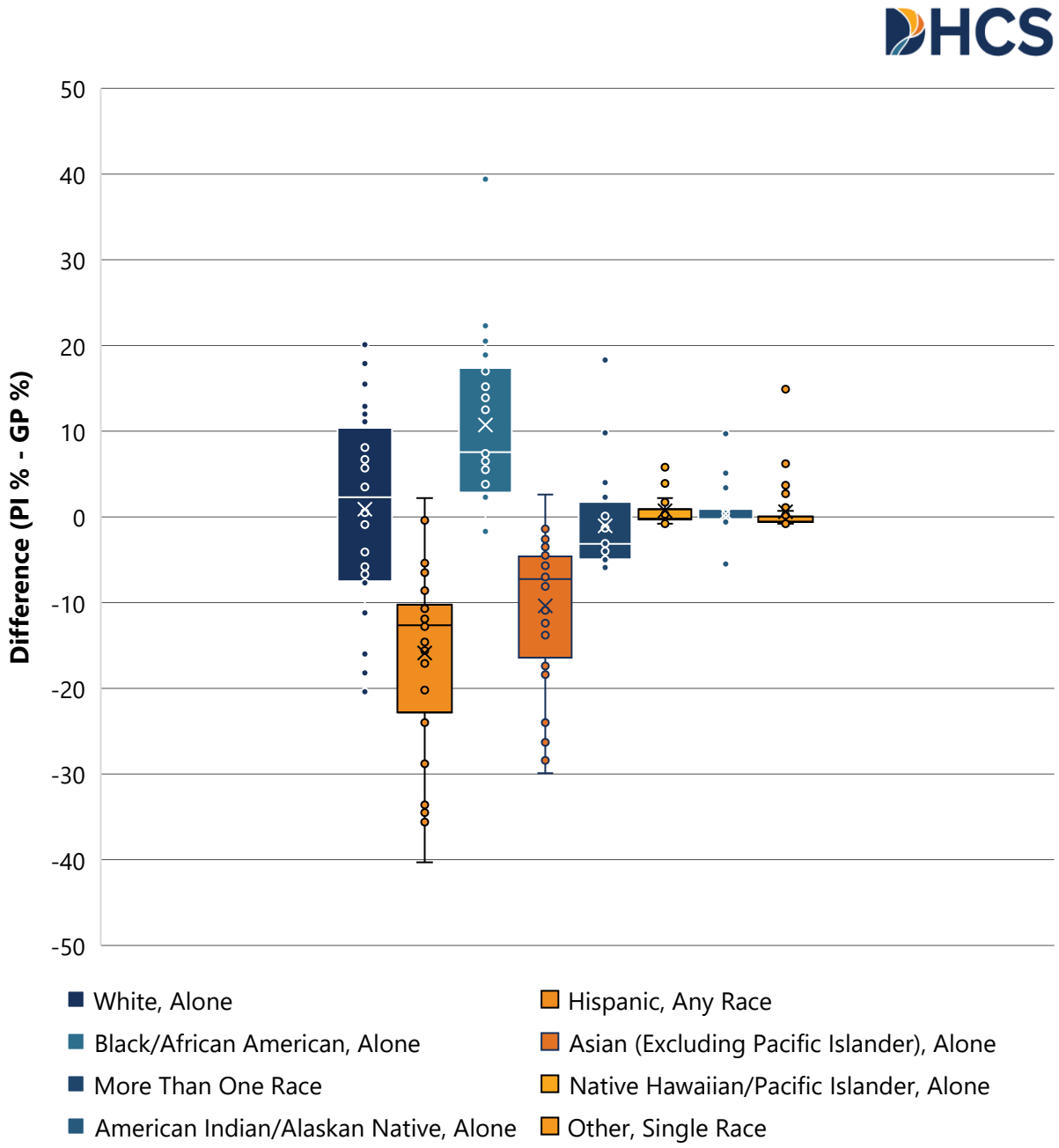


Data Source (Petitioned Individuals): *Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2025 | Date Downloaded: December 12, 2025 | Prepared by the California Department of Health Care Services.*

Data Source (General Population Comparisons): *2020 Census State Redistricting Data (Public Law 94-171) Summary File Prepared by the U.S. Census Bureau, 2021.*

Figure D.2 summarizes the percentage point difference between the Petitioned Individuals and the general population across 28 counties using a box and whisker plot. For each race category, the box provides five pieces of information. The midpoint of a box shows the median difference between the percentage of individuals in that race category between Petitioned Individuals and the general population. If the midpoint of a box is at −10, this means that when looking across counties, the median percentage of individuals of that race is ten points lower in among petitioned individuals than among the general population (i.e., that group is underrepresented among petitioned individuals). The tops and bottoms of the boxes indicate the 75^{th} and 25^{th} percentiles. The whiskers represent the high and low extremes of the data. Finally, individual data points are represented by circles within the plot. Counties are not indicated by name in this summary due to the risk of providing race on fewer than 11 individuals. 30 Counties were excluded from this summary because they have fewer than 11 petitioned individuals. **Figure D.2** indicates that the state-level finding in **Figure D.1** plays out similarly across many counties. There is variability in the over/underrepresentation of all races across counties. This can be seen in the first box for individuals in the White, alone category. The range is −25 to 25 percentage point differences; however the median difference is close to zero. A similar finding exists for individuals who are multiracial; American Indian/Alaskan Native, alone; Native Hawaiian/Pacific Islander, Alone; or some other single race. However, the distribution of differences between petitioned individuals and the general population show that Hispanic and Asian individuals are generally underrepresented among petitioned individuals while Black/African American individuals are over-represented. The precise mechanism behind this finding is not known but may reflect a variety of factors such as upstream disparities in the diagnosis of severe mental health disorders and attitudes or cultural barriers to participating in CARE.

Figure D.2. Summary of Differences in Race/Ethnicity Distributions Between CARE Participants and the California General Population Across Counties



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Data Source (CARE Act Data): *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 Source (Population Comparisons): *2020 Census State Redistricting Data (Public Law 94-171) Summary File Prepared by the U.S. Census Bureau, 2021.*