DHCS

The Community Assistance, Recovery, and Empowerment (CARE) Act Annual Report

July 2025

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EXECUTIVE SUMMARY

Introduction

On September 14, 2022, Governor Newsom signed the Community Assistance, Recovery, and Empowerment (CARE) Act, which created a new 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 a diagnosis of schizophrenia spectrum or other psychotic disorders 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.

The CARE Act was implemented in two cohorts. The seven counties that opted into Cohort I began implementation on October 1, 2023, and included Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne counties, and the City and County of San Francisco. Los Angeles County, though technically in Cohort II, elected to implement early, on December 1, 2023. The remaining counties that comprise Cohort II began implementation on or before December 1, 2024, with San Mateo implementing July 1, 2024, and Kern implementing October 1, 2024.

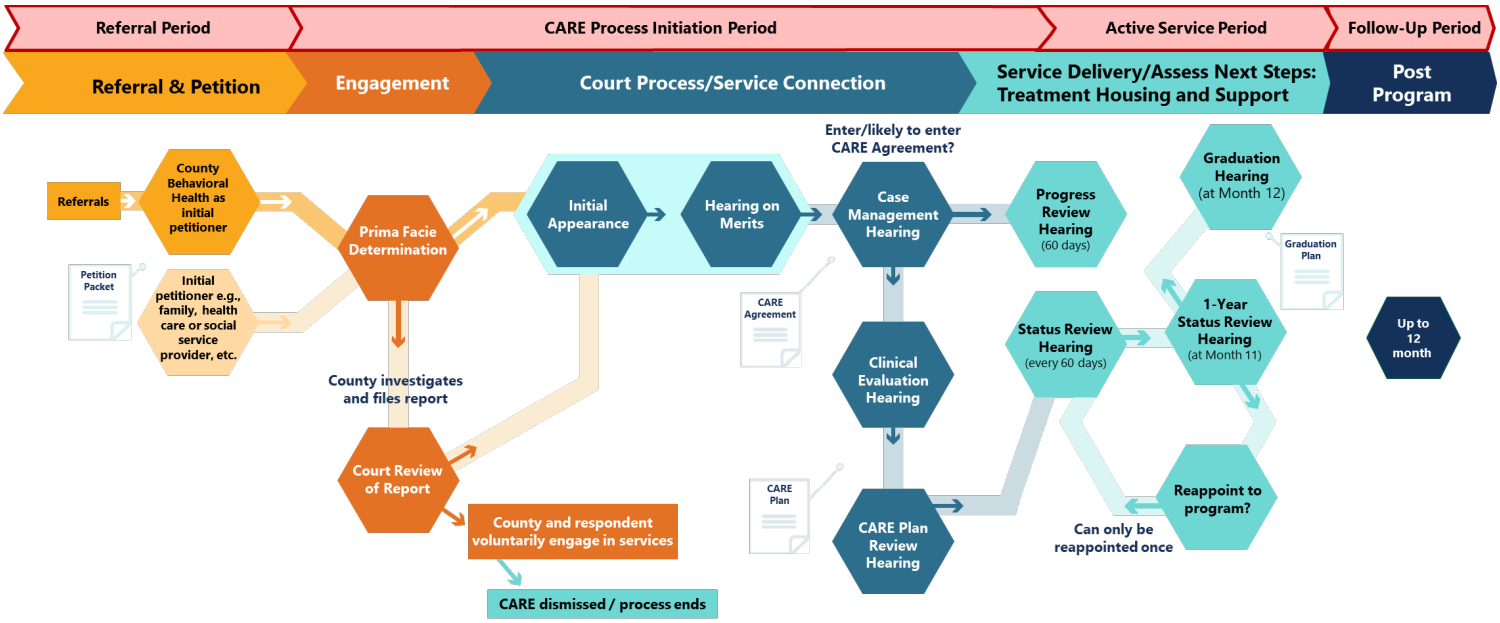
This first CARE Act Annual Report was produced by the Department of Health Care Services (DHCS) in consultation with the Judicial Council of California (JC), county behavioral health (BH) agencies, and other relevant stakeholders. **This report uses data from the first nine months of CARE Act implementation from October 1, 2023, through June 30, 2024.** It includes data from the eight pilot counties: Glenn, Los Angeles, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco. This first Annual Report builds upon the CARE Act Early Implementation Legislative Report that was released in November 2024, by providing deeper insights into CARE Act implementation, early participant data, and opportunities for enhancements to CARE processes.

The CARE Process: A High-Level Overview

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 and prioritizes those resources for individuals with high needs who meet CARE criteria. Following petitioning, **CARE respondents** (individuals who are the subject of the petition for the CARE process) 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 assigns a disposition (i.e., approves a CARE agreement, orders a CARE plan, or dismisses the petition). 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 order the development of 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 the creation of 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 **CARE participants**. An **elective client** is defined as a CARE-eligible individual who elects to voluntarily engage in county BH services and supports outside the CARE Act proceedings (in this case the court-assigned disposition is "dismissed").

As depicted in **Figure ES1** below, following disposition assignment, 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 voluntary county services outside CARE Act proceedings. A CARE participant may be reappointed to a CARE plan for an additional 12 months, which would extend the Active Service Period for up to a total of 24 months.

Figure ES1: CARE Act Process Flow



Highlights and Key Findings

Data from the first nine months of CARE implementation demonstrate that, even in its early stages, the CARE process is connecting people with schizophrenia and other psychotic disorders with evidence-based treatments and housing plans. This progress reflects a meaningful shift in helping the state's most vulnerable populations towards long-term recovery, lasting wellness, and housing stability. Highlights from the first nine months of CARE implementation are presented in the section below, and in greater detail in the full report that follows.

Petitions and Court Processes

Court Petitions and Assigned Dispositions

As seen in **Table ES1** below, 556 CARE petitions had been received by the courts as of June 30, 2024 (i.e., first nine months of CARE implementation). Of the filed CARE petitions, 217 (39 percent) were dismissed. There were 101 approved CARE agreements or ordered CARE plans. The remainder of filed CARE petitions were still in the court review process at the time of this report development and pending disposition assignment.

Table ES1: Cumulative CARE Petitions and Dismissals Reported by Courts

Reporting Quarter	Total Petitions, To-Date±	Dismissed Petitions, To-Date±
Quarter 4 2023	190	37 (20%)
Quarter 1 2024	386	123 (32%)
Quarter 2 2024	556	217 (39%)

± "To-Date" is defined as the last day of the Reporting Quarter.

Notes: 1) A petition dismissal may occur in the same reporting quarter, or a subsequent reporting quarter, as the petition filing date. 2) Los Angeles County implemented the CARE Act in December 2023.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024.

Prepared by the California Department of Health Care Services.

Unique CARE Respondents Sent to County Behavioral Health Agencies

Of the total 556 petitions submitted to the court, 497 CARE petitions were received by county BH agencies during the first nine months of CARE Act implementation (representing 490 unique CARE respondents).[1] The discrepancy between total petitions at the court level (data above in **Table ES1**) and the county level (data included below) exists because courts can dismiss a petition for not meeting eligibility criteria for CARE proceedings (i.e., a prima facie showing) prior to county BH agency involvement. County BH agencies are only aware of and able to track CARE petitions they file themselves or those they are ordered to investigate by the courts. Petitions may also be pending court determination at the end of the reporting period covered in this Annual Report.

Of the 490 unique CARE respondents that were sent to county BH agencies over the first nine months of CARE implementation, 101 had a CARE agreement approved, or CARE plan ordered by the court as their first CARE disposition; 160 were dismissed by the court; and 229 did not yet have a court disposition assigned. Among the 160 dismissed respondents:

- 15 became elective clients.

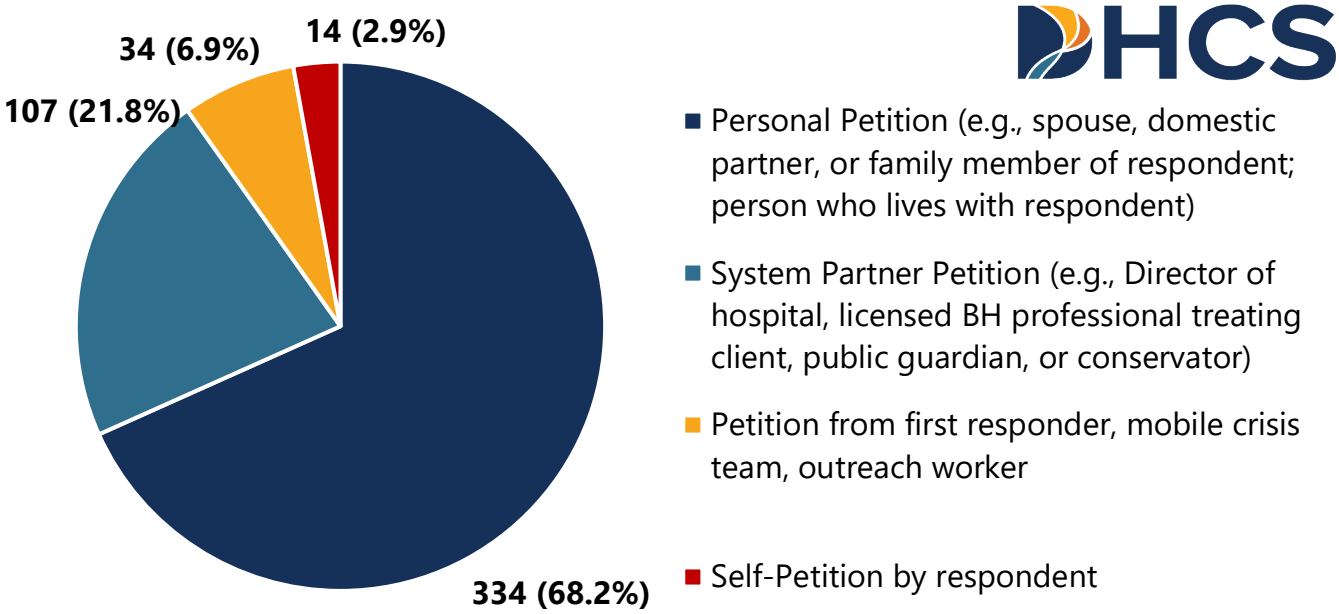
[1] The 497 CARE petitions represent 490 unique CARE respondents, given that some respondents were petitioned more than once.

- 55 were found to be ineligible for CARE but received county behavioral health services.
- 90 were found to be ineligible for CARE and did not receive any county behavioral health services.

CARE petitions dismissed by the courts will require further research, since the reasons for their dismissal are not available for this preliminary report. They could include people who were dismissed for successful voluntary engagement in care, people not eligible for CARE who receive needed treatment through other routes, or people who could not be engaged in care.

As a new opportunity for families and local leaders outside of county BH to petition a civil court for treatment and housing, CARE petitions can be filed by a range of individuals. As detailed in **Figure ES1** below, of the 490 CARE respondents that were sent to counties, 334 (68 percent) were petitioned by someone with a personal relationship to the respondent (referred to as a personal petition); 107 (22 percent) by a system partner (defined as a hospital director, licensed BH professional treating client, public guardian, or conservator); 34 (7 percent) by a first responder, mobile crisis team, or outreach worker; and 14 (3 percent) by the respondent themselves. The variety of petitioners is key to facilitate access to BH services and supports for vulnerable people with unmanaged mental illness.

Figure ES1: Origin of CARE Petitions Among CARE Respondents



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024

Prepared by the California Department of Health Care Services.

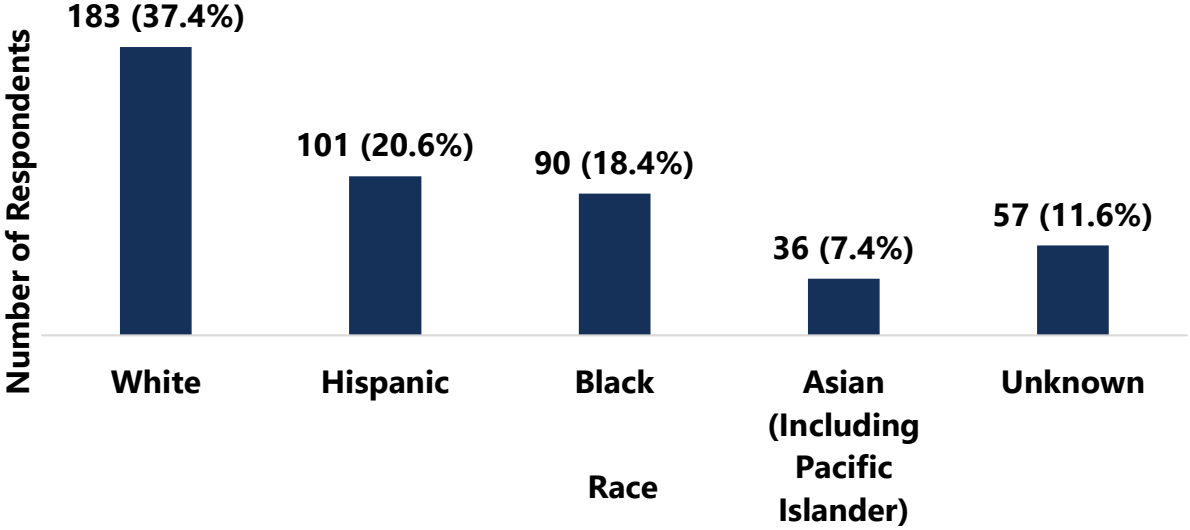
Supporter Involvement, and Timelines

- **Volunteer Supporters:** Volunteer supporters are considered a key feature of person-centered care for CARE respondents. A third (32 percent) of individuals with a CARE agreement or CARE plan had a volunteer supporter, of which the majority were family members.
- **Average from Petition to Disposition:** Among the 261 CARE respondents with an assigned disposition (CARE agreement, CARE plan, or dismissal), the average length of time from petition to first disposition was 76 calendar days (ranging from 8 – 253 days). Of the 261 CARE respondents, 223 (85 percent) took 31 or more days to have a petition disposition assigned. Courts may often provide counties with more time to engage respondents, when there are good faith efforts underway, even if this means repeated extensions of statutory timeframes aimed at speed. The State has provided funding for court and county staff to bill for this additional staff time, and this funding continues.

