

Berkeley Homeless
Services Panel of Experts

REGULAR MEETING AGENDA
September 10, 2025 – 7:00 PM
North Berkeley Senior Center, Poppy Room
1901 Hearst Ave., Berkeley, CA 94709

Mayor Ishii:
Carole Marasovic –
Vice Chair

Rashi Kesarwani:
Vacant

Terry Taplin:
Denah S. Bookstein

Ben Bartlett:
Paul Kealoha-Blake

Igor Tregub:
Mary Ann Meany

Shoshana O’Keefe:
Vacant

Brent Blackaby:
Steven Segal

Cecilia Lunaparra:
Donnell Jones - Chair

Mark Humbert:
Alan Levy

Josh Jacobs, Homeless Services Coordinator, Homeless Services Panel of Experts
Staff Secretary, jjacobs@berkeleyca.gov, 510.225.8035

All items are for discussion and possible action.

Public comment for items not on the agenda taken as stated on the agenda and limited to 2 minutes. Public comment for items on the agenda taken as item arises and limited to 2 minutes.

1. Roll call.
2. Reading of the land acknowledgment.
3. Public comment for items not on the agenda.

Action Items:

4. Approval of the agenda. Discussion and possible action.
5. Presentation from Gabrielle Birog, staff attorney, Mental Health Practice, Disability Rights California, on progress updates in settlement agreement in Disability Rights California v. Alameda County. Discussion and possible action.
6. Presentation from Dr. Roberta Chambers from Alameda County Behavioral Health Services on Alameda County Care Court implemented on December 1, 2024. Discussion and possible action.
7. Possible change of date of October, 2025 HSPE meeting from October 1, 2025 to October 8, 2025 based on religious holiday. Discussion and possible action.
8. Approval of minutes from July 2, 2025 HSPE meeting. Discussion and possible action.

A Vibrant and Healthy Berkeley for All

9. Update on County Measure W from Vice-Chair. Discussion and Possible Action.
10. Adjourn.

Attachments:

1. July 2, 2025 Minutes.
2. Land Acknowledgement Statement.
3. Disability Rights California Email to the Vice Chair.
4. Disability Rights California v. Alameda Settlement Agreement.
5. Disability Rights California v. Alameda County Fact Sheet.
6. Alameda County Findings Report.
7. Disability Rights California Initial Report 8.7.2024.
8. Disability Rights California Second Report.
9. MHSA INN Homeless Encampment Project Proposal.
10. Care Court Alameda County Behavioral Health.

Correspondence and Notice of Decision Requests:

Deadlines for Receipt:

- A) Supplemental Materials must be received by 5 PM the day before the meeting.
- B) Supplemental Communications must be received no later than noon the day of the meeting.

Procedures for Distribution:

- A) Staff will compile all Supplemental Materials and Supplemental Communications received by the deadlines above into a Supplemental Packet, and will print 15 copies of this packet for the Commission meeting.
- B) For any Supplemental Material or Communication from a Commissioner received after these deadlines, it is the Commissioner's responsibility to ensure that 15 printed copies are available at the meeting. Commissioners will not be reimbursed for any printing or materials expenses.
- C) Staff will neither print nor distribute Supplemental Communications or Materials for subcommittee meetings.

Procedures for Consideration:

- A) The Commission must make a successful motion to accept and receive all Supplemental Materials and Communications into the record. This includes the Supplemental Packet compiled by staff.
- B) Each additional Supplemental Material or Communication received by or before the meeting that is not included in the Supplemental packet (i.e., those items received after the respective deadlines above) must be individually voted upon to be considered by the full Commission.
- C) Supplemental Materials subject to a Commission vote that are not accepted by motion of the Commission, or for which there are not at least 15 paper copies (9 for each Commission seat, one for staff records, and 5 for the public) available by the scheduled start of the meeting, may not be considered by the Commission.

****Supplemental Materials*** are defined as any items authored by one or more Commissioners, pertaining to an agenda item but available after the agenda and packet for the meeting has been distributed, on which the Commission is asked to take vote at the meeting. This includes any letter to Council, proposed Council report, or other correspondence on behalf of the Commission for which a full vote of the Commission is required.

****Supplemental Communications** are defined as written emails or letters from members of the public or from one or more Commissioners, the intended audience of which is the full Commission. Supplemental Communications cannot be acted upon by the Commission, and they may or may not pertain to agenda items.

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection at Health, Housing & Community Services Department located at 2180 Milvia Street, 2nd Floor.

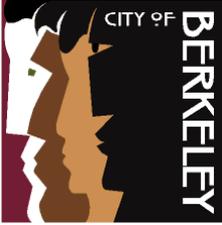
Public Comment Policy:

Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may not speak more than once on any given item. The Chair may limit public comments to 3 minutes or less.

COMMUNITY ACCESS INFORMATION

ADA Disclaimer "This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the ADA Program Coordinator at 510-981-6418 (V) or 510-981-6347 (TDD) at least three business days before the meeting date. Please refrain from wearing scented products to this meeting."

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing & Community Services Department does not take a position as to the content.



Berkeley Homeless
Services Panel of Experts

MEETING MINUTES

July 2, 2025

1. **Roll Call:** 7:01 PM
Present: Marasovic, Levy, Segal, Meany, Bookstein, & Kealoha-Blake.
Absent: Jones.
Staff: Jacobs.
Council: None.
Public: 1.

2. Reading of the Land Acknowledgement
3. Public Comment: 3

Action Items:

4. Approval of the Agenda

Action: M/S/C Meany/Levy move to approve the agenda as written.

Vote: *Ayes:* Marasovic, Levy, Segal, Bookstein, & Kealoha-Blake.
Noes: None. *Abstain:* None. *Absent:* Jones.

5. Approval of Minutes from June 4, 2025

Action: M/S/C Meany/Levy move to approve the minutes as written.

Vote: *Ayes:* Marasovic, Levy, Segal, Bookstein, & Kealoha-Blake.
Noes: None. *Abstain:* None. *Absent:* Jones.

6. Discussion and possible presentation regarding Latino population and homeless services. Discussion and possible action.

Discussion. No action taken.

7. Possibly reschedule September meeting from September 3, 2025 to September 10, 2025 or September 17, 2025. Discussion and possible action.

Action: M/S/C Meany/Levy move to reschedule the September 3, 2025 meeting to September 10, 2025.

A Vibrant and Healthy Berkeley for All

Homeless Services Panel of Experts
July 2, 2025

Vote: Ayes: Marasovic, Segal, Levy, Meany, Bookstein, & Kealoha-Blake.
Noes: None. *Abstain:* None. *Absent:* Jones.

8. City budget update, including status of County W funding, by Carole Marasovic, Vice-Chair. Discussion and possible action.

Discussion. No action taken.

9. Public data and accountability in homeless programs. Discussion and possible action.

Discussion. No action taken.

10. New permanent supportive housing opportunities. Discussion and possible action.

Discussion. No action taken.

11. Adjourn

Meeting adjourned at 9:00 PM.

Minutes Approved on: _____

Josh Jacobs, Commission Secretary: _____

Land Acknowledgement Statement

The City of Berkeley recognizes that the community we live in was built on the territory of xučyun (Huchiun (Hooch-yoon)), the ancestral and unceded land of the Chochenyo (Cho-chen-yo)-speaking Ohlone (Oh-low-nee) people, the ancestors and descendants of the sovereign Verona Band of Alameda County. This land was and continues to be of great importance to all of the Ohlone Tribes and descendants of the Verona Band. As we begin our meeting tonight, we acknowledge and honor the original inhabitants of Berkeley, the documented 5,000-year history of a vibrant community at the West Berkeley Shellmound, and the Ohlone people who continue to reside in the East Bay. We recognize that Berkeley's residents have and continue to benefit from the use and occupation of this unceded stolen land since the City of Berkeley's incorporation in 1878. As stewards of the laws regulating the City of Berkeley, it is not only vital that we recognize the history of this land, but also recognize that the Ohlone people are present members of Berkeley and other East Bay communities today. The City of Berkeley will continue to build relationships with the Lisjan Tribe and to create meaningful actions that uphold the intention of this land acknowledgement.

Please see below. Please make arrangements for virtual presentation by DRC.

Please place following attachments in packet.

Carole

Sent from my iPhone

Begin forwarded message:

From: Gabrielle Birog <Gabrielle.Birog@disabilityrightsca.org>

Date: September 5, 2025 at 11:17:11 AM MDT

To: carole marasovic <daphnesflight@yahoo.com>, Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Cc: Sarah Gregory <Sarah.Gregory@disabilityrightsca.org>

Subject: RE: Presentation to Homeless Services Panel of Experts

Hello Carole,

If it's fine with you, I'd like to present virtually.