Demographics of Respondents Referred to County Behavioral Health Agencies

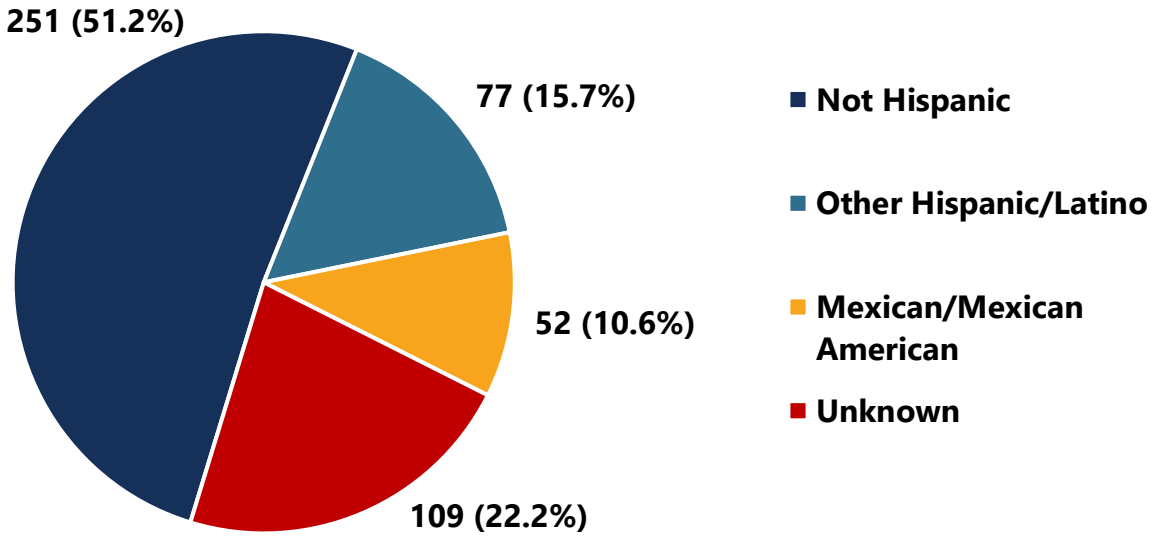
Demographic information for CARE respondents is collected and reported by counties. While demographic data is primarily identified by the client (client self-report), if a client is not able to provide this information, counties can report using collateral and/or volunteer supporter reports as a source. Most CARE respondents were between the ages of 26 – 45 years (64 percent) and male (64 percent). With regard to the racial makeup of CARE respondents, over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian (**Figure ES2**). Around half of CARE respondents (51 percent) identified as being of non-Hispanic ethnicity, 16 percent identified as being of Hispanic ethnicity, and 11 percent identified as Mexican or Mexican American (**Figure ES3**). Most CARE respondents reported English as their preferred language (84 percent).

Figure ES2: CARE Respondent Demographics: Race



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

Figure ES3: CARE Respondent Demographics: Ethnicity



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

The following social characteristics were observed of the 490 unique CARE respondents during their CARE Process Initiation Period[2]:

- The largest proportion of CARE respondents' employment status was in the "other" response category (60 percent), with the most common descriptors noting the respondent was unemployed, not seeking work, or unable to work due to a disability. Seven percent were reported to be in the unpaid workforce (e.g., student, retired, looking for work).
- Sixty five percent of CARE respondents were housed (permanent, institutional, or temporary), and 30 percent were unhoused. Most respondents were reported to be in permanent housing (41 percent), rather than institutional (16 percent) or temporary housing (8 percent).
- Most CARE respondents reported being Medi-Cal enrollees (51 percent), followed by "unknown" health coverage (43 percent) and Medicare enrollees (6 percent).

[2] For the purposes of this analysis, the first available data during the CARE Process Initiation Period was used to describe respondent employment status, housing status, and health care coverage at the time of petitioning.

Services and Supports for CARE Participants

Among the 101 CARE participants (those with a CARE agreement or CARE plan), the average time in their Active Service Period (from the time of disposition assignment to the last day of the reporting period) was 99 calendar days (Standard Deviation[3] [Std Dev.] 57.9 days), with a range of 3 – 223 days. Observations of service and support access for CARE participants at any time during their Active Service Period include:

- Over three quarters (76 percent) accessed a specialized program for individuals with serious mental disorders (e.g., Assertive Community Treatment or Full-Service Partnership) at any point during their Active Service Period.[4]
- The majority accessed mental health treatment services (93 percent) and stabilizing medications (72 percent). Of participants who received a stabilizing medication, 40 percent received a long-acting injectable.
- Nearly two-thirds (63 percent) accessed the three evidence-based services and supports that provide critical foundations for recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports). Another 28 percent accessed two of the three services and supports.

Meeting CARE Participant Needs

If, during a CARE participant's time in their Active Service Period, they become unhoused, require emergency room services, hospitalized, detained or involved with law enforcement, this is an indication of unmet needs.

The most common unmet need for CARE participants was securing and maintaining permanent housing. Of the CARE participants who were unhoused at time of their petitioning (33 percent of all participants), two-thirds had obtained some form of housing—whether temporary, institutional, or permanent—by the most recent reporting month of their Active Service Period. Of the 66 percent of CARE participants housed at the time of their petitioning, few were reported to be unhoused in the most current reporting month of their Active Service Period. Overall, the proportion of CARE participants with permanent housing increased over time, increasing from 46 percent at the time of petitioning to 56 percent in the most current reporting month of their Active

[3] Standard deviation is a statistical measure that quantifies the amount of variation or dispersion in a set of data values.

[4] The focus on point-in-time access in this first Annual Report is due to the limited ability to understand trends in service and support utilization or engagement with CARE participants only being in an Active Service Period for, on average, approximately three months. Future Annual Reports will expand upon this initial analysis.

Service Period. These findings suggest engagement in CARE may assist CARE participants with gaining or maintaining housing, but there are still opportunities to help ensure this critical need is met.

Additionally, available county data suggest that, during the Active Service Period, 25 percent of CARE participants were reported to have criminal justice involvement; 21 percent had an emergency department visit; 20 percent had an inpatient hospitalization; and 20 percent had been placed on a LPS hold. While the data indicate that the majority of CARE participants avoid undesirable outcomes during their Active Service Periods, it also highlights the need for ongoing collaboration with key system partners (e.g., first responders, jails, hospitals, LPS facilities) given the acuity of the CARE population.

Insights on Elective Clients

During the first nine months of CARE Act implementation, 15 petitioned CARE-eligible individuals were dismissed by the courts, following CARE petitioning, and diverted to receive county services and supports outside court jurisdiction. These clients are referred to as elective clients. While there are too few elective CARE clients to support a robust analysis, observations about this group suggest that elective clients may have different care patterns than CARE participants. This finding may also reflect challenges county BH agencies have reported in tracking individuals outside the court jurisdiction due to existing tracking mechanisms that focus only on CARE participants and sensitivities around reporting data due to privacy rules and regulations.

Available data for elective clients indicate that:

- The majority of elective clients did not receive all three evidence-based services and supports during their Active Service Period.
- Elective clients were primarily reported to receive only mental health services.
- Almost none were reported to receive stabilizing medications.
- None received substance use disorder treatments, CalAIM community supports, or social services and supports.

Data Considerations

This report provides preliminary insights into the first nine months of CARE Act implementation in the eight pilot counties. The following data considerations suggest caution in interpreting findings in this early report:

- Counties were not required to report on the reason for dismissal or track dismissed individuals beyond the court's decision (with the exception of elective clients who were eligible for CARE but were receiving county services and supports outside court jurisdiction).
- Counties were not required to report detailed information on respondents in the CARE Process Initiation Period (the period between when a petition is referred by the court to county behavioral health and when a disposition is reached), which extended over a month for the majority of respondents. Therefore, data on outreach and engagement attempts, service access, or events such as arrests and hospitalizations that occurred during this initiation phase were not available.

Based on learnings from the early months of CARE implementation, legislative amendments have been enacted to improve future CARE data reporting. These new reporting requirements went into effect on January 1, 2025, and will support the presentation of a more complete picture in future reports, including new data points (e.g., outreach and engagement efforts) and reporting for additional populations (e.g., inquiries about CARE directed to county BH agencies, referrals from key system partners, such as courts, to promote access among potentially eligible individuals).

Opportunities for Leveraging CARE Act Data

While the CARE Act is still in its early stages, it is showing promise in helping the state's most vulnerable populations towards long-term recovery and housing stability within the eight pilot counties. These promising results from the CARE Act underscore the state's ongoing investments in transforming the behavioral health system. The CARE Act, in conjunction with Proposition 1 and the Behavioral Health Services Act as well as Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) are creating more robust resources for helping California residents with significant BH needs access care through increased treatment capacity, housing supports and services, and workforce development.

The information in this report can help courts, counties, and system partners enhance the CARE Act processes and implementation. State partners are already working in coordination with a range of stakeholders and implementation partners on improvements to CARE process timelines, awareness of CARE among all petitioner types, data reporting, service connection, court involvement, and other components of successful implementation.

Key Takeaways

Data collected over the course of the first nine months of CARE Act implementation within the eight pilot counties illuminate several key takeaways:

- **The majority of CARE respondents engaged in the first nine months of the CARE Act implementation were males, between ages 26-45, and indicated English as their preferred language. Over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian.**
- **CARE Act processes—like all mental health and substance use disorder care—may require time to build trust and develop person-centered plans needed for long-term recovery and stability.** Of the 490 CARE petitions received by county behavioral health agencies at the time of this report development, 229 petitions were still in the CARE Process Initiation Period and had yet to receive a disposition assignment from the court at the end of this observation period. Of the 261 CARE respondents, 223 (85 percent) took more than 30 days to have a petition disposition assigned.
- **Ongoing housing services and supports are an area of high need for the CARE population.** Housing provides a stable foundation to help individuals manage serious mental illness and make progress toward long-term recovery. Overall, the proportion of CARE participants with permanent housing increased over the first nine months of CARE implementation, with 46 percent of participants being permanently housed at the time of petitioning and 56 percent in the most current reporting month of Active Service. These early findings suggest engagement in CARE may be a factor in gaining or maintaining housing. However, there is still a need for services to support permanent housing solutions and CARE participants appear to experience challenges with stable community-based living, even while on a CARE agreement or CARE plan. Challenges with stable housing are likely also compounded by other unmet needs among CARE respondents, with 25 percent of respondents experiencing criminal justice involvement, 21 percent requiring at least one emergency department visit, 20 percent experiencing at least one inpatient hospitalization, and 20 percent reporting at least one LPS hold in their Active Service Period. Maintaining permanent housing remains a common challenge for CARE participants, which underscores the need for continued prioritization of housing services and supports for this population.

- **Nearly two-thirds (63 percent) of CARE participants received the three evidence-based services and supports that provide critical foundations for recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports)**. In contrast, elective clients received relatively fewer services and county behavioral health agencies reported challenges with tracking and collecting data on these individuals. This disparity in services access between CARE participants and elective clients could indicate a gap in care quality that warrants closer monitoring and will be further explored in future reports.
- **The introduction of person-centered care tools, including psychiatric advance directives (PADs) and volunteer supporters, offered valuable insights to inform ongoing implementation efforts of the CARE Act.** Two available tools to support person-centered care for CARE participants—PADs and volunteer supporters—were monitored over the first nine months of implementation. While no PADs had been established by the time of this report, efforts to introduce and integrate them into care planning are ongoing. Approximately one-third of participants had an identified volunteer supporter, providing a foundation to build upon in future efforts.

Leveraging Findings: Legislative Changes

To expand the scope of collected data and reflect other learnings from the early months of implementation, legislative amendments have been enacted to improve future reporting. These new reporting requirements went into effect on January 1, 2025, and will support the presentation of a more complete picture in future reports. County CARE Act data collection and reporting requirements have been expanded to monitor:

- Referrals from key system partners to promote access among potentially eligible individuals (Senate Bill 42).[5]
- Outreach and engagement efforts to improve efficiency of the CARE process, understand the needs of respondents and the services provided to address

[5] Amended provisions of the CARE Act in a number of ways, including the creation of a formal pathway for facilities treating individuals under involuntary holds to refer those individuals to county behavioral health (BH) agencies if they believe the individual meets or is likely to meet CARE criteria and allowance for communication between CARE courts and referring courts (juvenile, Lanterman-Petris-Short [LPS], Assisted Outpatient Treatment [AOT], Misdemeanor Incompetent to Stand Trial [MIST]) while both cases are pending.

them during an extended CARE Process Initiation Period and engage hard-to-reach and under-represented populations (Senate Bill 1400).[6]
- Outcomes and patterns of service access among individuals petitioned to CARE who receive different dispositions (e.g., CARE participants vs. elective clients) to understand the potential value of court involvement (Senate Bill 1400).

Leveraging Findings: Information Sharing and Partnerships

To directly address key takeaways from the early implementation of CARE, a number of efforts are underway that fall into three general categories:

1) Training and technical assistance to courts, counties, and system partners to more effectively implement best practices in outreach and engagement.
2) Training and technical assistance to promote evidence-based best practices for service and support delivery to CARE-eligible populations.
3) Intentional information sharing and partnerships to cross-promote efforts to serve CARE respondents.

Training and technical assistance to courts, counties, and system partners to more effectively implement best practices in outreach and engagement.

- Continuing to aid courts, counties, and system partners to optimize and improve CARE Act processes. Such efforts include sharing effective strategies for outreach and engagement, improving court referral processes, and cross-system collaborations to reduce variations in CARE-eligibility determinations and petition dispositions.

Training and technical assistance to promote evidence-based best practices for service and support delivery to CARE-eligible populations.

- Expanding technical assistance efforts to promote awareness of best practices and improve access to all three foundations for recovery. This includes key features of person-centered care—such as psychiatric advance directives and volunteer supporters—to facilitate long-term recovery.
- Continuing to actively address unmet needs that may contribute to emergency department visits, hospitalizations, encounters with law enforcement and LPS holds.

[6] Amended provisions of the Penal Code related to referrals to CARE of individuals deemed Incompetent to Stand Trial (IST). Additionally amends provisions of the California Welfare and Institutions Code (W&I Code) to expand the requirements for data reporting, including data related to inquiries and referrals.

Intentional information sharing and partnerships to cross-promote efforts to serve CARE respondents.

- Expanding efforts to raise awareness about the CARE Act and its potential for helping individuals achieve long term recovery and lasting wellness, especially among system partners and other potential petitioners who may be well-positioned to refer and connect individuals to CARE. State and local partners are providing relevant technical assistance and coordinating with system partners (i.e., hospitals, first responders, Department of State Hospitals [DSH], California Department of Corrections and Rehabilitation [CDCR]) across the state to develop petition pipelines.
- Prioritizing housing services and supports for CARE participants and ensuring they have access to federal and state programs that support the housing needs of eligible individuals.
- Increasing awareness of initiatives and programs that prioritize CARE participants for permanent rental subsidies, housing services, and supports, and evidence-based practice models such as those supported through the BH-CONNECT, Proposition 1, and the Behavioral Health Services Act (BHSA).

To access CARE Act training and resources, please visit the CARE Act Resource Center.

CARE in Action: Building Trust & Creating Consistency

Building Trust and Recovery

A young individual living with schizophrenia struggled for a long time to engage in voluntary services, did not have access to the intensive support they needed, and was hospitalized repeatedly, prompting their parent to file a CARE petition on their behalf. Through consistent, compassionate engagement, the CARE team earned their trust, helped manage relapses, and supported their goals—ultimately enabling the individual to live with their parent and contribute to the household in ways that feel meaningful to them. "Looking at a client's interests and hopes helps make them comfortable, and we want to build from where the client was before the crisis," said a county behavioral health services administrator. Today, with the support of the county's CARE team, the individual is working toward their high school diploma and dreams of giving back to their community through volunteering for the city.

From Crisis to Consistent Care

A licensed clinical social worker and a parole agent, both with CDCR, collaborated to file the first CARE petition from CDCR's Behavioral Health Reintegration Program. They identified an individual with a long history of mental illness and incarceration as a strong candidate. Despite previous challenges—such as walking away from housing due to paranoia and cycling frequently in and out of hospitals and jails—the CARE

petition, supported by detailed case notes and photos, led to immediate intervention. The individual now receives consistent support, including housing, and has time for recovery and further strengthening of the therapeutic alliance that has now been initiated. Their CARE team expects that they will experience fewer adverse events (e.g., arrests) over time. This continuity of care, they said, offers the individual a safety net they've never had before.

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 schizophrenia spectrum or other psychotic disorders 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 a pathway to long-term recovery. The CARE Act created a new 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 LPS conservatorships.

The CARE Act was implemented in two cohorts.

- Counties who 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.[7]

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—focuses 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.[8] As such, data from Cohort II counties are not included in this report. Pursuant to Welfare and Institutions (W&I) Code section 5985(e), the Annual Report shall include 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 the CARE Act implementation, including:

[7] 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.
[8] Los Angeles County implemented the CARE Act in December 2023.

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

Pursuant to Assembly Bill 102 (Ting, Section 133, Provision 24(a)-(d), Budget Act of 2023), DHCS, in consultation with JC, released the CARE Act Early Implementation Legislative Report in November 2024. The CARE Act Early Implementation Legislative Report included aggregate data from courts, with a focus on petition volume, CARE hearing counts, and petition dispositions during the first nine months of CARE Act implementation. This report was intended to inform decisions about funding needs for the ongoing implementation of the CARE Act; it does not include key outcome metrics necessary to measure the impact of the CARE Act. This first Annual Report builds upon the CARE Act Early Implementation Legislative Report by providing deeper insights into CARE Act implementation, early participant data, and opportunities for enhancement of CARE processes .

Of note, 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 the RAND Corporation) 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.

Additionally, an independent report authored by the Legal Services Trust Fund Commission (LSTFC) at the State Bar is included in Appendix B. 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 originates from an independent source and is collected through a distinct methodology; therefore, variances or discrepancies in comparison to other data sets presented in the DHCS annual report may occur and should be interpreted accordingly.

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 Version 1.0. To minimize the burden of data collection and reporting, the CARE Act Data Dictionary was purposefully aligned (to the extent possible) with existing state and federal data requirements and industry standards. These data were used to produce the Annual Report.

JC Data: Data submitted by JC includes aggregated data from county 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 respondents served by county BH agencies. Quarterly county submissions capture information on the socio-demographic characteristics of petitioned individuals; services and supports provided to CARE participants and elective clients; and other key adverse events (e.g., emergency department visits, hospitalizations, incarcerations and LPS holds).

Table 1 below highlights the three reporting quarters of data used to develop this report, covering CARE Act implementation from October 1, 2023, to June 30, 2024. Data used in this report was exported from the cumulative CARE Act dataset for analysis on November 19, 2024, following a final review by both county BH agencies and JC.

Table 1: Data Included in First CARE Act Annual Report

Reporting Quarter and Year	Dates Covered
Quarter 4 2023	October 1 – December 31, 2023
Quarter 1 2024	January 1 – March 31, 2024
Quarter 2 2024	April 1 – June 30, 2024
Note: Los Angeles County implemented the CARE Act in December 2023.	

To contextualize the JC and county-reported quantitative data, this report considers and leverages several additional sources of information. These include information from 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. Administrative claims data were not used for this report.

2.1 Data Analysis

Quality assurance process. Prior to analysis, data was cleaned and validated according to a standard quality assurance process based on four key dimensions: **c**ompleteness, **a**ccuracy, **r**easonability, and **t**imeliness (C.A.R.T.). Technical specifications on data validation processes and construction of key variables can be found in Appendix A.

Inclusion of missing and "unknown" data. Prior to development of the descriptive statistics presented in this report, bivariate analyses were conducted (tetrachoric correlation) to assess the relationship between variables. This analysis of CARE Act data revealed moderate to strong associations among some sociodemographic characteristic variables and outcome variables, indicating that missing or "unknown" data is not randomly distributed. As a result, missing and "unknown" values are displayed and/or noted in tables to prevent misinterpretation on key outcome variables of interest.

Methods. Descriptive statistics were generated to summarize CARE Act data. Generated statistics included means and standard deviations for continuous variables and frequency counts for categorical variables. Where possible, descriptive statistics were stratified to highlight differences across CARE dispositions (those with CARE agreements or plans compared to dismissed and elective clients). For some categorical data, variables were grouped into broader, meaningful categories. For service provision and adverse events (e.g., jail days), variables were re-coded 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 reviewed and free text responses were re-categorized.

Privacy protection and data suppression methods. Due to 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. The display and visualization of all data was conducted in accordance with the DHCS Data De-identification Guidelines (DDG) v2.2. This means, 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. Variables with a very high proportion of "unknown" or missing values were not displayed to avoid misinterpretation and/or to comply with data suppression requirements for small numbers. For respondents who were petitioned more than once in the first nine months of implementation, data associated with the last petition was included in the individual-level analysis.

3. Findings: Civil Court Data

Each court hearing and required activity of the CARE process are defined in W&I Code sections 5970 – 5987. While some components of the law are prescriptive, the CARE process is intended to be person-centered and flexible for petitioned individuals. Using aggregated data from JC, this section describes the number of CARE petitions filed and their progression through the courts.

3.1 Petitions Submitted to the Courts

The CARE Act authorizes a range of individuals to file petitions and initiate CARE Act proceedings, such as family members, health care or social service providers, and first responders. As detailed in **Table 2** and **Figure 1** below, 556 petitions were filed between October 1, 2023, through June 30, 2024.

Table 2: CARE Petitions Submitted, by Reporting Quarter and Year

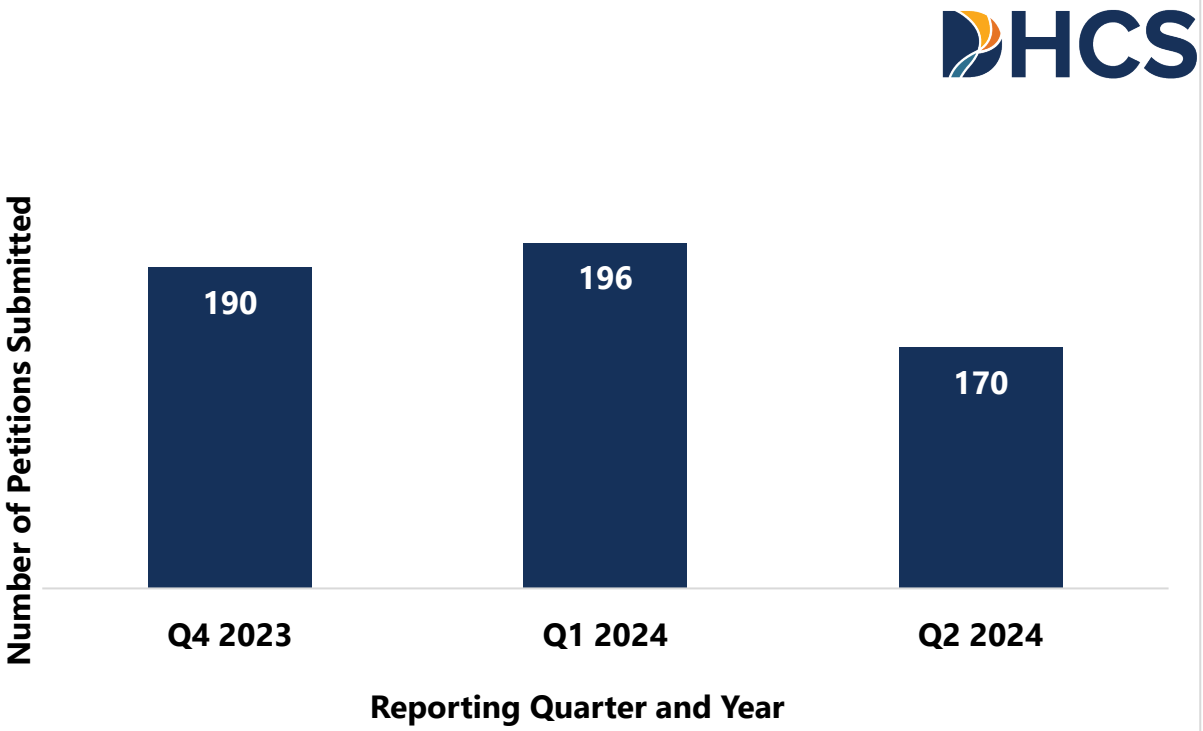
Reporting Quarter and Year	Submitted Petitions
Quarter 4 2023	190
Quarter 1 2024	196
Quarter 2 2024	170
Total	**556***

*This data differs slightly from the data in the CARE Act Early Implementation Legislative Report, which included pre-validated data.
Note: Los Angeles County implemented the CARE Act in December 2023.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024.

Prepared by the California Department of Health Care Services.

Figure 1: CARE Petitions Submitted, by Reporting Quarter and Year



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024
Prepared by the California Department of Health Care Services.
Note: Los Angeles County implemented the CARE Act in December 2023

3.2 Initial CARE Appearances/Hearings Set and Held by the Courts

Following the filing of a CARE petition, the court decides if the petition shows that the individual meets, or may meet, eligibility criteria for CARE proceedings (i.e., prima facie showing). This may include—in instances where the petition is filed by someone other than the county BH agency—ordering an investigation by a county BH agency to make recommendations regarding CARE eligibility. If the court determines that the petition demonstrates 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). As detailed below in **Table 3** and **Figure 2**, within the first nine months of the CARE Act implementation, 606 initial CARE appearances were set, and 403 initial CARE

appearances were held.[9] Note, each initial CARE hearing or appearance may be calendared several times before it is held.

Table 3: Initial CARE Appearances/Hearings Set and Held, by Reporting Quarter

Reporting Quarter	Initial CARE Appearances Set	Initial CARE Appearances Held
Quarter 4 2023	104	80
Quarter 1 2024	252	172
Quarter 2 2024	250	151
Total	**606**	**403**

Each petition may be associated with multiple initial appearances/hearings, and each initial CARE hearing or appearance may be calendared several times before it is held.

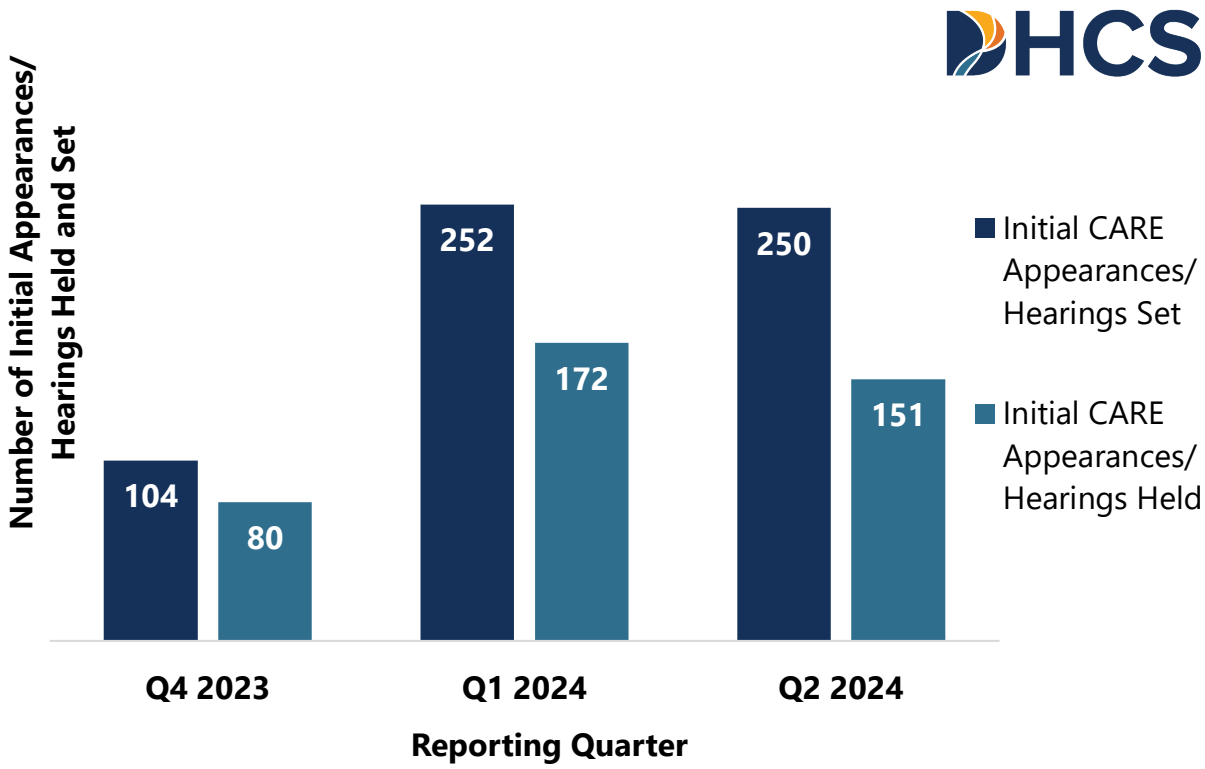
Los Angeles County implemented the CARE Act in December 2023.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024.

Prepared by the California Department of Health Care Services.

[9] 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 re-set due to postponement.

Figure 2: Initial CARE Appearances/Hearings Set and Held, by Reporting Quarter



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024
Prepared by the California Department of Health Care Services
LA County implemented the CARE Act in December 2023.