Please find attached:

1. Settlement Agreement Between DRC, Alameda County, and the United States
2. DRC v. Alameda County Settlement Fact Sheet
3. Notice Regarding Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail
4. Dr. Karen Baylor's Six-Month Report
5. Dr. Karen Baylor's 14-Month Report

We also have a resource page on our website with more information:
<https://www.disabilityrightsca.org/cases/disability-rights-california-lawsuit-against-alameda-county>.

Sincerely,

Gabrielle Birog (she/her)

Staff Attorney, Mental Health Practice Group

Disability Rights California

1831 K Street

Sacramento, CA 95811

Tel: (510) 267-1217

gabrielle.birog@disabilityrightsca.org

Website: www.disabilityrightsca.org | www.disabilityrightsca.org/espanol

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From: carole marasovic <daphnesflight@yahoo.com>

Sent: Friday, September 5, 2025 10:03 AM

To: Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Cc: Gabrielle Birog <Gabrielle.Birog@disabilityrightsca.org>; Sarah Gregory <Sarah.Gregory@disabilityrightsca.org>

Subject: Re: Presentation to Homeless Services Panel of Experts

You don't often get email from daphnesflight@yahoo.com. Learn why this is important

ALERT / Third-Party Email from outside DRC - Do not click links or open attachments unless you recognize the sender's email address and know the content is safe.

Thanks and good luck, Jennifer.

Will the presentation then be virtual?

Can you send me attachments for our packet the link to the DOJ investigative findings, the link to the DOJ settlement agreement, the link to updated court monitor reports and any other relevant info? I have to set the agenda now, with attachments, and am at the 11th hour.

Thank you.

Carole

Sent from my iPhone

On Sep 5, 2025, at 10:50 AM, Jennifer Stark <Jennifer.Stark@disabilityrightsca.org> wrote:

Dear Carole,

Thank you for your patience as I worked with my colleagues to determine whether someone from the DRC v. County of Alameda case can present next week.

My colleague, Gabby Birog, is willing to provide a short, general update about where things currently stand with the settlement agreement and what's next. The information that she provides will be based on information that is publicly available. Gabby will not be able to answer specific questions from the community that involve information that is considered privileged under our settlement agreement.

If this is satisfactory for you, please feel free to coordinate directly with Gabby (who is CC'd).

In addition, I wanted to let you know that I have moved across the country and will be transitioning out of my role at DRC in the next few weeks. As such, for future requests, I recommend that you contact Gabby, Sarah, and/or Oscar.

Thank you,

Jennifer

From: carole marasovic <daphnesflight@yahoo.com>

Sent: Thursday, September 4, 2025 1:57 PM

To: Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Subject: Fwd: Presentation to Homeless Services Panel of Experts

ALERT / Third-Party Email from outside DRC - Do not click links or open attachments unless you recognize the sender's email address and know the content is safe.

Sent from my iPhone

Begin forwarded message:

From: carole marasovic <daphnesflight@yahoo.com>

Date: September 4, 2025 at 12:13:20 AM MDT

To: Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Subject: Fwd: Presentation to Homeless Services Panel of Experts

Sent from my iPhone

Begin forwarded message:

From: carole marasovic <daphnesflight@yahoo.com>

Date: September 2, 2025 at 2:42:48 PM MDT

To: Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Subject: Re: Presentation to Homeless Services Panel of Experts

Jennifer,

Have you had any luck identifying an attorney who can present virtually, on the DRC v. Alameda County settlement agreement to the Homeless Services Panel of Experts on Wednesday, September 10th at 7:00 p.m. or 8:00 p.m. ? Thank you.

Carole

Sent from my iPhone

On Aug 29, 2025, at 8:49 AM, carole marasovic <daphnesflight@yahoo.com> wrote:

Jennifer,

Let me check if we are equipped to do it virtually and get back to you. I believe that we can.

Carole

Sent from my iPhone

On Aug 29, 2025, at 8:35 AM, Jennifer Stark <Jennifer.Stark@disabilityrightsca.org> wrote:

Dear Carole,

Thank you for your email. Would a virtual presentation be sufficient or do you need someone to come in person? I am asking because the two attorneys who are now leading the case do not live in the Bay Area.

Thanks,

Jen

Get Outlook for iOS

From: carole marasovic <daphnesflight@yahoo.com>

Sent: Tuesday, August 26, 2025 2:42:56 PM

To: Jennifer Stark <Jennifer.Stark@disabilityrightsca.org>

Subject: Presentation to Homeless Services Panel of Experts

ALERT / Third-Party Email from outside DRC - Do not click links or open attachments unless you recognize the sender's email address and know the content is safe.

Hello Jennifer,

Since it has been over a year since you presented at the City of Berkeley Homeless Services Panel of Experts on the DRC v. Alameda County, would you be available to present with an update to HSPE on Wednesday, September 10th?

There is so much going on with homelessness and mental health and the political climate/funding that it would be helpful to know how this settlement agreement fits in the current response to those issues.

Thank you.

Carole Marasovic

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SETTLEMENT AGREEMENT

This Settlement Agreement (the “Agreement”) is entered into between the County of Alameda and Alameda County Behavioral Health Care Services (“ACBH”) (collectively, the “County”), Disability Rights California (“DRC”), and the United States (“United States”). DRC, the United States, and the County are hereinafter collectively referred to as “the Parties”.

RECITALS

- A. The United States and DRC contend that the County has violated Title II of the Americans with Disabilities Act as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999) (“*Olmstead*”), as set forth in the United States’ “Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail” and accompanying Notice, both dated April 22, 2021 (collectively, the “April 22, 2021 Notice”) and DRC’s amended complaint in *Disability Rights California v. County of Alameda, et al.*, No. 3:20-CV-05256, ECF No. 52 (February 22, 2021).
- B. The County is committed to providing, and asserts it does provide, high-quality essential behavioral health services to the residents of Alameda County.
- C. The County asserts that it has always, and continues to, make significant efforts to expand community-based behavioral health services to disabled individuals. The County asserts that it expands community-based services in an effort to best serve the residents of Alameda County and irrespective of DRC’s complaint, DRC’s filing of an amended complaint, and the United States’ publication of its April 22, 2021 Notice.
- D. Following the District Court’s dismissal without prejudice of DRC’s complaint, DRC’s filing of an amended complaint, and the United States’ publication of its April 22, 2021 Notice, the Parties invested their efforts in identifying commitments to community-based behavioral health services that are mutually desirable.
- E. For good and valuable consideration, including the mutual covenants contained herein, the Parties, intending to be legally bound, hereby enter into this Agreement under the terms and conditions set forth below.

TERMS AND CONDITIONS

PART I. INTRODUCTORY TERMS

1. This Agreement settles the litigation in *Disability Rights California v. County of Alameda, et al.* and resolves the United States’ investigation under Title II of the Americans with Disabilities Act as interpreted by *Olmstead*, of the County’s mental health service system, as set forth in the United States’ April 22, 2021 Notice. This Agreement does not resolve the United States’ investigation of Santa Rita Jail, as described in the same April 22, 2021 Notice.
2. The County denies all violations alleged by DRC and the United States. By entering into this Agreement, the County does not admit the truth or validity of any claim or allegation

made against it by DRC or the United States. Nothing in this Agreement shall be construed as an acknowledgment, an admission, or evidence of liability in any civil or criminal proceeding, except proceedings to enforce or implement this Agreement.

3. To the extent this Agreement obligates the County to change its community-based behavioral health system, the Parties view these changes as mutually desirable. The County does not admit that any such change or alteration is required under the ADA or *Olmstead*.
4. The Parties acknowledge the County's commitment to compliance with its obligations pursuant to the ADA and *Olmstead*. This Agreement is intended to ensure that services, programs, and activities offered by the County to individuals with disabilities will be provided in the most integrated setting appropriate to meet their needs.
5. The County commits to provide the services described herein to Alameda County residents with serious mental illness as needed to avoid future or continued unnecessary institutionalization at John George Psychiatric Hospital ("John George") or an institution for mental disease ("IMD"),¹ and to avoid unnecessary criminal justice involvement.
6. The County may ensure provision of the services and supports described in this Agreement either by providing those services and supports directly or through contracted providers with County oversight.
7. The Effective Date is the date on which the Court enters an order of dismissal retaining jurisdiction over this Agreement.