3.3 Total CARE Hearings Held by the Courts

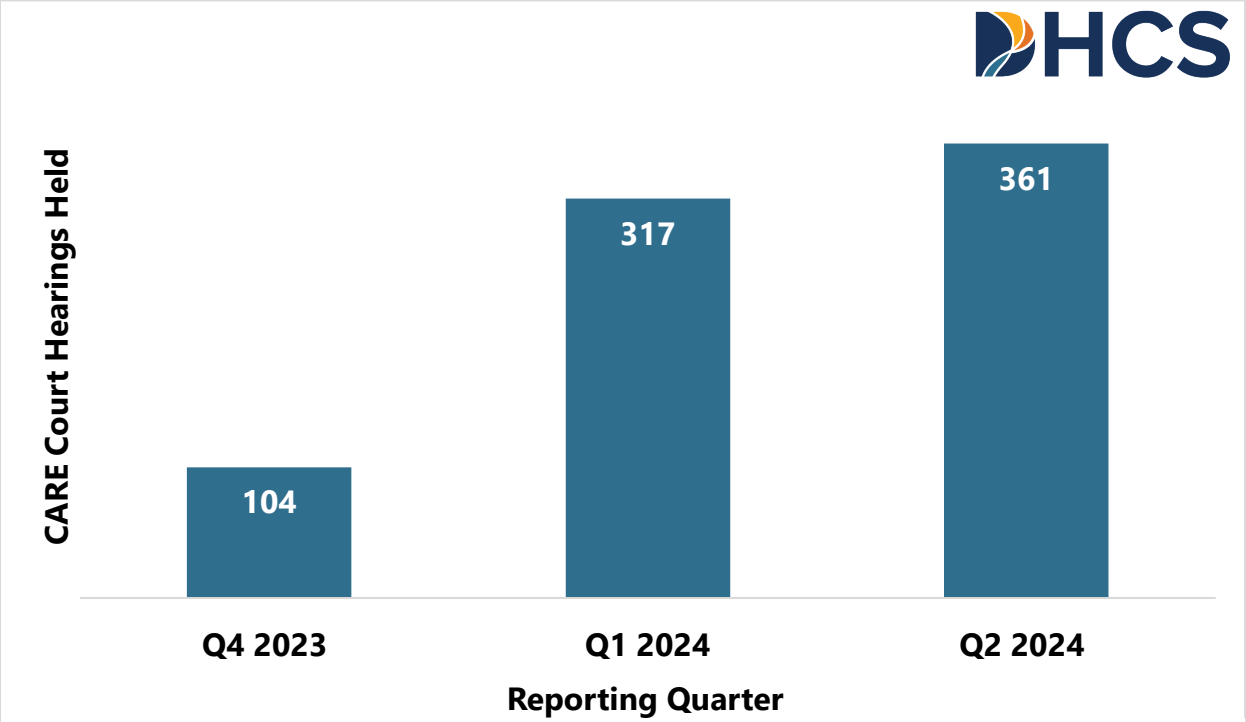
As detailed in **Table 4** and **Figure 3** below, 782 court hearings were held. This total accounts for all hearings associated with a petition including the initial appearance, hearing on the merits of the petition, case management, clinical evaluation review, CARE plan review, progress review, and status review.

Table 4: Total Court Hearings Held Associated with CARE Petition, by Reporting Quarter

Reporting Quarter	Hearings Held
Quarter 4 2023	104
Quarter 1 2024	317
Quarter 2 2024	361
Total	**782**

Reporting Quarter	Hearings Held
Los Angeles County implemented the CARE Act in December 2023. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024. Prepared by the California Department of Health Care Services.	

Figure 3: Total Court Hearings Held Associated with CARE Petition, by Reporting Quarter



LA County implemented the CARE Act in December 2023.
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024
Prepared by the California Department of Health Care Services

3.4 CARE Petition Disposition Assignment

Following review, the court decides the respondent's CARE eligibility and assigns a CARE disposition (i.e., CARE agreement, CARE plan, dismissal). Services may include medically necessary stabilization medications, housing resources and supports, treatment for substance use disorder (SUD), and social services. Overall, 101 petitions (18 percent of all petitions filed) had an assigned disposition of an approved CARE agreement or an

ordered CARE plan.[10] Due to the number of CARE agreements and CARE plans in the first nine months of implementation, quarterly data is not provided in this report, in compliance with California state privacy laws.

At the judge's discretion, a petition may be dismissed by the court after being filed. Although all petitions will eventually be dismissed, there are several reasons why a petition may be dismissed early in the CARE process. For example, not demonstrating a prima facie showing, successfully engaging a respondent in voluntary services outside of court jurisdiction, or not meeting CARE eligibility criteria after county BH investigation. Of note, beginning in 2025, county BH agencies will be required to report on why they recommended a petition dismissal, and if relevant, reasons for CARE ineligibility. As shown in **Table 5** and **Figure 4** below, 217 total petitions (39 percent) of all filed CARE petitions were dismissed by the courts during the first three reporting quarters.

Table 5: Cumulative CARE Petitions and Dismissals

Reporting Quarter	Total Petitions, To-Date±	Dismissed Petitions, To-Date
Quarter 4 2023	190	37 (20%)
Quarter 1 2024	386	123 (32%)
Quarter 2 2024	556	217 (39%)

± "To-Date" is defined as the last day of the Reporting Quarter.

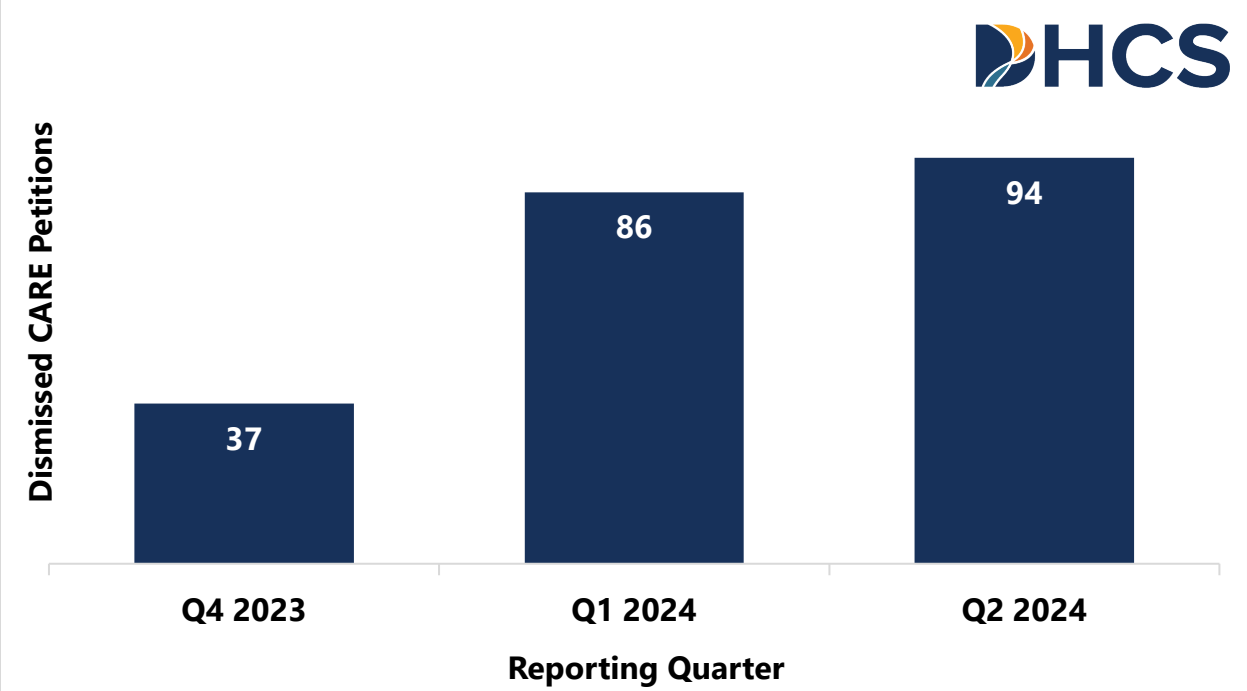
Notes: 1) A petition dismissal may occur in the same reporting quarter, or a subsequent reporting quarter, as the petition filing date. 2) Los Angeles County implemented the CARE Act in December 2023.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024.

Prepared by the California Department of Health Care Services.

[10] **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 plan of community-based services and supports relevant to the CARE respondent. **CARE plans** include the same elements as a CARE agreement (e.g., plan for individualized services and supports) but are court-ordered.

Figure 4: Total Count of CARE Petitions Dismissed, by Reporting Quarter and Year



LA County implemented the CARE Act in December 2023.
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: November 19, 2024
Prepared by the California Department of Health Care Services

4. Findings: County Behavioral Health CARE Participant Data

Of the total 556 petitions submitted to the court, 497 CARE petitions were received by county BH agencies during the first nine months of CARE Act implementation. This discrepancy exists because courts can dismiss a petition for not demonstrating a prima facie showing or petitions may be pending court determination at the end of the reporting period covered in this Annual Report. County BH agencies are only aware of and able to track CARE petitions they file themselves or those they are ordered to investigate by the courts.

4.1 CARE Respondents Sent to County Behavioral Health Agencies

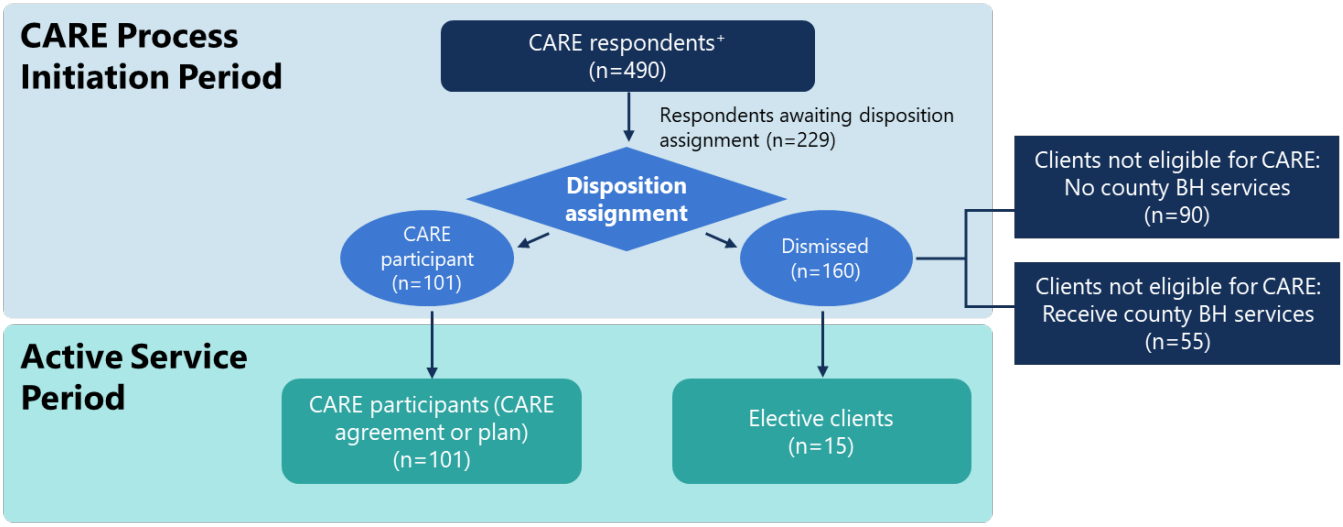
Figure 5 below shows the flow of petitions from courts to county BH, including disposition assignment by courts and county action. These petitioned respondents are in their **CARE Process Initiation Period**, which begins when a petition is filed or the court orders a county to file a written report and concludes when the court assigns a disposition (i.e., approves a CARE agreement, orders a CARE plan, or dismisses the petition). As some respondents were petitioned more than once, the 497 CARE petitions represent 490 unique CARE respondents. Of the 490 unique CARE respondents that flowed to county BH agencies, 160 were dismissed by the court. Among the 160 dismissed:

- 15 became **elective clients**. An elective client is defined as a CARE-eligible individual who elects to voluntarily engage in county BH services and supports outside the CARE Act proceedings.
- 55 were found to be ineligible for CARE but received county BH services.
- 90 were found to be ineligible for CARE and did not receive any county BH services.

An additional 101 CARE respondents were found to meet CARE eligibility requirements and had a CARE agreement approved, or a CARE plan ordered by the court. Individuals who have a CARE agreement approved, or CARE plan ordered are referred to as **CARE participants**. Following disposition assignment, CARE participants and elective clients move into their **Active Service Period**, which continues for 12 months for all CARE participants and elective clients or up to a total of 24 months for those reappointed in a CARE plan.

At the end of June 30, 2024, petitions for 229 respondents received by county BH agencies did not yet have a disposition assigned by the court.

Figure 5: Flow of CARE Respondents Through County Behavioral Health Agencies



+ 497 total CARE petitions, representing 490 unique CARE respondents, were received by county BH agencies

4.1.1 Time from Petition to First Disposition

As detailed in **Table 6**, across the 261 CARE respondents with a petition disposition, the average number of days from petition to first disposition was 75.6 calendar days, or approximately 2.5 months (range: 8 – 253 days). Of the 261 CARE respondents with a petition disposition, 223 (85 percent) took 31 or more days to have a petition disposition assigned. During a respondent's CARE Process Initiation Period, a range of activities can occur simultaneously, such as outreach and engagement, service and support delivery, county investigation and information gathering for the purposes of court disposition assignment, and trust building with the respondent. Future Annual Reports will include the information about the extent of county BH outreach and engagement efforts, as well as services and supports provided during the CARE Process Initiation Period, per Senate Bill 1400 signed into law in September of 2024.

Among the 101 CARE participants, the average number of days from petition to first disposition was 79.3 calendar days (range: 8 – 253 days) compared to 73.2 days (range: 16 – 235 days) among those dismissed by the court.

Table 6: Mean Time from CARE Petition to First Disposition Assignment

Respondent Group	Time from CARE Petition to First Disposition Assignment (in Days)			
	Mean	Min	Max	Std. Dev.
All CARE Respondents with Assigned Disposition (n=261)	75.6	8	253	43.9
CARE participants (CARE agreements and CARE plans) (n=101)	79.3	8	253	47.3
Dismissed (including elective clients) (n=160)	73.2	16	235	41.5
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.				

4.1.2 CARE Respondent Socio-demographic Characteristics

Table 7 below summarizes the demographic characteristics of CARE respondents. The data are displayed to highlight socio-demographic differences by disposition type. As a reminder, demographic information for CARE respondents is collected and reported by counties. While demographic data is primarily identified by the client (client self-report), if a client is not able to provide this information, counties can report using collateral and/or volunteer supporter reports as a source.

The majority of CARE respondents were between the ages of 26 – 45 years (64 percent) and male (64 percent). With regard to the racial makeup of CARE respondents, over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian. Around half (51 percent) identified as being of non-Hispanic ethnicity, 16 percent identified as being of Hispanic ethnicity, and 11 percent identified as Mexican or Mexican American. Most CARE respondents reported English as their preferred language (84 percent).

Table 7: Demographics of CARE Respondents, by Disposition Type

Demographic Variable	Total CARE Respondents (n=490) ±	Total Respondents with Assigned Disposition (n=261)	
		Total Dismissed (includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
	n (%)	n (%)	n (%)
Age (missing=18)			
18 – 25 years	27 (5.6%)	*	*
26 – 45 years	313 (63.9%)	88 (55.0%)	64 (63.4%)
46 – 65 years	117 (23.9%)	50 (31.3%)	*
66+ years	15 (3.1%)	*	*
Sex (missing=0)			
Male	314 (64.1%)	108 (67.5%)	60 (59.4%)
Female	160 (32.7%)	49 (30.6%)	34 (33.7%)
Unknown	16 (3.3%)	3 (1.9%)	7 (6.9%)
Race (missing=0)			
White	183 (37.4%)	64 (40.0%)	41 (40.6%)
Hispanic	101 (20.6%)	27 (16.9%)	19 (18.8%)
Black	90 (18.4%)	21 (13.1%)	14 (13.9%)
Asian (Including Pacific Islander)	36 (7.4%)	*	*
Unknown	57 (11.6%)	*	*
Ethnicity (missing=0)			
Not Hispanic	251 (51.2%)	77 (48.1%)	51 (50.5%)

Demographic Variable	Total CARE Respondents (n=490) ±	Total Respondents with Assigned Disposition (n=261)	
		Total Dismissed (includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
Other Hispanic/Latino	77 (15.7%)	18 (11.3%)	14 (13.9%)
Mexican/Mexican American	52 (10.6%)	13 (8.1%)	24 (23.8%)
Unknown	109 (22.2%)	52 (32.5%)	12 (11.9%)
Gender Identity (missing=0)			
Male	263 (53.7%)	82 (51.3%)	56 (55.5%)
Female	136 (27.8%)	37 (23.1%)	27 (26.7%)
Unknown	88 (18.0%)	40 (25.0%)	16 (15.8%)
Preferred Language (missing=0)			
English	413 (84. 3%)	118 (73.8%)	92 (91.1%)
Unknown	66 (13.5%)	38 (22.2%)	9 (8.9%)

* 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. This table excluded data points for Other Disability (52 percent unknown), Sexual Orientation (58 percent unknown), Veteran Status (55 percent unknown), and Tribal Affiliation (57 percent unknown) due to large proportions of unknown values and the need to suppress cells with small values, creating a potential for misinterpretation when only partial data could be displayed.

± "CARE respondents" represent the 490 unique individuals that were petitioned to CARE and sent to county BH agencies over the first nine months of CARE Act implementation. This category represents all petitioned individuals, whether they remain in the CARE Act Initiation Period or have been assigned a disposition by the court at the time of report generation.

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

Prepared by the California Department of Health Care Services.

Table 8 below provides an overview of key characteristics of CARE respondents at the time of petitioning,[11] by petition disposition type. Notable findings include:

- Of the 490 unique CARE respondents, 7 percent were reported to be in the unpaid workforce (e.g., student, retired, looking for work). The largest proportion of CARE respondents' employment status was in the "other" response category (60 percent), with the most common descriptors noting the respondent was unemployed, not seeking work, or unable to work due to a disability.
- Among CARE respondents, 65 percent were housed (permanent, institutional, or temporary), and 30 percent were unhoused at the time of petitioning. Most respondents were reported to be in permanent housing (41 percent) rather than institutional (16 percent) or temporary housing (8 percent).
- Regarding health care coverage, about half of CARE respondents reported being Medi-Cal enrollees (51 percent) and a small proportion reported being Medicare enrollees (6 percent) at the time of petitioning. A large proportion of CARE respondents had unknown health care coverage (43 percent).

Table 8: Characteristics of CARE Respondents at the Time of Petitioning, by Disposition Type

Characteristic	Total CARE Respondents (n=490)±	Total CARE Respondents with Assigned Disposition (n=261)	
		Total Dismissed (includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
	n (%)	n (%)	n (%)
Employment Status (missing=8)			
Employed (Full or Part Time)	*	*	*
Not in Paid Workforce	32 (6.5%)	*	*
Other	293 (59.8%)	79 (49.4%)	65 (64.4%)

[11] For the purposes of this analysis, the first available data during the CARE Process Initiation Period was used to describe respondent employment status, housing status, and health care coverage at the time of petitioning.

Characteristic	Total CARE Respondents (n=490)±	Total CARE Respondents with Assigned Disposition (n=261)	
		Total Dismissed (includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
Unknown	*	*	26 (25.7%)
Health Care Coverage Status (missing=10)			
Medicaid (Medi-Cal)	248 (50.6%)	77 (48.1%)	70 (69.3%)
Medicare	30 (6.1%)	*	11 (10.9%)
Private Pay	*	*	*
Uninsured	*	*	*
Unknown	209 (42.7%)	67 (41.9%)	27 (26.7%)
Housing Status/Living Situation (missing=8) +			
Housed	320 (65.3%)	90 (56.3%)	66 (65.3%)
Permanent	200 (40.8%)	58 (36.3%)	46 (45.5%)
Institutional	80 (16.3%)	*	*
Temporary	40 (8.2%)	*	*
Homeless (or unhoused)	146 (29.8%)	56 (35.0%)	33 (32.7%)
Unknown	12 (2.5%)	14 (8.8%)	2 (2.0%)

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

+ 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.

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

Prepared by the California Department of Health Care Services.

4.1.3 CARE Petitioners

As detailed in **Table 9**, of the 490 CARE respondents, 334 respondents (68 percent) were petitioned by someone with a personal relationship to the respondent (referred to as a personal petition); 107 (22 percent) by a system partner (defined as a hospital director, licensed BH professional treating client, public guardian, or conservator); 34 (7 percent) by a first responder, mobile crisis team, or outreach worker; and 14 (3 percent) by the respondent themselves.

A much higher proportion of personal petitions were dismissed, compared to petitions originating from system referrals (62 percent vs. 26 percent).

Table 9: Origin of CARE Petitions Among CARE Respondents, by Disposition Type

Origin of Petition	Total CARE Respondents (n=490)	Total Respondents with Assigned Disposition (n=261)	
		Total Dismissed (Includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
	n (%)	n (%)	n (%)
Personal Petition (e.g., spouse, domestic partner, or family member of respondent; person who lives with respondent)	**334 (68.2%)**	**99 (61.9%)**	**59 (58.4%)**
A spouse or registered domestic partner, parent, sibling, child, or grandparent of the respondent.	281 (57.3%)	85 (53.1%)	**
A person who stands in the place of a parent to the respondent.	12 (2.4%)	*	*
A person who lives with the respondent.	41 (8.4%)	*	*
System Partner Petition (e.g., Director of hospital, licensed BH professional treating client, public guardian, or conservator)	**107 (21.8%)**	**41 (25.6%)**	**31 (30.7%)**
The public guardian or public conservator	*	*	*
The director of a public or charitable organization, agency, or home who is or has been, within the reporting month, providing behavioral	15 (3.1%)	*	*

Origin of Petition	Total CARE Respondents (n=490)	Total Respondents with Assigned Disposition (n=261)	
		Total Dismissed (Includes Elective Clients) (n=160)	Total CARE Participants (CARE Agreements and Plans) (n=101)
health services to the respondent.			
The director of a hospital in which the respondent is hospitalized.	*	*	*
The director of the county behavioral health agency	33 (6.7%)	*	13 (12.9%)
A licensed behavioral health professional who is or has been, within the reporting month, treating or supervising the treatment of the respondent.	37 (7.6%)	14 (8.8%)	*
Petition from first responder, mobile crisis team, outreach worker	**34 (6.9%)**	*	*
Self-Petition by respondent	**14 (2.9%)**	*	*

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

** Values are not shown to protect confidentiality of the individuals summarized in the data. However, the majority of participants had this response.

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

Prepared by the California Department of Health Care Services.

4.2 Services and Supports Among CARE Participants

For this report, data on services and supports were collected only for CARE participants and CARE-eligible elective clients and monitored after disposition assignment. During the first nine months of CARE Act implementation, almost all CARE participants continued to be engaged in county BH services and supports as of June 2024. The average length of time a CARE participant was engaged in services and supports during their **Active Service Period** (defined as the time from disposition assignment to the last day of the reporting period used for this report) was 98.8 calendar days (Std Dev. 57.9 days), with a range of 3 – 223 days.

4.2.1 CARE Participant Access to Services and Supports

For the purposes of this first 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. This first Annual Report focuses on point-in-time access due to the short span of time that CARE participants spent in Active Service Period (3 months on average), which limits the ability to observe trends in service and support utilization and engagement. Future Annual Reports will expand upon this initial analysis. **Table 10** below summarizes the number and proportion of CARE participants who accessed a service or support during their Active Service Period. Where possible, the top two most accessed service types within each service and support category are also presented in Table 10.

Specialized Programs

Three quarters of CARE participants (76 percent) were reported to be enrolled in a specialized program at some point during their Active Service Period. The most accessed specialized program was Assertive Community Treatment (ACT), with nearly half of all CARE participants (48 percent) enrolled in ACT at some point during their Active Service Period.[12,13] The second most accessed specialized program was Full-Service Partnership

[12] ACT is an evidence-based comprehensive, time-unlimited psychosocial and community-based intervention and alternative to hospitalization for individuals with serious mental illness.
[13] 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.

(FSP).[14,15] Nearly one third (31 percent) of CARE participants were enrolled in an FSP program during the Active Service Period. A few clients moved from FSP to ACT during the Active Service Period. No CARE participants were enrolled in Early Psychosis Intervention or Forensic ACT (FACT) during the Active Service Period.

Specific Services and Supports

The most common service type accessed was mental health (MH) treatment services, with 93 percent of CARE participants receiving at least one MH treatment service during their Active Service Period. The top two most accessed MH services were targeted case management and medication support. The least commonly received service type provided was SUD treatment services.

The majority of participants also received stabilizing medications (72 percent) and social services and supports (60 percent). Of participants who received a stabilizing medication, 40 percent (29 percent of all participants) received a long-acting injectable. Across CARE participants who accessed a social service or support in their Active Service Period, the two most frequently provided were CalFresh and Supplemental Security Income/State Supplementary Payments.

Of the 16 percent of CARE participants who accessed a California Advancing and Innovating Medi-Cal (CalAIM) community support, housing tenancy and sustaining services and housing transition navigation services were the most frequently provided.

Meeting Basic Needs Through CARE: Food, Money, and Housing Supports

During their Active Service Period, most CARE participants received vital supports to help provide stability.

- **60 percent** accessed social services and supports, with **CalFresh** (food assistance) and **Supplemental Security Income/State Supplementary Payments (SSI/SSP)** (financial assistance) being the most commonly provided.
- **16 percent** accessed CalAIM community supports, most often **housing tenancy and sustaining services** and **housing transition navigation services**.

[14] 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. FSP is a core program within the largest of the five the Mental Health Services Act (MHSA) components: community services and supports (CSS).
[15] 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.

- Additionally, **72 percent** of participants received stabilizing medications, with 40 percent of those (29 percent of all participants) receiving a **long-acting injectable** to support consistent treatment.

Table 10: Number and Proportion of CARE Participants Who Had a Service or Support Provided at Any Time in Active Service Period, by Category

Service or Support Category	Total CARE Participants (CARE Agreements + Plans) (n=101)	
	Total with Service or Support (n)	Total with Service or Support (%)
Specialized Program (Any)	**76**	**76.2%**
Assertive Community Treatment (ACT)+	48	47.8%
Full-Service Partnership (FSP)	31	30.0%
Mental Health Treatment Service	**94**	**93.1%**
Targeted Case Management	88	87.1%
Medication Support	81	80.2%
Stabilizing Medication	**73**	**72.3%**
Long-Acting Injectable Medication	29	28.7%
Social Service or Support	**61**	**60.4%**
CalFresh services	37	36.6%
Supplemental Security Income/State Supplementary Payment	22	21.8%
CalAIM Community Support	**16**	**15.8%**
Housing Tenancy and Sustaining Services	11	10.9%
Housing Transition Navigation Services	11	10.9%
Substance Use Disorder Treatment Service	*	*

+ Not all counties had active ACT programs at the time of this report.

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

Note: Where possible, the top two most common services or supports within each service category have been included in this table.

Service or Support Category	Total CARE Participants (CARE Agreements + Plans) (n=101)	
	Total with Service or Support (n)	Total with Service or Support (%)
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.		

Housing 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.[16] At the time of petitioning, 33 percent of CARE participants were reported to be unhoused. Fifteen percent of CARE participants received a CalAIM housing service or support (i.e., CalAIM enrollee benefit) at some point in their Active Service Period (**Table 11**). Thirty-one percent of CARE participants 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 11**).

Table 11: Number and Proportion of CARE Participants Who Had a Housing Service or Support Provided at Any Time in Active Service Period

Housing Service or Support Category	Total CARE Participants (CARE Agreements + Plans) (n=101)	
	Total with Service or Support (n)	Total with Service or Support (%)
Any CalAIM Housing Support	15	14.8%
Any County, State, or Federally Funded Housing Support (Not CalAIM)	31	30.7%
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024.		

[16] 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

Housing Service or Support Category	Total CARE Participants (CARE Agreements + Plans) (n=101)	
	Total with Service or Support (n)	Total with Service or Support (%)
Prepared by the California Department of Health Care Services.		

4.2.2 Evidence-Based Foundations for Recovery

CARE participants are individuals who have severe and persistent symptoms related to schizophrenia or other psychotic disorders and who 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.[17] While data on access to each of these individual components is detailed in the section above, the receipt of comprehensive services and supports that include these three components of care serves as a useful metric for evaluating the CARE Act's effectiveness. As seen below in **Table 12**, 63 percent of CARE participants received all three key services and supports during their Active Service Period and one quarter received two of the three key services and supports.[18] Of the participants that received two of the three services and supports, the most commonly observed combination was housing supports and psychosocial and community-based treatment.