PART II. SERVICE COMMITMENTS

1. Crisis Services

- a. The County will continue to offer a countywide crisis system and expand crisis intervention services as follows:
 - i. Maintain a 24/7 crisis hotline. The crisis hotline will provide screening and de-escalation services on a 24/7 basis. No later than eighteen (18) months after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership ("FSP") clients on a 24/7 basis.
 - (1) Beginning no later than eighteen (18) months after the Effective Date, the crisis hotline will have a clinician available to support crisis hotline services 24/7.

¹ IMD, as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center.

- (2) The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available), to ensure there is “no wrong door” for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmline teams to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.
 - (3) The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.
- ii. Provide mobile crisis response services on a county-wide basis.
- (1) Mobile crisis teams will provide a timely in-person response to resolve crises as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.
 - (2) Mobile crisis services shall be provided with the purposes of reducing, to the greatest extent possible, interactions with law enforcement during a mental health crisis, reducing 5150 and John George psychiatric emergency services (“PES”) placement rates, and increasing use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkage to services).
 - (3) The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams, and agrees to maintain this as a minimum capacity.
 - (4) The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than one year after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”). The Mobile Crisis Assessment will be informed by and will appropriately take into account (i) community and stakeholder input; and (ii) all necessary data and information sufficient to assess the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.
 - (5) The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer (see section III.1.a of this

Agreement) for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the Mobile Crisis Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final Mobile Crisis Assessment will promptly be made available to the public.

- (6) Based on the County’s Mobile Crisis Assessment, the County will reasonably expand² its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis responses.
 - (7) FSPs will provide crisis intervention as set forth in section II.2.m in this Agreement.
 - (8) Each mobile crisis team shall include at least one mental health clinician.
- iii. Trained peer support specialists shall be part of the County’s crisis services team and shall be included in outreach and engagement functions.
- b. The County will provide crisis residential services as follows:
- i. Maintain forty-five (45) crisis residential treatment (“CRT”) beds.
 - ii. Within two years of the Effective Date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based provider(s) to add a mixture of 25 additional CRT and/or peer-respite beds.
 - iii. A purpose of CRT facilities and peer-respite homes is to promptly de-escalate or avoid a crisis and reduce unnecessary hospitalization. CRT facilities and peer-respite homes are intended to be used by people experiencing or recovering from a crisis due to their mental health disability for short-term stays and to provide support to avoid escalation of a crisis. CRT facilities and peer-respite homes are unlocked.

² A reasonable expansion, as used here, means an expansion that would constitute a reasonable modification, and not a fundamental alteration of the nature of the County’s services for people with disabilities, consistent with the Americans with Disabilities Act, as interpreted by *Olmstead*. Notwithstanding section III.1 of this Agreement, the Independent Reviewer will not render a legal conclusion as to whether the County’s expansion of its mobile crisis services is a “reasonable modification” or a “fundamental alteration”, and therefore will not render a compliance determination as to section II.1.a.ii.(6). If the Parties are unable to agree as to whether an expansion constitutes a reasonable modification or a fundamental alteration, the Parties will proceed through the dispute resolution process as set forth in sections III.2.b-c.

- iv. Peer staff will be on-site 24/7 at peer-respite homes. Peer-respite homes shall serve no more than six (6) individuals at a time.
 - v. Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.
 - vi. CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis teams.
- c. The County's crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.

2. Full Service Partnerships

- a. The County offers FSPs through community-based providers that provide services under the Community Services and Supports ("CSS") service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10.
- b. Within two years from the Effective Date, the County will add 100 FSP slots for adults and transition aged youth, for a total of 1,105 FSP slots for that population. The County will utilize the FSP slots that are added under this Agreement to serve individuals 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.
- c. Within one year from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the "FSP Assessment").
- d. The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to:
 - i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services;
 - ii. Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment, and length of time from identification to enrollment;
 - iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES,

John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups; and

- iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.
- e. The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before finalizing the County's FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.
- f. Based on the County's FSP Assessment, the County will further reasonably expand³ its FSP program as necessary in order to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.
- g. As used in this Agreement, one "slot" (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time.
- h. FSPs will provide services necessary to attain the goals identified in each FSP recipients' Individual Services and Supports Plan ("ISSP"), which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1).
- i. Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person's individualized goals and the Full Spectrum of Community Services necessary to attain those

³ A reasonable expansion, as used here, means an expansion that would constitute a reasonable modification, and not a fundamental alteration of the nature of the County's services for people with disabilities, consistent with the Americans with Disabilities Act, as interpreted by *Olmstead*. Notwithstanding section III.1 of this Agreement, the Independent Reviewer will not render a legal conclusion as to whether the County's expansion of its FSP program is a "reasonable modification" or a "fundamental alteration", and therefore will not render a compliance determination as to section II.2.f. If the Parties are unable to agree as to whether an expansion constitutes a reasonable modification or a fundamental alteration, the Parties will proceed through the dispute resolution process as set forth in sections III.2.b-c.

goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual.

- j. Services provided through FSPs will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals' needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.
- k. FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.
- l. FSP programs will be implemented using high fidelity to the Assertive Community Treatment ("ACT") evidence-based practice, including that:
 - i. FSP programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals.
 - ii. FSP teams operate at a 1:10 mental health staff to client ratio.
- m. FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than eighteen (18) months after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBH-contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.
- n. FSPs will provide or arrange for appropriate Individual Placement and Support ("IPS") supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.
- o. Housing: The Parties recognize that permanent, integrated, stable housing with Housing First principles is critical to improving treatment engagement and supporting recovery.
 - i. FSP clients will receive a housing needs assessment, and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services

Agency's Coordinated Entry System ("CES"), or through other County and community resources.

- ii. As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.
- iii. If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.
- iv. Permanent housing provided under this section II.2.o will be provided in the least restrictive and most integrated setting that is appropriate to meet individuals' needs and preferences.
- v. Nothing in this section II.2.o is intended to override an FSP client's preferences.

3. Service Teams (Intensive Case Management)

- a. The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.
- b. The County will explore community needs and opportunities for expanding Service Teams as appropriate.
- c. Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and will be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.
- d. Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through CES and other available programs.

4. Outreach, Engagement, Linkages, and Discharge Planning

- a. The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.
- b. The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of

services by ACCESS or its successor, in order to facilitate prompt and appropriate connection to services following an eligible individual's contact with ACCESS.

- c. When an individual with serious mental illness (1) is identified by the County through section II.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBH-contracted entity for behavioral health services, the County or an ACBH-contracted community provider will determine the person's eligibility for community-based behavioral health services and, unless the person can no longer be contacted or declines further contact, will provide a complete clinical assessment of the individual's need for community-based behavioral health services (an "assessment").
 - i. Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services.
 - ii. This assessment and assignment process will be promptly completed and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.
 - iii. Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations. Following a quality review, the County will take appropriate action, if any is indicated, based on the results of the quality review, and the results will inform the County's FSP Assessment under Section II.2.c.
- d. Within two (2) years of the Effective Date of the Agreement, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.
- e. The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. In order to do so, this system will focus on factors that include, among others, whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), frequent hospitalizations for mental health reasons, and/or frequent incarcerations (and, in the case of incarcerations, received behavioral health services during an incarceration). The County will connect such individuals, as needed, to FSPs, Service Teams, or other community-based services. The County will use a

culturally responsive, peer driven approach that builds on the person’s strengths and goals and seeks to address the individual’s concerns regarding treatment (including service refusals). Outreach and engagement will include frequent, in-person contact in the field in locations convenient to the person. Outreach and engagement will include using the Familiar Faces program to identify and connect with individuals who do not follow up regarding services after experiencing a crisis. Beginning no later than six (6) months after the Effective Date, the County will track progress in connecting individuals to needed services.

- f. The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts, and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact, and will coordinate with these entities to rapidly connect individuals to those services as appropriate.
- g. The County will provide information and education to ACBH-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact, and will coordinate with these entities to rapidly connect individuals to those services as appropriate.
- h. The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).
- i. The County will ensure that people with co-occurring substance use disorder (“SUD”) can access and receive services, including through the development of two (2) substance use mobile outreach teams, within two (2) years of the Effective Date.
- j. In-Reach to, and Discharges to Community-Based Services from, IMDs⁴
 - i. “IMD” as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center.
 - ii. Within twelve (12) months of the Effective Date of this Agreement, the County will begin initial implementation of a utilization review (“UR”) pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual’s needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess

⁴ This section does not apply to individuals under Murphy conservatorships.

appropriateness for discharge in light of community-based services appropriate to the individual.

- iii. Promptly after an individual eligible for ACBH services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual's discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual's needs, consistent with the individual's preferences. As part of assisting individuals to transition to the most integrated setting appropriate, appropriate community-based services will be identified. Where applicable and with the individual's (and, when relevant, his or her legal representative's) consent, FSP and Service Team providers will participate in the discharge planning process.
 - iv. If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBH (or designee) will be notified, and the County will work to arrange such services as promptly as possible.
 - v. The County will promptly notify ACBH-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.
- k. Linkages for Services Following Discharge from John George PES and Inpatient
- i. The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5.
 - ii. The County will collaborate with John George to support John George's safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate, including through ACBH's critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services. Beginning no later than eighteen (18) months after the Effective Date, the County's role in this collaboration will include, to the fullest extent reasonably practicable: (1) using available data to promptly identify individuals registered by John George who are both (a) likely to be, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration, and (b) likely to be eligible for and in need of FSP or

Service Team services; (2) upon identification, to the extent that the individual has not yet been discharged, promptly coordinate with John George to determine whether the individual is eligible for and in need of any such services; and (3) if the individual is eligible for and in need of any such services and to the extent that the individual has not yet been discharged, promptly connecting the individual to an FSP or Service Team to commence engagement, which may include participation in discharge planning and commencement of services upon the individual's discharge.

- iii. The County will request that John George invite and actively include representatives of an individual's FSP or Service Team (if any) in the discharge planning process and, with respect to patients determined eligible for an in need of such services under section II.4.k.ii above, invite and actively include representatives of the County or a County-contracted community-based service provider in the discharge planning process. To the fullest extent reasonably practicable and within the direct control of the County and its community-based service providers, and with the individual's consent, the County will ensure that: (1) representatives of the FSP or Service Team are included in the discharge planning process for those individuals who are assigned to or are clients of a County FSP or Service Team; and (2) representatives of the County or a County-contracted community-based service provider are included in the discharge planning process for those individuals who are not assigned to an FSP or Service Team but who have been identified as eligible for an FSP or Service Team under section II.4.k.ii above. To the extent that John George routinely does not include such representatives in the discharge planning process, the County will seek to identify and reasonably address barriers to John George's inclusion of such representatives in discharge planning.
- iv. Beginning no later than eighteen (18) months after the Effective Date, the County will use electronic health record and registration information provided to the County by John George to promptly identify individuals with serious mental illness who are discharged to the community and who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration in accordance with section II.4.e. and will comply with its obligations under section II.4.c.
- v. The County will use programs designed to reach individuals who do not follow up regarding services, consistent with section II.4.e.
- vi. The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP's or Service Team's prompt resumption of services upon discharge.

1. Linkages for Services Following Release from Santa Rita Jail
 - i. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the *Babu v. County of Alameda* Consent Decree (including section III.I, “Discharge Planning,” page 49:13-51:18). The County will ensure that ACBH collaborates with the County Sheriff’s office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the *Babu* consent decree) who are eligible for ACBH services.
 - ii. Beginning no later than eighteen (18) months after the Effective Date, the County will periodically (at least every six (6) months) evaluate FSPs’ and Service Teams’ (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.
 - iii. Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an individual identified by ACBH as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.
 - iv. With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any, based on the results of the evaluation in section II.4.1.ii and the quality reviews in section II.4.1.iii. Where appropriate, the results of the quality reviews under section II.4.1.iii will inform the County’s FSP Assessment under section II.2.c.
 - v. The County will use programs designed to reach individuals who do not follow up regarding services, consistent with section II.4.e.

5. Culturally Responsive Services

- a. The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. The County will continue to provide and expand culturally responsive behavioral health services, including through community-based and peer-run organizations, and will continue to identify and implement culturally and linguistically

appropriate and affirming strategies and practices to help reduce behavioral health disparities across racial, ethnic, cultural, and linguistic groups.

- b. The County will continue to operate the Office of Health Equity within ACBH, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBH, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client-centered care that considers the whole person and all their needs.
 - i. No later than fifteen (15) months after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one (1) month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website setting forth aggregated data metrics on the populations served by ACBH (including individual racial and ethnic groups broken down by geographic area within the County) and various communities' service needs (including racial and ethnic groups' needs for FSP, Service Team, and IHOT services in geographic areas within the County).
 - ii. The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meeting on how to improve culturally responsive services in the County. The Health Equity Officer will periodically make recommendations to the Director of ACBH on how to improve culturally responsive services in the County and coordinate with the County's other diversity, equity, and inclusion programs and activities.
- c. The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community-focused services for Black/African American residents within the County's service delivery system. The African American Wellness Hub facility will serve as a hub and coordinating center for a variety of behavioral health services, community-based supports, and linkages for the Black/African American community in the County. The County will provide opportunities for community and stakeholder engagement over the course of this project to further the project's focus on providing culturally inclusive, respectful, and relevant supports to the County's Black/African American clients and community.
- d. The County has implemented and will continue to provide periodic and ongoing trainings to all ACBH staff and ACBH-contracted community-based providers regarding: culturally responsive services; trauma-informed care; inequities across race, ethnicity, sex, sexual orientation, gender identity, and disability; anti-racism

and implicit bias. A primary intent of such trainings is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.

PART III. PROCESS, ENFORCEMENT, AND GENERAL TERMS

1. Independent Reviewer

- a. The Parties have jointly selected an independent expert reviewer, Dr. Karen Baylor (“Independent Reviewer”). The Independent Reviewer will have responsibility and authority to review relevant facts and assess and report on the County’s progress in implementing this Agreement for its duration.
- b. The Parties will cooperate fully with the Independent Reviewer as the Independent Reviewer carries out their responsibilities specified herein. The Independent Reviewer will pursue a problem-solving approach so that disagreements can be amicably resolved when possible and the Parties’ energies can be devoted to implementation.
- c. Reasonable fees, costs, and expenses of the Independent Reviewer, including the cost of any consultants or staff hired by the Independent Reviewer, during the term of the Agreement shall be borne by the County up to (a) a maximum of \$100,000 for reasonable fees, costs, and expenses for the period leading up to, and including the preparation of, the first Reviewer Report (as defined in section III.1.i of this Agreement), (b) a maximum of \$125,000 for reasonable fees, costs, and expenses for the period leading up to, and including the preparation of, the second Reviewer Report, (c) a maximum of \$85,000 per Reviewer Report for reasonable fees, costs, and expenses for the period leading up to, and including the preparation of, each of the third, fourth, and fifth Reviewer Reports, and (d) a maximum of \$32,000 for the time period following the completion of the final Reviewer Report and until the termination of the Agreement. The Independent Reviewer shall provide an accounting justifying their reasonable fees, costs, and expenses monthly, and the County will pay such reasonable fees, costs, and expenses monthly, except that the County may withhold up to 40% of the maximum for each reporting period, with any remainder to be paid after the Reviewer Report is completed.
- d. Within the budget described in section III.1.c above, the Independent Reviewer may retain or utilize staff and consultants, in consultation and subject to reasonable objections by the County to assist in their evaluations of the County’s compliance with this Agreement.

- e. The Independent Reviewer will have reasonable access to all non-privileged information, individuals, programs, services, documents,⁵ and facilities within the County's custody or control and reasonably necessary to assess the County's progress and implementation of the Agreement. Access will include departmental records, and other records, unless not permitted under applicable California and Federal privacy and confidentiality laws, including but not limited to, the California Constitution, article I, section 1; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and their respective implementing guidance and regulations as they currently exist and as may be amended or adopted; California Civil Code § 56.10; California Welfare and Institution Code § 5328; and 42 C.F.R. Part 2.
- f. To the extent reasonably necessary to assess the County's progress and implementation of the Agreement, the Independent Reviewer may also, in their discretion:
 - i. review any publicly-available information and attend any public meetings relevant to the County's progress and implementation of the Agreement, including but not limited to public meetings of the County Mental Health Advisory Board and its committees; and
 - ii. meet with individuals who receive or may need services contemplated by this Agreement, to the extent consistent with the individual's preference.
- g. The Independent Reviewer may have *ex parte* communications at any time with the Parties, including counsel for the Parties, and employees, agents, contractors, and all others working for or on behalf of the County or the United States to implement the terms of this Agreement. All Parties will have access to any information considered by the Independent Reviewer, except for *ex parte* communications with other Parties or where such access is not permitted under applicable California or Federal law. Neither DRC nor the United States is a monitor or reviewer, but the Parties nonetheless agree that DRC and the United States may make reasonable requests for information not otherwise produced to the Independent Reviewer, provided the requests are not unduly burdensome to the County and are relevant to the implementation of this Agreement. The County will not unreasonably withhold information in response to requests that are not unduly burdensome and are relevant to implementation. Nothing in this Agreement is intended to limit any Party's authority under federal and state law to access information and documents.