Access to Key Services and Supports Among CARE Participants

Most CARE participants received multiple key services and supports during their Active Service Period. Specifically, **nearly two-thirds received all three critical services—stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports**—while one quarter received two of the three, most often a combination of housing supports and psychosocial treatment.

[17] 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

[18] 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.

Table 12: CARE Participant Receipt of Evidence-Based Components for Recovery

Three Foundational Components for Recovery±	Total CARE Participants (CARE Agreements + Plans) (n=101)	
	Total with Service or Support (n)	Total with Service or Support (%)
All Three Components	64	63.4%
Two of Three Components	*	*
One of Three Components	*	*
No Components	*	*

± 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 housed in permanent, temporary, or institutional housing.

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

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

Prepared by the California Department of Health Care Services.

With regard to housing supports, specifically, early data suggests that participating in CARE may help individuals gain or maintain housing. Of the CARE participants who were unhoused at the time of their petitioning (33 percent of all participants), two-thirds had obtained some form of housing—whether temporary, institutional, or permanent—by the most recent reporting month of their Active Service Period. Of the 66 participants reported to be housed at the time of petition, few were reported to be unhoused in the most current reporting month of their Active Service Period. Overall, the proportion of CARE participants with permanent housing increased over time, with 46 percent of participants being permanently housed at the time of petitioning and 56 percent in the most current reporting month of Active Service. Of note, housing status data was complete (i.e., no "unknown" values or missing data) for all CARE participants during their most recent reporting month used in this report.

4.2.3 Most Frequently Ordered Services and Supports Not Provided

Table 13 provides an overview of the number and proportion of CARE participants who, at any time during their Active Service Period, had a service or support ordered or approved but not provided to them. A participant may have multiple types of services or supports ordered within the categories listed below. While Table 13 lists the category of service or support that was not provided, the participant may still receive other services within the category.

Table 13: Number and Proportion of CARE Participants with a Service or Support Ordered, but Not Provided, by Category

Service or Support Category	Participants with a Service or Support Ordered but Not Provided (n (%))
Specific Social Service or Support	83 (82.2%)
Specific Mental Health Treatment Service	57 (56.4%)
Specific Substance Use Disorder Treatment Service	17 (16.8%)
CalAIM Community Support	13 (12.9%)
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool I Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.	

As a category, social services and supports were the most frequently ordered or approved service type that was not provided, with 82 percent of participants with one or more of these services ordered but not received. The most common social services and supports ordered but not provided to participants (not represented in Table 12) included education and employment services (57 percent) and Supplemental Security Income (SSI)/State Supplemental Payments (SSP) (45 percent).

Over half (56 percent) of CARE participants did not receive at least one ordered MH service during their Active Service Period. The most common MH treatment services ordered but not provided to participants (not represented in Table 13) included peer support services (60 percent of those who did not receive an ordered MH service), medication supports (51 percent), and therapy services (51 percent).

For 31 percent of all services or supports ordered but not provided, county BH agencies did not know or specify the reason why the service was not provided. The top known

reasons for undelivered services were that the service was "pending application" for a social service or support (21 percent), the "client declined" a service (16 percent), and that the service was not available" (12 percent). Reasons for the delay or lack of service provision are likely complex and appear to vary by type of services or supports. For example, counties reported administrative challenges in accessing social services (e.g., time it takes to qualify or enroll in a service) or the lack of available services in the county. However, the data also suggests that client choice may play a part in unprovided services. Counties also noted that specific services were, at times, not needed during a reporting month (e.g., crisis stabilization). This data highlights technical assistance opportunities to target specific challenges in client access to ordered services, including cross-system collaboration efforts.

Barriers to Service Delivery in CARE Agreements or CARE Plans

Not all services and supports outlined in CARE agreements or CARE plans were provided. The top reasons included:

- **Pending application of social services and supports** — 21 percent
- **Client declined services or support** — 16 percent
- **Services or supports unavailable within the county** —12 percent

Counties reported that administrative hurdles, limited local service availability, and participant choice often contributed to service gaps. In some cases, services were not needed during a given reporting month (e.g., crisis stabilization).

4.2.4 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)[19] and volunteer supporters.[20]

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

[20] Volunteer supporters, as outlined in W&I Code section 5981(a), are individuals who may accompany CARE respondents 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.

Psychiatric Advance Directives

Specific to the CARE Act, PADs can be a useful tool to ensure services are delivered to an individual in alignment with their preferences throughout court and beyond.[21,22] At the time of this report, no PADs had yet been established for any CARE participant. Because participants must have capacity to create a PAD, many participants may not be in a position 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.

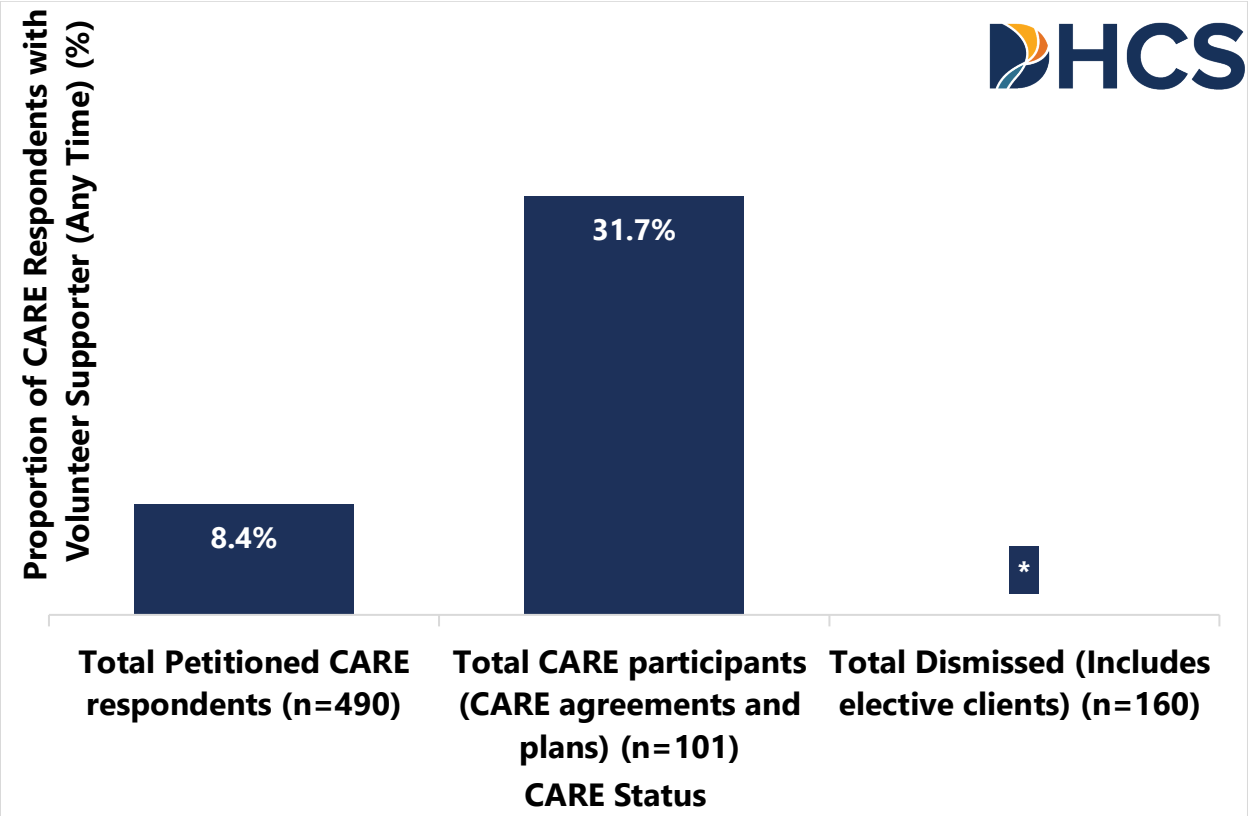
Volunteer Supporters

Volunteer supporters are considered a key feature of person-centered care for CARE respondents and may be identified at any time during the CARE process. **Figure 6** below details the proportion of CARE participants with a volunteer supporter; data for CARE respondents and dismissed respondents are also shown for comparison. One third of CARE participants (32 percent) had an assigned volunteer supporter, while only eight percent of the overall population of CARE respondents received by county BH and three percent of dismissed CARE respondents had a volunteer supporter. This finding may suggest that individuals engaged in CARE as participants are more likely to identify a volunteer supporter. Of the small number of volunteer supporters, the majority were family members (80 percent).

[21] 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/

[22] For more information on PADs and the CARE process: Psychiatric Advance Directives - CARE Act Resource Center

Figure 6: Proportion of CARE Respondents with Volunteer Supporter, by CARE Status



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

4.3 County Capacity to Meet CARE Participant Needs

Table 14 below summarizes the number and proportion of CARE participants who had an event that may signal a need that was not addressed within a community-based setting at some point during their Active Service Period.

Distinct from the potential unmet needs related to participant access to specific services or supports included in the previous section (e.g., MH treatment services), the most common unmet need for CARE participants was securing and maintaining permanent housing. At some point during their Active Service Period, 28 percent were unhoused, 12 percent were temporarily housed, and 20 percent were institutionally housed for, at minimum, the majority of a month. Other events that may signal unmet needs of CARE participants during their Active Service Period included criminal justice involvement (25

percent), emergency department visits (21 percent), inpatient hospitalizations (20 percent) and LPS holds (20 percent). About 15 percent of county-reported data on criminal justice involvement, law enforcement encounters, emergency department visits, and hospitalizations was "unknown" and may represent an undercount of these negative events.

Unmet Needs Impacting Community Stability

Many CARE participants faced challenges securing or maintaining stable, community-based living during their Active Service Period:

- 28% were unhoused for at least part of the period.
- 12% were temporarily housed.
- 20% spent a majority of a month in institutional settings.

Other indicators of unmet needs among CARE participants included:

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

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

Table 14: Number and Proportion of CARE Participants with Event that May Signal Unmet Need within Active Service Period

Event Type	Total CARE Participants (n=101)		
	Yes n (%)	No n (%)	Unknown n (%)
Any LPS Hold	20 (19.8%)	*	*
Any LPS Conservatorship	*	**	*
Any Criminal Justice Involvement	25 (24.8%)	61 (60.4%)	15 (14.9%)
Any Law Enforcement Encounters	18 (17.8%)	67 (66.3%)	16 (15.8%)
Any Jail Days	17 (16.8%)	*	*
Any Prison Days	*	**	*
Any Arrests	19 (18.8%)	*	*

Event Type	Total CARE Participants (n=101)		
	Yes n (%)	No n (%)	Unknown n (%)
Living Situation: Unhoused (Homeless) +	28 (27.7%)	73 (72.3%)	0 (0%)
Living Situation: Institutional Housing +	20 (19.8%)	81 (80.2%)	0 (0%)
Living Situation: Temporary Housing	12 (11.8%)	89 (88.1%)	0 (0%)
Any Emergency Department Visits	21 (20.7%)	65 (64.4%)	15 (14.9%)
Any Hospitalizations	20 (20%)	65 (64.4%)	16 (15.8%)

* Values are not shown to protect confidentiality of the individuals summarized in the data. Note: Data on Misuse of Illegal/Controlled Substances are not displayed due to the large proportion of unknown data reported (66 percent).

** Values are not shown to protect confidentiality of the individuals summarized in the data. However, the majority of participants had this response.

+ 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. Temporary housing generally includes staying with family, friends, or in transitional housing. More detailed definitions for each living situation type are included in the CARE Act Data Dictionary.

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

Prepared by the California Department of Health Care Services.

4.4 County Provision of Services to Elective CARE Clients

During the first nine months of CARE Act implementation, 15 petitioned CARE-eligible clients were diverted to receive county services and supports outside court jurisdiction. These clients are referred to as elective clients. The number of elective CARE clients is not sufficient to support a robust analysis for this Annual Report; however, general observations about this group of individuals are highlighted below to inform potential

CARE Act enhancements. As the number of elective clients increases, future Annual Reports will expand on this group.

- The majority of elective clients did not receive all three evidence-based services and supports (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports) during their Active Service Period. Elective clients were primarily reported to receive only MH services. Almost none were reported to receive stabilizing medications, and none received SUD treatments or services, CalAIM community supports, or social services and supports. Notably, data quality may be a factor in this early assessment of elective client service access, as counties have reported challenges in tracking individuals no longer under court jurisdiction
- In terms of specialized programs, about half of elective clients were enrolled in ACT, but none were engaged in FSP, Early Psychosis Intervention, or Forensic ACT (FACT) services during the first nine months of CARE Act implementation.
- Elective clients averaged 82.5 calendar days (Std. Dev. 65.1) in active service with a range of 18 days to 195 days. This is fewer calendar days in active service than what was observed for CARE participants, who averaged 98.8 days (Std. Dev. 57.9 days) in active service, with a range of 3 days to 223 days.

5. Data Limitations

All CARE data received from county BH agencies and JC were reviewed for data quality. Aggregated data submitted from JC were complete and timely. However, given JC and county BH agencies submit data separately, there were discrepancies identified in the reported counts of CARE plans ordered and CARE agreements approved. Counties and courts have been encouraged to identify opportunities to improve coordination and alignment of submitted data.

Individual-level data were submitted in a timely manner from county BH agencies over the first three CARE Act reporting quarters. Missing data from county BH agencies accounted for under one percent of total reported data. The most commonly missing data points included Employment Status, Volunteer Supporter Presence, Type of Housing Support, Secondary Substance Frequency, and Number of Arrests.

The proportion of data reported with an "unknown" response decreased over the CARE Act implementation reporting periods from 15 percent in Quarter 4 of 2023 to 11 percent in both Quarter 1 and Quarter 2 of 2024. The largest number and proportion of "unknown" values were reported for the Misuse of Illegal/Controlled Substances and

Diagnosis of SUD data points. Notably, county BH agencies reported fewer "unknown" or "unable to answer" responses for CARE participants than for dismissed CARE respondents. These data quality issues likely reflect the inherent challenges county BH agencies face in tracking individuals outside the court jurisdiction (e.g., elective clients) and sensitivities around reporting particular data points (e.g., substance use) due to privacy rules and regulations.

These data limitations and challenges related to data completeness indicate a need to interpret findings with caution, as missing and unknown data were not randomly distributed and were more frequently observed among certain data points. For this reason, data presented in this Annual Report focuses on descriptives and patterns observed. Where possible, administrative claims data should be considered to augment or verify county-reported data, particularly those related to service utilization and key outcomes of interest. This will be the focus of the independent evaluation of the CARE Act.