⁵ The word "documents" as used here includes individual medical and mental health records. At present, the Parties disagree as to whether access to individual medical and mental health records will be reasonably necessary to assess the County's progress and implementation of the Agreement. The Parties will ensure that appropriate mechanisms are in place to allow the Independent Reviewer to have access to relevant records should such access be necessary.

- h. Access is not intended, and will not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with such information.
- i. During the term of this Agreement, the Independent Reviewer will draft and finalize comprehensive public reports on the County's progress and implementation of this Agreement including recommendations, if any, to facilitate or sustain substantial compliance (each a "Reviewer Report") as follows:
 - i. The first Reviewer Report will be completed and submitted no later than six (6) months after the Effective Date of this Agreement.
 - ii. Each of the subsequent Reviewer Reports will be completed and submitted no later than fourteen (14), twenty (20), twenty-five (25), and thirty-one (31) months, respectively, after the Effective Date of the Agreement.
 - iii. The Independent Reviewer will complete five (5) Reviewer Reports. Notwithstanding the foregoing, the Parties may agree in writing to one or more full or partial additional Reviewer Report(s). No Party will unreasonably deny another Party's request for such additional Reviewer Report(s), but cost may be a reasonable consideration with respect to such a request.
 - iv. At least thirty (30) days prior to the finalization of any Reviewer Report, the Independent Reviewer will provide the complete draft Reviewer Report to the Parties. The Parties may submit comments and responses to the draft Reviewer Report no later than fifteen (15) days after receipt of the complete draft Reviewer Report, and the Independent Reviewer will consider and address the Parties' timely comments and responses when finalizing the Reviewer Report. The finalized Reviewer Report will be submitted to the Parties and made public, with any redactions necessary under California or Federal law.
- j. The Independent Reviewer, and any staff or consultants retained by the Independent Reviewer:
 - i. Will not be liable to the Parties for any claim, lawsuit, or demand arising out of their activities under this Agreement and will not be subject to formal discovery propounded by the Parties in any litigation involving the services or provisions reviewed under this Agreement, including, but not limited to, depositions, requests for documents, and requests for admissions, interrogatories, or other disclosures. This paragraph does not apply to any proceeding related to alleged privacy violations, payment or non-performance of services under contracts into which they have entered in connection with their work under the Agreement.
 - ii. May provide their findings in any mediation under section III.2.b-c and may testify in *Disability Rights California v. County of Alameda, et al.*

regarding any matter relating to the implementation, enforcement, or termination of the Agreement, including the Independent Reviewer's observations, findings, and recommendations in this matter.

- iii. While serving as the Independent Reviewer, will not contract with any Party (other than for purposes of serving as the Independent Reviewer) and will not voluntarily serve as an expert witness against any Party in any other administrative or civil proceeding of whatever nature brought before any federal or state court or other administrative or judicial tribunal. This limitation shall be a required term in the County's contract with the Independent Reviewer.

- k. In the event that the Independent Reviewer resigns or the Parties agree to replace the Independent Reviewer (each a "Replacement Event"), the Parties will meet and confer in good faith within ten (10) business days of the Replacement Event to select a qualified individual to serve as an Independent Reviewer. An individual is qualified if they have expertise in the provision of community-based behavioral health services to persons with serious mental illness in California, including experience with Federal, California, and local programs, funding, and laws regarding the provision of services to individuals with serious mental illness, and is free of conflicts of interest with any Party. Individuals who were previously interviewed by all Parties in connection with the role of the independent reviewer are not qualified individuals under this paragraph. Candidates with experience as a county behavioral health director for a California county will be given priority consideration. If the Parties are unable to agree on a replacement Independent Reviewer, the County will and the United States and DRC will, within thirty (30) days of the Replacement Event, nominate up to two qualified individuals and will jointly engage the services of a mutually agreed-upon mediator. The Parties will thereafter participate in good faith in one or more mediation session(s) to select a replacement Independent Reviewer. If the Parties are unable to agree upon a replacement Independent Reviewer within sixty (60) days of the Replacement Event, each Party may file a motion for administrative relief under Local Civil Rule 7-11 requesting the Court to select the replacement Independent Reviewer from among those qualified individuals nominated by the Parties.

2. Enforcement, Dispute Resolution, and Termination

- a. No later than ten (10) days after the Agreement is fully executed, (i) the United States will file a motion to intervene in *Disability Rights California v. County of Alameda, et al.*; (ii) the Parties will file a joint motion asking the Court to waive the pleading requirements under Federal Rule of Civil Procedure ("FRCP") 24(c); and (iii) the Parties will file a joint motion for an order conditionally dismissing the United States' and DRC's action pursuant to FRCP 41(a)(2), subject to reinstatement for the purpose of enforcing the Agreement and will file this Agreement as an exhibit to this joint motion for dismissal. The joint motion for conditional dismissal will request that the dismissal order state that the Court will retain jurisdiction over the Agreement for the purpose of enforcing the Agreement

until the Agreement terminates. If the Court does not grant the United States' motion to intervene or the Parties' motion for conditional dismissal, the Parties will meet and confer to seek to resolve the Court's concerns. Absent an agreement by the Parties, after thirty (30) days of the Court's denial of the motion or subsequent related motion (e.g., a motion for reconsideration), this Agreement will become null and void, and all Parties will have the right to revive any claims or defenses otherwise barred by operation of this Agreement.

- b. The Parties agree to work collaboratively to achieve the purpose of this Agreement. In the event of any dispute over the Agreement's language, requirements, or construction, the Parties will meet and confer in an effort to achieve a mutually agreeable resolution. If such meet and confer efforts are unsuccessful, the Parties will further participate in good faith in mediation, as outlined in section III.2.c, in a further effort to achieve a mutually agreeable resolution.
- c. **Dispute Resolution and Enforcement Actions**
 - i. If DRC or the United States believes that the County has not substantially complied with an obligation under this Agreement, it will notify the County and the Independent Reviewer in writing and include reasonably specific information regarding the alleged substantial noncompliance ("Notice of Noncompliance").
 - ii. The Parties will meet and confer within thirty (30) days of the Notice of Noncompliance to negotiate in good faith to resolve informally any dispute. If the Parties are unable to agree on a resolution within sixty (60) days of the Notice of Noncompliance or following meet and confer efforts under Section III.2.b, the Parties shall engage the services of a mutually agreed-upon mediator and in good faith engage in mediation for a period to last no more than thirty (30) days.
 - iii. Any Party may request that the Independent Reviewer participate in meet and confer discussions and/or mediation sessions to provide their findings.
 - iv. If the Parties are unable to agree on a resolution following a thirty (30) day mediation period under section III.2.c.ii above, any Party may bring a motion before the Court seeking appropriate relief.
- d. The Parties may agree in writing to extend any deadlines specified in this Agreement. The Parties will not unreasonably deny requested extensions.
- e. This Agreement will terminate either (1) on the date that is the later of three (3) years and three (3) months after the Effective Date or five (5) months after the final Reviewer Report, or (2) upon the County's demonstration of sustained substantial compliance with the provisions set forth herein, whichever is sooner, subject to section III.2.f.

- f. If the United States duly files or joins a motion to enforce the Agreement pursuant to section III.2.c.iv., the Agreement will not terminate until the Court has ruled on such motion or such motion has been withdrawn. On such a motion or any other motion to enforce the Agreement pursuant to section III.2.c.iv., the Court may extend or further extend the Agreement and order additional partial or full Reviewer Reports by the Independent Reviewer, as appropriate.
- g. For the purposes of this Agreement, substantial compliance will mean something less than strict or literal compliance. Substantial compliance is achieved if (1) any violations of the Agreement are minor or occasional and are not systemic, and (2) substantial compliance is sustained or otherwise demonstrated to be durable. Sustained substantial compliance refers to substantial compliance for a period of no less than six (6) months. Non-compliance with or due to mere technicalities, or isolated or temporary failure to comply during a period of otherwise sustained substantial compliance, will not constitute failure to sustain substantial compliance.

3. Attorney's Fees

- a. The County agrees to pay DRC to cover its reasonable attorneys' fees, expenses, and costs incurred in connection with this matter (including, but not limited to, DRC's investigation, litigation, and settlement of this matter) before or after the Effective Date in the amount of \$1,800,000, except that this amount does not include fees or costs to which DRC may become entitled upon the Court's determination that DRC is a prevailing party in an enforcement action under section III.2.c.iv. Payment will be transmitted to be received by Goldstein, Borgen, Dardarian & Ho by the date that is 45 days from the Effective Date or December 29, 2023, whichever is later.
- b. DRC shall be entitled to reasonable attorneys' fees, costs, and expenses incurred in an enforcement action under section III.2.c.iv to the extent that the Court determines that (1) the County is not in substantial compliance with this Agreement as that term is defined in section III.2.g, (2) DRC is a prevailing party with respect to such enforcement action as that term is used in 42 U.S.C. § 12205 and relevant case law, and (3) DRC participated in good faith in dispute resolution processes as set forth in section III.2.c.

4. General Provisions

- a. The Agreement is binding on all successors, assignees, employees, agents, and all others working for or on behalf of the County to implement the terms of this Agreement.
- b. During the term of this Agreement, the United States and DRC are barred from bringing any action against the County for any claim or allegation under Title II of the Americans with Disabilities Act as interpreted by *Olmstead*, in any way related to those set forth in the United States' "Investigation of Alameda County,

John George Psychiatric Hospital, and Santa Rita Jail” and accompanying Notice, both dated April 22, 2021, and in *Disability Rights California v. County of Alameda, et al.* However, this provision does not bar action by the United States against the County for claims or allegations under the Americans with Disabilities Act or other laws relating to conditions in Santa Rita Jail, including those described in Sections V to VII of the United States’ April 22, 2021 Investigation of Alameda County, John George, and Santa Rita Jail.

- c. Nothing in this Agreement shall be read to alter the right of an individual to notice, to grieve or to appeal, using the County’s current procedures and by exercising their due process rights under federal and state Medicaid or other law. Such grievance, appeal or fair hearing shall not be limited by any provisions in this Agreement.
- d. The use of the future tense in a term or provision of the Agreement does not imply that the County does not currently comply with such term or provision.
- e. This Agreement does not obligate the County to provide any individual with any service that is not appropriate for that individual or that is inconsistent with the individual’s preferences after the individual has been offered the opportunity to learn of services appropriate for that individual.
- f. No amendment to this Agreement shall be effective unless it is in writing and signed by all Parties to this Agreement. Notwithstanding the prior sentence, to the extent this Agreement incorporates existing laws and regulations, the Parties understand and agree that this Agreement should be interpreted consistent with such laws and regulations, including interpretive guidance relating thereto. To the extent a change in the law necessitates a change to any term in the Agreement, the County will provide written notice of such change, and the Parties will confer.
- g. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein will not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.
- h. The Parties will promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof.
- i. The Parties represent and acknowledge this Agreement is the result of extensive, thorough, and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of a Party is duly authorized to enter into this Agreement and to bind that Party to the terms and conditions of this Agreement. All Parties to this Agreement have participated in its drafting; consequently, any ambiguity shall not be construed for or against any Party.

- j. This Agreement may be executed in counterparts, each of which will be deemed an original, and the counterparts will together constitute one and the same Agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.
- k. The performance of this Agreement will begin immediately upon the Effective Date.
- l. DRC and the County have agreed upon a joint public statement regarding the Agreement, which both parties shall use in announcing the settlement.
- m. “Notice” under this Agreement will be provided by overnight courier, or by any other agreed upon method, to the signatories below or their successors:

On Behalf of the United States

Date: 11/03/2023

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On Behalf of Disability Rights California

Date: 11/03/2023

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ANDY IMPARATO
Executive Director

On Behalf of County of Alameda

Date: Nov 2 - 2023

Nate Miley

NATE MILEY
President, Board of Supervisors

On Behalf of Alameda County Behavioral Health Care Services Department

Date: 11/2/2023

DocuSigned by:


DR. KARYN TRIBBLE
Director

Approved as to Form

Date: 11/03/2023



JENNIFER STARK
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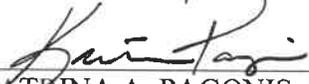
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Date: 10/31/23



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Date: October 30, 2023



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Disability Rights California v. County of Alameda **Fact Sheet**

On January 31, 2024, a federal court approved a [Settlement Agreement](#) between Disability Rights California (DRC), the U.S. Department of Justice (DOJ), and Alameda County about the County's mental health system. We are pleased to have reached this agreement and have summarized the key provisions of the agreement below.

Q: What is this case about?

In 2018, we began to investigate Alameda County's mental health system. We found a troubling pattern where people in need of mental health support were cycling through psychiatric hospitalization, incarceration, and homelessness, rather than receiving community-based mental health services. We found that this issue disproportionately impacted Black residents in Alameda County.

In 2020, DRC and our co-counsel filed a lawsuit in federal court based on our findings. We then partnered with the U.S. Department of Justice to negotiate with Alameda County. In November 2023, we signed a final settlement agreement. The federal court approved this settlement on January 31, 2024.

Q: What does the settlement agreement require Alameda County to do?

The goal of the agreement is to minimize unnecessary cycling into and out of psychiatric facilities for people with serious mental health disabilities and to ensure that they receive services in the community whenever possible. The settlement also seeks to minimize involvement of people with mental illness with the criminal legal system. This means that Alameda County Behavioral Health Care Services must:

1. Promptly conduct an assessment for community-based services when they identify an individual who is at-risk of unnecessary institutionalization, hospitalization, or incarceration, including when the individual, or someone else on their behalf, requests such services.
2. Identify people at John George Hospital, Santa Rita Jail, Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, or Morton Bakar Center who may be eligible for community-based mental health services. The County must then take steps to connect people to such services.

February 2024

3. Address barriers to immediately connecting people to community-based mental health services upon release from Santa Rita jail.
4. Expand culturally responsive and affirming behavioral health services, including through community-based and peer-run organizations.
5. Conduct a needs assessment, with community input, to determine the extent to which Alameda County must expand its mobile crisis services beyond the nine mental health mobile crisis teams it has committed to maintain.
6. Conduct an assessment, with community input, to determine the needs and gaps in Full-Service Partnership (FSP) services. FSPs offer wraparound services to people with serious mental health disabilities, including therapy, housing, and employment. Alameda County must “reasonably expand” these FSP services based on the results of the assessment.
7. Make reasonable efforts to add 25 peer respite and/or crisis residential beds. These are places where people can go if they are experiencing a mental health crisis but do not want to go to John George Hospital.
8. Make efforts to connect individuals to appropriate mental health services through real-time appointment scheduling, timely in-the-field assessments, and authorization of services. ACCESS is a number you can call if you want mental health services (1-800-491-9099).
9. Publish data about Alameda County’s mental health services, which must include data about the race of people served.
10. Host a community meeting about culturally responsive services, which must be open to all members of the public.

Q: Who will monitor whether Alameda County is implementing the agreement?

An Independent Reviewer will assess and publish reports about Alameda County’s implementation of the Settlement Agreement.

Q: How long will the settlement agreement last?

The settlement agreement will last approximately three years.

Q: Who can I contact if I have questions about the settlement agreement?

If you have questions about the agreement, you can call the DRC intake line at 1-800-776-5746 or TTY 1-800-719-5798 on Monday, Tuesday, Thursday, or Friday from 9 am – 3 pm. You can also email DRCvAC@disabilityrightsca.org.



U.S. Department of Justice

Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
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April 22, 2021

Keith Carson
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Mark Fratzke
Alameda Health System
Interim Chief Operating Officer
1411 E. 31st St.
Oakland, CA 94602

Re: Notice Regarding Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail

Dear President Carson, Sheriff Ahern, and Interim Chief Operating Officer Fratzke:

The Civil Rights Division has completed the investigation into the conditions and practices at Santa Rita Jail and John George Psychiatric Hospital, and into whether Alameda County's reliance on John George Psychiatric Hospital and sub-acute psychiatric facilities to provide mental health services to adults with mental health disabilities violates those individuals' right to receive services in the most integrated setting appropriate to their needs. The investigation was conducted under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, and Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134, and the ADA's implementing regulation, 28 C.F.R Part 35.

Consistent with the statutory requirements of CRIPA, we provide this Notice of the alleged conditions that we have reasonable cause to believe violate the Constitution and federal law and the supporting facts giving rise to those violations. 42 U.S.C. § 1997b(a)(1); 42 U.S.C. § 1997c(b)(1). This Notice also sets forth the Department's findings of fact and conclusions of law under the ADA. 42 U.S.C. §§ 12131–12134; 28 C.F.R. § 35.172(c). We also notify you of the minimum remedial measures that we believe may remedy the alleged violations.