Fewer than one percent of submitted data from county BH agencies was found to be inaccurate or unreasonable. No patterns of inaccurate or unreasonable data were identified across reporting periods, indicating that challenges experienced by county BH agencies are being addressed through established quality assurance processes.

6. Key Takeaways and Recommendations to Leverage CARE Act Data

The first nine months of the CARE Act implementation have illuminated several opportunities to optimize services and supports for individuals petitioned to CARE.

The majority of CARE respondents engaged in the first nine months of the CARE Act implementation were White, male, between ages 26 – 45, and indicated English as their preferred language. Regarding the racial makeup of CARE respondents, over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian.

- **Opportunities to Leverage Findings:** These findings suggest a need to expand efforts to raise awareness about the CARE Act, especially for particular populations. Efforts should focus on the public, as well as those involved in CARE Act implementation, and be aligned with ensuring equitable access to CARE for potentially eligible individuals. Specific opportunities, most of which are already underway, include:

- Expanding efforts to raise awareness about the CARE Act, especially among system partners and other potential petitioners who may be well-positioned to refer and connect individuals to CARE.
- Expanding outreach and engagement efforts in CARE Act implementation, ensuring equitable access for eligible individuals who may be difficult to reach. Counties should consider opportunities to gain insights on ways to engage harder-to-reach populations that are underrepresented in the CARE respondent population to-date.
- Expanding county CARE Act data collection and reporting requirements to monitor outreach and engagement efforts.[23]

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

Of the 490 CARE petitions received by county BH agencies at the time of this report development, 229 petitions were still in the CARE Process Initiation Period and had yet to receive a disposition assignment from the court. Across the 261 CARE respondents with a petition disposition, the average length of time from petition to disposition was 75.6 calendar days (approximately 2.5 months), with a wide range from 8 – 253 days. Of the 261 CARE respondents, 223 (85 percent) took 31 or more days to have a petition disposition assigned.

During a respondent's CARE Process Initiation Period, a range of activities can happen simultaneously, such as outreach and engagement, service and support delivery, county investigation and information gathering for the purposes of court disposition assignment, and trust building with the respondent.

- **Opportunities to Leverage Findings:** The petition process for CARE respondents is not uniform, with significant variability in how individuals progress through the petitioning and initiation processes. Certain populations may require additional time to move through court processes due to the complexity of their situation. Efforts, many of which are already underway, should aim to streamline, support, and optimize court processes where possible. These may include:
  - Continuing to aid courts, counties, and system partners to optimize and improve CARE Act processes. Such efforts include sharing effective strategies for outreach and engagement, improving court referral processes, and cross-system collaborations to reduce variations in CARE-

[23] Note, this expanded data collection requirement was included in SB 1400 and will be required for reporting beginning January 1, 2025, in accordance with CARE Data Dictionary 2.0.

eligibility determinations and petition dispositions. It also includes identifying opportunities for increased court involvement during the CARE Process Initiation Period to encourage more active county efforts in engaging CARE respondents and reducing length of time to disposition.
    - Expanding county CARE Act data collection to include new data on referrals from key system partners to promote access among potentially eligible individuals and outreach and engagement efforts to improve CARE process efficiency.[24]

Ongoing housing services and supports are an area of high need for the CARE population. Housing provides a stable foundation that is essential to helping individuals manage serious mental illness and make progress toward long-term recovery.

Of the CARE participants who were unhoused at time of their petitioning (33 percent of all participants), two-thirds had obtained some form of housing—whether temporary, institutional, or permanent—by the most recent reporting month of their Active Service Period. Of the 66 percent of CARE participants housed at the time of their petitioning, few were reported to be unhoused in the most current reporting month of their Active Service Period. Overall, the proportion of CARE participants with permanent housing increased over time, with 46 percent of participants being permanently housed at the time of petitioning and 56 percent in the most current reporting month of Active Service. These early findings suggest engagement in CARE may be a factor in gaining or maintaining housing. However, there is still a need for services to support permanent housing solutions.

- **Opportunities to Leverage Findings:** CARE participants appear to experience challenges with stable community-based living, even while on a CARE plan or CARE agreement. Maintaining permanent housing remains a common challenge for CARE participants, which underscores the need for continued prioritization of housing services and supports for this population. Multiple efforts are underway to assist CARE participants with securing permanent housing, including:
    - Prioritizing housing services and supports for CARE participants and ensuring they have access to federal and state programs that support the housing needs of eligible individuals.

[24] Note, this expanded data collection requirement was included in SB 1400 and will be required for reporting beginning January 1, 2025, in accordance with CARE Data Dictionary 2.0.

- Increasing awareness of programs under which CARE participants may qualify and potentially be prioritized for permanent rental subsidies, housing services, and supports, such as the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), Proposition 1, and the Behavioral Health Bridge Housing program (BHBH).

Nearly two-thirds (63 percent) of CARE participants received the three evidence-based services and supports that provide critical foundations for recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports). In contrast, elective clients appear to have received fewer services.

Relative to CARE participants, the vast majority of elective clients did not receive all three components, which was primarily driven by the finding that a low proportion received MH treatment services or stabilizing medications. Across all service and support types, elective clients were found to access services at lower rates than CARE participants. This disparity in services access between CARE participants and elective clients could indicate a gap in care quality that warrants close monitoring.

These findings suggest the CARE Act may be effective in facilitating access to critical services and supports for individuals with severe and persistent symptoms related to schizophrenia or other psychotic disorders. These early findings also suggest the CARE civil process and court involvement associated with a CARE agreement or CARE plan may enhance client access and engagement in services and improve county accountability in efforts to engage these individuals. Findings may also reflect inherent differences between those who are diverted and elect to receive services outside court jurisdiction. Notably, data quality for elective clients may also be a factor, as counties have reported and demonstrated challenges in tracking and reporting on individuals no longer under court jurisdiction.

The introduction of person-centered care tools, including PADs and volunteer supporters, offered valuable insights to inform ongoing implementation efforts of the CARE Act.

- Two available tools to support person-centered care for CARE participants—PADs and volunteer supporters—were monitored over the first nine months of implementation. While no PADs had been established by the time of this report, efforts to introduce and integrate them into care planning are ongoing.

Approximately one-third of participants had an identified volunteer supporter, providing a foundation to build upon in future efforts.

- **Opportunities to Leverage Findings:** Findings suggest there is room for improvement in assisting CARE participants and respondents with engagement in evidence-based services and supports to promote recovery. Opportunities to promote access and engagement that are underway and planned include:
    - Expanding technical assistance efforts to promote awareness of best practices and improve access to all three foundations for recovery. This includes key features of person-centered care—such as PADs and volunteer supporters—to facilitate long-term recovery.
    - Continuing to actively engage and address unmet needs that may contribute to undesirable encounters with the criminal justice system, emergency department visits, hospitalizations, and LPS holds.
    - Expanding county CARE Act data collection to include new data that will allow for more robust analysis of access and quality of care among individuals petitioned to CARE who receive different dispositions (e.g., CARE participants vs. elective clients) to understand the potential value of court involvement.[25]

[25] Note, this expanded data collection requirement was included in SB 1400 and will be required for reporting beginning January 1, 2025, in accordance with CARE Data Dictionary 2.0.

APPENDICES

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 as detailed in the table 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 B.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 a reporting quarter and corrections of data deficiencies are due 15 days after the issuing of the Quality Assurance report.

Appendix B: State Bar of California: CARE Act Annual Report (Reporting Period: August 1, 2023–June 30, 2024)

The State Bar of California

Community Assistance, Recovery, and Empowerment (CARE) Act Annual Report

Reporting Period: August 1, 2023–June 30, 2024

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EXECUTIVE SUMMARY

Governor Newsom signed the Community Assistance, Recovery, and Empowerment (CARE) Act on September 14, 2022.[26] It created a new court program where adults with qualifying, severe mental health issues can access behavioral health care, stabilization medication, housing, and other community services. The program launched on October 1, 2023, in seven counties (cohort one) and on December 1, 2023, in Los Angeles County. It must launch in all remaining counties (cohort two) by December 1, 2024.[27]

Courts must appoint qualified legal services projects (QLSPs) to represent those who are the subject of a CARE Act petition (respondents). Where no QLSP has agreed to represent respondents, the Court must appoint a public defender instead.[28] The Legal Services Trust Fund Commission (LSTFC) funds QLSPs and public defender offices to provide those services. It also funds qualified support centers and other entities to provide legal training and technical assistance to implement the CARE Act.[29]

This report covers nine months of CARE Act services, from October 1, 2023, to June 30, 2024.[30] During the nine-month reporting period, the funding recipients:

- Opened 506 cases to represent respondents and closed 182 cases.
- Spent over 25,600 hours—over 1,400 hours in-court—representing respondents.
- Advocated in 897 hearings or appearances and 487 negotiations.[31]
- Represented 181 respondents who were unhoused at the start of their CARE Act case.
- Represented 341 respondents whose family member filed their CARE Act petition.
- Pursued 45 legal outcomes in the areas of public benefits, housing assistance, and social services.
- Held 11 live trainings with 762 participants, created five on-demand trainings,

[26] Welfare and Institutions Code §§ 5970–87.

[27] Welfare and Institutions Code § 5970.5. The program launched October 1, 2023, in Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne counties. Los Angeles County is part of cohort two but launched its program one year early.

[28] Welfare and Institutions Code § 5977.

[29] See footnote seven, *infra*, for information about the Budget Act of 2023. QLSP and support center status is a requirement to receive some state and federal funding to provide or support civil legal aid to indigent Californians. Nonprofit organizations and nonprofit law school clinics must reapply for QLSP and support center status every year. They are then subject to monitoring by the State Bar of California. For more information, see Business and Professions Code sections 6210–6228.

[30] See footnote seven, *infra*, for information about the Budget Act of 2023. QLSP and support center status is a requirement to receive some state and federal funding to provide or support civil legal aid to indigent Californians. Nonprofit organizations and nonprofit law school clinics must reapply for QLSP and support center status every year. They are then subject to monitoring by the State Bar of California. For more information, see Business and Professions Code sections 6210–6228.

[31] See footnote 18, *infra*, for how counsel to respondents report their CARE Act appearances.

organized two convenings with 69 attendees, and provided 29 instances of technical assistance.

Overall, the eight counties that began implementing the CARE Act in 2023 focused on building their capacity to represent respondents in this new court program for California.

DISTRIBUTION OF FUNDS AND EXPENDITURES

The Budget Act of 2023 (Budget Act) provided the funding for these services between October 1, 2023, and June 30, 2024. It provided $20,400,000 for QLSPs and public defender offices to represent respondents and up to $1,020,000 for support centers and other qualifying entities (other entities) to provide legal training and technical assistance to implement the CARE Act. Any funds remaining from the amount for support centers and other entities went to represent respondents. The Budget Act also provided $1,432,000 to the LSTFC and State Bar to administer CARE Act funds and reporting.[32]

Table 1. Distribution of 2023–2024 CARE Act Funds[33]

Entity type	Amount	% of funds
Public defender office	$20,413,055	95%
QLSP	$752,095	4%
Other entity	$254,850	1%
Total	**$21,420,000**	**100%**

As of July 2024, the funding recipients had reported spending over $3.1 million between August 1, 2023, and June 30, 2024.[34]

[32] The Budget Act, as amended, is available at leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB104 (accessed on October 24, 2024).

[33] The formula to determine an amount available for each county was:

1. (Step 1) Allocate the funds by general population: Divide each county's population by the total population of all participating counties. Multiply the resulting percentage by the total funding for QLSPs and public defenders. This yielded an initial amount for each county.
2. (Step 2) Set a funding floor: If step 1 provides less than $60,000 to a county, raise its allocation to $60,000 and adjust the remaining counties' allocations proportionally.
3. (Step 3) Adjust for the relative cost of providing counsel: Except for counties where the allocation is $60,000 pursuant to step 2, apply a cost-of-counsel factor. This calculation was based on the average combined salary/wage for public defender attorneys and paralegals in each county.

[34] Those reporting may spend their 2023–2024 funds through December 31, 2024. Services and expenditures data are subject to corrections in future reports

Table 2. Expenditures by County (August 1, 2023–June 30, 2024)

County	Expenditures
Glenn	$6,354
Los Angeles	$321,611
Orange	$1,124,544
Riverside	$337,284
San Diego	$486,127
San Francisco[35]	$598,770
Stanislaus	$94,500
Tuolumne	$1,139
Statewide (OSPD)	$167,528
Total	**$3,137,857**

DATA COLLECTION

All recipients of CARE Act funds report quarterly on expenditures and services. For those providing legal representation, this includes reporting on new, ongoing, and closed representation of respondents. Reporting included, e.g.:

- Respondent demographics;
- Petitioner status;
- Legal outcomes;
- Legal resolutions;
- CARE Act workload, such as hours and hearings or appearances; and
- Economic benefits (i.e., confirmed payments to and costs saved for) clients.

Support centers and other entities providing legal training and/or technical assistance to counsel for respondents reported quantitative data about trainings, convenings, research, and other support for QLSPs, public defenders, courts, county behavioral health agencies, and others. Funding recipients also submitted a final evaluation about the effectiveness of their services and service delivery successes and challenges, among other topics. QLSPs and public

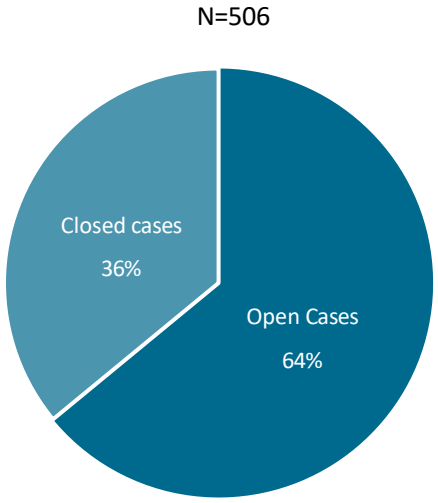
defender offices could report “unknown” and provide a narrative response where data was unavailable (e.g., about a client’s legal outcomes).

[35] The expenditures for the City and County of San Francisco are from three entities: Justice & Diversity Center of the Bar Association of San Francisco (JDC), Legal Assistance to the Elderly (LAE), and the San Francisco Public Defender's Office. San Francisco is the only county where QLSPs received awards to represent CARE Act respondents in state fiscal year 2023–2024.

OPEN AND CLOSED CASES

QLSPs and public defender offices opened 506 cases during the reporting period. Of those, 182—36 percent—had closed by June 30, 2024.