After carefully reviewing the evidence, we conclude that there is reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at the Santa Rita Jail, and that Alameda County violates the ADA as interpreted by *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999). Specifically, we have reasonable cause to believe that: (1) Alameda County violates the ADA by failing to provide services to qualified individuals with mental health disabilities in the most integrated setting appropriate to their needs by unnecessarily institutionalizing them at John George Psychiatric Hospital and sub-acute facilities; (2) Santa Rita Jail fails to provide constitutionally adequate mental health care to prisoners with serious mental health needs, including those at risk of suicide; (3) Santa Rita Jail's use of prolonged restrictive housing under current conditions violates the Eighth and Fourteenth Amendment rights of prisoners with serious mental illness; and (4) Santa Rita Jail violates the ADA by denying prisoners with mental health disabilities access to services, programs, and activities because of their disabilities.¹

We thank Alameda County, Alameda Health System, and the Alameda County Sheriff's Office for accommodating our investigation and providing access to facilities, staff, documents, and data. We are obligated to advise you that 49 days after issuance of this Notice, the Attorney General may initiate a lawsuit under CRIPA to correct the alleged conditions we have identified if Alameda County officials have not satisfactorily addressed them. 42 U.S.C. § 1997b(a)(1). CRIPA also authorizes the Department to move to intervene in a related private suit 15 days after issuing the Notice. 42 U.S.C. § 1997c(b)(1).

We hope, however, to resolve this matter through a cooperative approach and look forward to working with Alameda County leadership and staff to address the violations of law we have identified. The lawyers assigned to this investigation will, therefore, contact Alameda County to discuss options for resolving this matter amicably. Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.

¹ The Department of Justice (Department) opened this investigation to examine five issues: (1) whether the County's reliance on psychiatric institutions to provide mental health services to adults with mental health disabilities violates the ADA; (2) whether the conditions of confinement and practices at Santa Rita Jail deprive persons with serious mental illness of their constitutional rights; (3) whether the conditions at Santa Rita Jail violate the rights of persons with mental health disabilities under the ADA; (4) whether the practices at John George Psychiatric Hospital violate the rights of persons with mental health disabilities under the ADA to receive services in the most integrated setting appropriate to their needs; and (5) whether the conditions at John George Psychiatric Hospital deprive persons with serious mental illness of their constitutional rights. This Notice Letter applies to the first four issues. With regard to the remaining issue, the Department did not reach a conclusion as to whether there are systemic unconstitutional conditions at John George Psychiatric hospital and is closing its investigation.

If you have any questions regarding this correspondence, please call Steven H. Rosenbaum, Chief of the Special Litigation Section, at (202) 616-3244.

Sincerely,



Pamela S. Karlan
Principal Deputy Assistant Attorney General
Civil Rights Division

cc: Donna Ziegler
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Attachment: Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail

**INVESTIGATION OF ALAMEDA
COUNTY, JOHN GEORGE
PSYCHIATRIC HOSPITAL, AND SANTA
RITA JAIL**



United States Department of Justice
Civil Rights Division

April 22, 2021

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I. INTRODUCTION

After an extensive investigation, the United States provides notice, pursuant to Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131–12134, and the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, that there is reasonable cause to believe that Alameda County and the Alameda County Sheriff’s Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at the Santa Rita Jail and that Alameda County violates the ADA in its provision of public mental health services. Specifically, we have reasonable cause to believe that: (1) Alameda County fails to provide services to qualified individuals with mental health disabilities in the most integrated setting appropriate to their needs, instead relying on John George Psychiatric Hospital and sub-acute psychiatric facilities (collectively, “psychiatric institutions”)¹ to provide such services; (2) Santa Rita Jail fails to provide constitutionally adequate mental health care to prisoners with serious mental health needs, including those at risk of suicide; (3) Santa Rita Jail’s use of prolonged restrictive housing under current conditions violates the constitutional rights of prisoners with serious mental illness; and (4) Santa Rita Jail denies prisoners with mental health disabilities access to services, programs, and activities because of their disabilities.²

Specifically, the United States provides notice of the following findings:

- **Alameda County relies on psychiatric institutions to serve adults with mental health disabilities who are eligible for public mental health services, rather than providing services in the most integrated setting appropriate to their needs.** On any given day in Alameda County, hundreds of people are institutionalized for lengthy stays at one of several large, locked, sub-acute psychiatric facilities or are hospitalized at John George Psychiatric Hospital (John George). Depending on the facility, people live at the sub-acute facilities for an average of anywhere from six months to two years. Of those hospitalized at John George, a significant subset will spend weeks or even months there; many, lacking any alternatives, are funneled to other segregated facilities on discharge. Even more adults with mental health disabilities are at serious risk of admission to these psychiatric institutions.

¹ For purposes of our findings related to the integration mandate of the ADA, we considered only *psychiatric* institutional settings. See 28 C.F.R. pt. 35, App. B, at 708 (2018); 28 C.F.R. § 35.130(d) (2019); see also 42 U.S.C. § 12101(a)(2), (b)(1). We did not consider Santa Rita Jail to be an institutional or segregated setting in making those findings. At the same time, for the CRIPA portion of our investigation, the Santa Rita Jail is an “institution” as defined by CRIPA. See 42 U.S.C. § 1997.

² The Department of Justice (Department) opened this investigation to examine five issues: (1) whether the County’s reliance on psychiatric institutions to provide mental health services to adults with mental health disabilities violates the ADA; (2) whether the conditions of confinement and practices at Santa Rita Jail deprive persons with serious mental illness of their constitutional rights; (3) whether the conditions at Santa Rita Jail violate the rights of persons with mental health disabilities under the ADA; (4) whether the practices at John George Psychiatric Hospital violate the rights of persons with mental health disabilities under the ADA to receive services in the most integrated setting appropriate to their needs; and (5) whether the conditions at John George Psychiatric Hospital deprive persons with serious mental illness of their constitutional rights. This Notice Letter applies to the first four issues. With regard to the remaining issue, the Department did not reach a conclusion as to whether there are systemic unconstitutional conditions at John George Psychiatric hospital and is closing its investigation.

- **With appropriate community-based services, supports, and coordination, people with mental health disabilities could live at home and be integrated in their communities.** Evidence-based services, such as Assertive Community Treatment and Permanent Supported Housing, are proven effective in enabling people to live in their own homes in the community, even for people with the highest level of need for mental health services. Community-based crisis response services are also critical to avoid unnecessary hospitalizations and maintain people successfully in the community. A strong crisis system, along with other comprehensive community-based services, can ensure that the majority of adults with mental health disabilities in Alameda County avoid psychiatric institutionalization. Alameda County fails to make these needed community-based services available in adequate capacity or intensity. Alameda County also fails to ensure that people who are in institutions receive professionally-adequate discharge planning and a connection upon discharge to needed services. Without connection to adequate community-based services, people return to John George in crisis again and again. Deficiencies in the community-based service system, including crisis services, at times also contribute to the incarceration of people with mental health disabilities in Santa Rita Jail (Jail). This incarceration further increases a person’s risk of institutionalization in John George and the sub-acute psychiatric facilities after release, due in part to the unconstitutional conditions described below.
- **For those who are incarcerated at Santa Rita Jail, the Jail fails to provide constitutionally adequate mental health treatment.** The Jail’s mental health program lacks many of the hallmarks of a constitutionally adequate system. Specifically, the Jail’s current program fails to: provide adequate psychotherapy; provide adequate treatment planning, discharge planning, and programming; and properly treat and supervise suicidal prisoners. As a result, prisoners with serious mental health needs can experience worsening mental health conditions, repeated cycling for acute care at John George, prolonged restrictive housing, and, at times, serious physical harm or death. From 2015 to 2019, at least 14 prisoners died by suicide in the Jail. Two other prisoners have died by suicide at the Jail within the last two months.
- **The Jail’s use of prolonged restrictive housing under current conditions, which include the failure to provide adequate mental health care, violates the constitutional rights of prisoners with serious mental illness.** The Jail subjects prisoners with serious mental illness to prolonged periods of restrictive housing under conditions that place them at a substantial risk of serious harm. Half of the people in “administrative segregation” at any given time in the Jail are estimated to have serious mental illness. On the date of our last visit to the Jail, there were 75 prisoners in administrative segregation who had been there for over 90 days. Eleven of the 14 people who died by suicide between 2015 and 2019 were held in restrictive housing at some point, and half of the other instances of self-harm that we reviewed occurred while prisoners were in restrictive housing.

- **The Jail denies prisoners with mental health disabilities equal access to needed programming and services.** The Jail offers an array of programming and transition services to prisoners in the general population, but prisoners with mental health disabilities who are held in the Jail’s segregated “mental health unit” or in administrative segregation are denied access to these programs.