Figure 1. Percent of Open and Closed Cases



CLOSED CASES: LEGAL OUTCOMES AND RESOLUTIONS

Legal Outcomes

QLSPs and public defender offices report legal outcomes when they close a case. They reported only 45 legal outcomes in their first seven to nine months. This may reflect how cases closed before reaching a CARE plan or agreement—see Table 4, below, for how cases resolved. It also reflects that connecting respondents to services can take several months. As a result, most cases were still open on June 30.

At the time of reporting, the legal outcomes options reflected a list of supports that the CARE Act permits for CARE plans. This statutory list refers to specific funding sources (e.g., "Access to housing resources Through the No Place Like Home Program").[36] Where information about a support's funding source was unavailable, QLSPs and public defender offices could report "program/funding source unknown" in the following categories:

- Access to behavioral health services;
- Access to housing resources; and
- Access to social services; and
- Other.

[36] Welfare and Institutions Code § 5982.

These program/funding source unknown options were the most common outcomes that recipients reported. QLSPs and public defender offices have noted that it is unlikely they will be able to report the exact funding sources for their clients' CARE Act services and supports—even those for which they negotiate. County behavioral health agencies, however, might be in a better position to identify that information. To address this, the State Bar plans to generally move away from outcomes reporting that requires knowledge of each service's or support's exact funding stream.

Nearly half—49 percent—of the legal outcomes reported involved access to behavioral health services. The remaining outcomes involved access to housing resources or social services. QLSPs and public defender offices reported known funding sources for 38 percent of the legal outcomes.

Table 3. Legal Outcomes (Closed Cases)[37]

Legal outcomes	Count	%
Increased access to housing resources or social services	23	51%
Increased access to behavioral health services	22	49%
Total	**45**	**100%**

Economic Benefits

Funding recipients have the option to report economic benefits for cases that resulted in a calculable award (e.g., public benefit payment) and/or identifiable savings to the client. They may report only confirmed benefits. QLSPs and public defender offices reported no economic benefits for closed cases during the reporting period.

Legal Resolutions

QLSPs and public defender offices closed 182 cases during the reporting period. Common reasons included the client lacked a qualifying severe mental illness or enrolled or was likely to

enroll in behavioral health treatment outside the CARE Act process. Additional reasons included the respondent was unwilling to engage and/or difficulty to find.

Table 4. Legal Resolutions

[37] Adhering to the DHCS De-Identification Guidelines, this report suppresses categories with fewer than 11 data points when necessary to protect the privacy of individuals. Where possible, it combines those categories into broader ones, such as in Table 3. Where the report is unable helpfully to combine categories, it redacts that data. The State Bar has provided the necessary disaggregated data—e.g., about legal outcomes—to other agencies as required by law.

Legal resolution for dismissed cases	Count	%
Client enrolled/likely to enroll in behavioral health treatment	34	19%
Client without a qualifying severe mental illness	34	19%
Client unlikely to benefit from CARE plan/agreement	14	8%
Client already stabilized in on-going voluntary treatment, failure to satisfy Welfare & Institutions Code 5972(d), or less restrictive option(s) available	12	7%
Case dismissed for any other reason (e.g., inability to find client or client substituted their own counsel)	88	48%
Total	**182**	**100%**

NEW CASES: PETITIONER STATUS AND RESPONDENT DEMOGRAPHICS

QLSPs and public defender offices reported on who filed the CARE Act petition for each respondent. They also reported their respondents' demographics.

Petitioner Status

The CARE Act identifies who may file a petition.[38] Family members filed over two-thirds of petitions. Behavioral health agencies, behavioral health providers, and first responders each accounted for six to nine percent of the filings. In 19 cases, respondents filed petitions on behalf of themselves. Respondents' counsel reported zero petitions from adult protective services, public charities, tribal courts, and tribal health agencies.

Table 5. Petitioner Types

Petitioner	Petitions filed	% of petitions
Family member	341	67%
Behavioral health agency	43	9%
First responder	38	8%
Behavioral health provider	32	6%
Respondent	19	4%
Public guardian or conservator	17	3%
Other (e.g., hospital or roommate)	16	3%
Total	**506**	**100%**

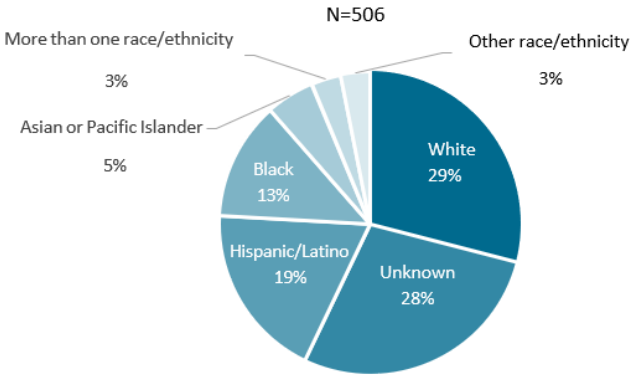
Respondent Race/Ethnicity

The respondent identified their race/ethnicity in 72 percent of the cases that QLSPs and

[38] Welfare and Institutions Code § 5974.

public defender offices reported. During the reporting period, 29 percent of respondents identified as white, 19 percent as Hispanic/Latino, 13 percent as Black, and five as percent Asian or Pacific Islander. By comparison, 34 percent of California's population identifies as white alone, not Hispanic/Latino, 40 percent as Hispanic/Latino, seven percent as Black, and 17 percent as Asian.[39]

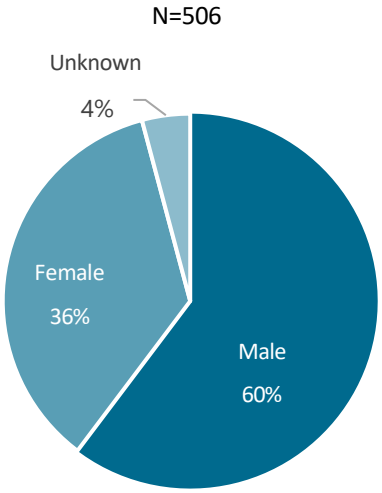
Figure 2. Respondent Race/Ethnicity



Respondent Gender Identity

Although half of Californians are female, 60 percent of CARE Act respondents identified as male and 36 percent identified as female.

Figure 3. Respondent Gender Identity



[39] United States Census Bureau, "QuickFacts," available at www.census.gov/quickfacts/fact/table/CA/PST045223 (accessed on October 24, 2024). The U.S. Census Bureau uses different race/ethnic categories than does the State Bar.

Respondent Age

Respondents must be adults. QLSPs and public defender offices reported that in 437 (86 percent of) cases the respondent was a non-senior adult (18 to 59 years old) and in 69 (14 percent of) cases they were a senior (60+ years old).

Respondent Disability Statuses

Funding recipients report on disability statuses beyond those that qualify the respondent for the CARE Act process.[40] For the 506 cases they opened, QLSPs and public defender offices reported an additional mental disability in 103 instances and limited data about other disabilities.

Table 6. Respondent Disability Statuses

Disability status	Count[41]	% of disability statuses
Unknown disability status	341	67%
Mental disability	103	20%
No additional disability	54	11%
Other disability[42]	13	3%

Respondent Veteran and Limited English Proficiency (LEP) Statuses

QLSPs and public defender offices reported that the respondent's veteran status was unknown in 52 percent of cases. Where they were able to identify that status, nearly all respondents were non-veterans. Similarly, where they were able to identify the client's LEP status (in 341 cases), nearly all respondents were non-LEP.

Respondent Housing Status

QLSPs and public defender offices reported that 36 percent of respondents were unhoused, 27 percent were in permanent housing, and 20 percent had an unknown housing status. The remaining categories—institutional, temporary, and other housing—accounted for 18 percent of the housing statuses.

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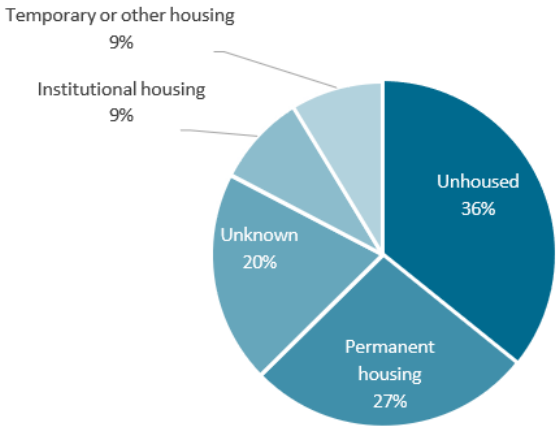
[40] Welfare and Institutions Code section 5972(b) provides, e.g., that respondents be "currently experiencing a serious mental disorder, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders."

[41] The total reported number of disability statuses was 511. Funding recipients could report multiple disabilities per respondent.

[42] This category combines data about developmental, hearing, mobility, speech, visual, and other disabilities that are separate from those qualifying the respondent for CARE Act proceedings.

Figure 4. Respondent Housing Status

N=506



CARE ACT WORKLOAD

QLSPs and public defender offices spent over 25,600 hours representing respondents in CARE Act cases. Of that amount, over 1,400 hours were in court. Additionally, QLSPs and public defender offices attended 897 hearings or appearances and 487 negotiations.[43] They counted only hearings or appearances and negotiations to represent respondents in CARE Act proceedings and matters related to CARE agreements and plans.

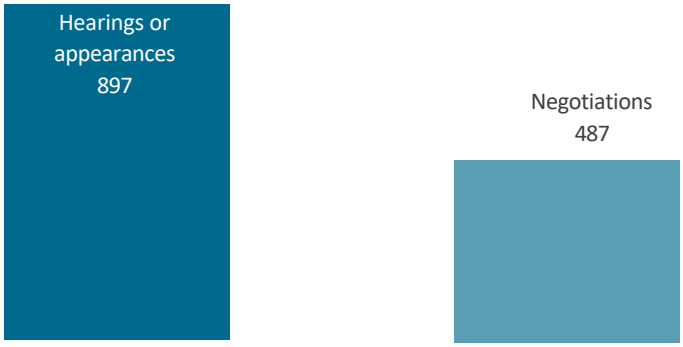
Figure 5. Hearings or Appearances and Negotiations

N=1,384

[43] CARE Act hearings or appearances may include, but are not limited to:

- Initial appearances;
- Hearings on the merits;
- Case management hearings;
- Progress hearings (for CARE agreements);
- Clinical evaluation hearings;
- CARE plan review hearings;
- Status review hearings (for CARE plans);
- One-year status hearings; and
- Graduation hearings.

A hearing begins when one or more parties or counsel appear and oral arguments, presentations relevant to the proceedings, witness testimony, and/or documents or tangible objects are submitted to the court (i.e., "first evidence"). Respondent's counsel may also report continuance proceedings in which they appeared to provide representation in CARE Act proceedings, matters related to CARE agreements, and CARE plans.



TRAINING AND TECHNICAL ASSISTANCE

The Office of the State Public Defender (OSPD) provided legal training and technical assistance to implement the CARE Act. During the reporting period, OSPD:

- Conducted 11 live trainings with 762 participants—268 from QLSP and public defender offices.
- Created five on-demand trainings with 108 views at the time of reporting.
- Held two convenings, with 69 participants—43 from QLSP and public defender offices.
- Provided 29 instances of individual technical assistance.

FACTORS IMPACTING SERVICES

QLSPs and public defender offices measured the success of their representation in part by how often they helped connect CARE Act respondents with crucial services such as health care, housing, and case management. This often involved interacting extensively with county behavioral health agencies, the courts, and others. Progress was sometimes incremental as CARE Act cases can be complex and respondents hesitant to engage.

Locating respondents at the start of cases was especially challenging due to their at-times unstable housing or other limited resources (e.g., technology and transportation). Compounding this challenge was that many respondents were skeptical of the CARE Act process. Finally, recruiting staff (e.g., due to geography) was an initial challenge for some offices.

As a new court program, informational resources were somewhat limited. QLSPs and public defender offices noted that OSPD's webinars and practice guides—specifically on health interventions and related legal frameworks—were particularly helpful. In-person convenings also provided opportunities for QLSPs and public defender offices to network with each other and share effective strategies to implement their CARE Act roles.

CONCLUSION

The QLSPs and public defender offices serving Glenn, Los Angeles, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties worked to build the necessary infrastructure to implement the CARE Act. They overcame various implementation challenges to deliver meaningful legal support to individuals with complex needs. The best practices and data from these first eight counties to implement the CARE Act will be invaluable to those launching after June 30, 2024.

APPENDICES

Appendix A: Awards and Funding Amounts

Table 7. Awards and Funding Amounts for 2023-2024 Funding Recipients

Organization name	Type	County(ies)	2023–2024 expenditures [44]	2023–2024 funding
Glenn County Public Defender Office	Public Defender	Glenn	$6,354	$60,000
Justice & Diversity Center of the Bar Association of San Francisco	QLSP	San Francisco	$230,520	$370,401
Law Offices of the Los Angeles County Public Defender	Public Defender	Los Angeles	$321,611	$10,541,281
Law Offices of the Public Defender, County of Riverside	Public Defender	Riverside	$337,284	$2,584,957
Legal Assistance to the Elderly	QLSP	San Francisco	$339,638	$381,694
Office of the Public Defender, County of Orange	Public Defender	Orange	$1,124,544	$2,960,554
Office of the Public Defender, County of San Diego	Public Defender	San Diego	$486,127	$3,253,752
Office of the Public Defender, County of Stanislaus	Public Defender	Stanislaus	$94,500	$427,746
Office of the Public Defender, County of Tuolumne	Public Defender	Tuolumne	$1,139	$60,000
Office of the State Public Defender	Other Entity	Statewide	$167,528	$254,850
San Francisco Public Defender's Office	Public Defender	San Francisco	$28,612	$524,765
Total			**$3,137,857**	**$21,420,000**

[44] See footnote nine, *supra*

APPENDIX B: OFFICE OF THE STATE PUBLIC DEFENDER (OSPD) SERVICES

Table 8. Total Number of OSPD Trainings[45]

# of live trainings	# of participants from QLSP and PD offices	# of participants not from QLSP and PD offices	# of on-demand trainings	# of on demand trainings views
11	268	494	5	108

Table 9. Total Number of OSPD Convenings

# of convenings	# of participants from QLSP and PD offices	# of participants not from QLSP and PD offices
2	43	26

Table 10. Total Number of OSPD Technical Assistance (TA)

Research for QLSP and PD offices	Brief TA to QLSP and PD offices	In-depth TA to QLSP and PD offices	TA to non-QLSPs and public defenders
4	6	16	3

[45] These trainings were in the following areas of law, among others: disability rights, health and long-term care, and housing.