Together, these alleged violations result in a system where people with mental health disabilities in Alameda County find themselves unnecessarily cycling in and out of psychiatric institutions, lacking access to proven, evidence-based practices that would allow them to recover and participate in community life. Many also have encounters with the criminal justice system driven in part by unmet mental health needs. Those who are incarcerated at Santa Rita Jail experience severely deficient mental health treatment, lengthy stays in restrictive housing, and discrimination on the basis of their disabilities, all of which can result in serious harm or even death while incarcerated, and place them at serious risk of repeated or unnecessarily lengthy psychiatric institutional stays after release.

The Department has received multiple complaints from and on behalf of prisoners with serious mental illness at Santa Rita Jail and people who rely on Alameda County for mental health services and experience unnecessary psychiatric institutionalization. Alameda County has long been on notice of the deficiencies in its mental health service system and the harmful conditions at Santa Rita Jail, but these problems continue. Reports by County bodies, including the Board of Supervisors’ own committees, and outside consultants have identified many of these and other concerns as far back as at least 2015. News articles repeatedly highlight deaths at Santa Rita Jail, the allegedly dangerous conditions that exist there, and the overcrowding in John George’s emergency room, among other issues. Several lawsuits have been filed in recent years alleging a litany of serious problems in the Jail, and California’s federally-designated protection and advocacy organization, Disability Rights California, in 2019 sent the County a “probable cause” findings letter regarding many of the same ADA violations we identify. Advocates and family members of those who have died in the Jail have called for an audit of the Alameda County Sheriff’s Office for years. In 2018, midway through our investigation, we shared many of our concerns and observations with the County and Jail leadership.

The County is well-positioned to make crucial changes, with many of the needed services already available in limited amounts in the community and with leadership that recognizes the need for change. But today, people with mental health disabilities continue to experience needless psychiatric institutionalization and unconstitutional, discriminatory, and harmful treatment at Santa Rita Jail as they wait for change that still has not come.

II. INVESTIGATION

In January 2017, the Department of Justice notified the County of Alameda, the Alameda County Sheriff’s Office, and Alameda Health System that it was opening an ADA and CRIPA investigation into whether the County of Alameda unnecessarily uses psychiatric institutional settings to provide services to adults with mental health disabilities and whether the conditions of confinement in John George Psychiatric Hospital and Santa Rita Jail subject individuals to

unlawful harm. Our ADA investigation focused on whether the County provides meaningful community-based services as alternatives to, and effective discharge planning to help people with mental health disabilities transition out of and avoid re-entering, psychiatric institutional care.

Two nationally recognized expert consultants assisted with our investigation: a forensic psychiatrist with over 20 years of clinical and forensic experience in a variety of academic and correctional settings, and a community psychiatrist with experience as a medical director of a statewide community services provider and as a bureau chief for a state mental health authority. These experts accompanied us on site visits, participated in interviews with County and facility staff and community members, reviewed documents, and provided their expert opinions and insight to help inform our investigation and its conclusions.

During our investigation, we visited Santa Rita Jail, John George Psychiatric Hospital, sub-acute psychiatric facilities, and board and care homes. During our site visits, we interviewed staff at these facilities, as well as people who were receiving services in the facilities. We also met with providers of community mental health services, individuals with mental health disabilities who receive community-based services from the County, and mental health and criminal justice advocates and other stakeholders in the County. Finally, we met with officials from Alameda County Behavioral Health Care Services and the Alameda County Sheriff's Office. In addition to these visits and interviews, we reviewed the documents and information provided by the County, reviewed publicly available data and reports, and considered the opinions of a wide range of individuals knowledgeable about the County's mental health system.

Following several visits, Department attorneys and experts provided briefings to County and Sheriff's Office staff and leadership about preliminary concerns identified by our experts. It is evident that County and Sheriff's Office leadership and staff took these briefings seriously. By the time of our last visit in August 2019, the County had taken some positive steps, described further in Sections IV.B.2 and IV.D, and leadership elaborated on its vision of and plans for further progress. We appreciate the commitment to making these urgently needed changes, but remain concerned that there has been little actual progress to resolve the discrimination that is occurring in the County's mental health system and the unconstitutional conditions and discrimination in the Santa Rita Jail.

We thank the County for the assistance and cooperation extended to the Department of Justice thus far and acknowledge the courtesy and professionalism of all of the County officials and counsel involved in this matter to date. We also thank the people we met who are affected by the violations we were investigating, especially for their willingness to share their often-difficult experiences with us and take time away from their jobs and lives to do so.

III. SYSTEM OVERVIEW

Alameda County administers, funds, and controls its public mental health system. Within Alameda County, responsibility for administering public mental health and substance use services falls primarily on Alameda County Behavioral Health Care Services (BHCS). BHCS is

responsible for providing mental health services for people with moderate to severe mental health needs as well as for substance use disorder services. Alameda County residents are generally eligible for services from BHCS if they have a mental health disability that impairs their daily functioning.³ California delegates responsibility to and authorizes counties to provide an array of mental health services under Medicaid (referred to in California as Medi-Cal) and state-only funds, including the Mental Health Services Act (MHSA).⁴ In delegating responsibility for behavioral health services to counties, California affords counties significant flexibility in administering both Medicaid and state-only-funded programs; however, California expects the emphasis of MHSA programs to be on evidence-based, recovery-oriented community services, including crisis services, employment services, preventative services, supported housing, and intensive support services.⁵ Counties also fund additional mental health services, such as long-term psychiatric institutional programs, that are not reimbursed by Medicaid or state programs.

Alameda County provides acute inpatient hospitalization and crisis stabilization services at John George Psychiatric Hospital, a County-owned, dedicated psychiatric emergency and inpatient facility in San Leandro, California. BHCS contracts with Alameda Health System for operation of and provision of services at John George. John George has three inpatient units with a total of 69 beds, as well as an emergency room, called Psychiatric Emergency Services (PES). PES is intended to provide crisis stabilization services. Utilization of these crisis services routinely exceeds capacity. Alameda County also funds and provides long-term, sub-acute inpatient and residential services for about 200 people at a time in several “sub-acute facilities” that range in size from 39 to 78 beds, where people regularly stay for months or years.⁶ Services provided in these locked facilities include medication management, psychosocial rehabilitation, support groups, and assistance with some activities of daily living, like grooming. Many more people in Alameda County are placed in “board and care” facilities which provide residential services as well as minimal daily supports.

Many of the same or equivalent supports provided in these inpatient and segregated settings in Alameda County are also available—but in extremely limited supply—through various

³ See CAL. WELF. & INST. CODE § 5600.3(b) (West 2019); CAL. CODE REGS. tit. 9, § 1830.205 (2020). A mental health disability is a qualifying disability under the ADA. 42 U.S.C § 12102 (2012) (defining “disability” as a “physical or mental impairment that substantially limits one or more major life activities”). Mental health disabilities include serious mental illness, or SMI, which is defined as “a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment” of an individual over the age of 18 that “substantially interferes with or limits one or more major life activities” within the last year. *Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH ADMIN., <https://www.samhsa.gov/find-help/disorders> (last visited Apr. 6, 2020).

⁴ Under the MHSA, California requires counties to provide safety net mental health services for people without insurance. Cal. Welf. & Inst. Code §§ 5801–5809; Cal. Prop. 63, Mental Health Services Act, § 3 (2005, 2020 supp.).

⁵ CAL. WELF. & INST. CODE §§ 5801(b)(9), 5802, 5848.5; Cal. Prop. 63, Mental Health Services Act, § 3 (2005, 2020 supp.).

⁶ These facilities are considered Institutes for Mental Disease under Medicaid, and must be paid solely with County, not Medicaid, funds; equivalent services provided in community-settings would instead be eligible for Federal Medicaid funds.

outpatient programs. Full Service Partnerships and less intensive Service Teams use multidisciplinary team models to provide high-intensity outpatient support services to people in the places where they live. Alameda County also funds and operates limited integrated residential services for people with mental health disabilities, such as permanent supported housing. Alameda County also makes some limited crisis services available through crisis stabilization units, crisis residential facilities, and mobile crisis services.

Alameda County also funds the Santa Rita Jail, which is administered and controlled by the Alameda County Sheriff's Office. Santa Rita Jail, opened in 1989, has the capacity to hold approximately 4000 prisoners. During most of the time of our investigation, however, the actual prisoner count has been closer to 2400. Until recently, Alameda County Sheriff's Office also operated the Glenn Dyer Jail in Oakland, but in mid-2019, it closed that jail and transferred its population to Santa Rita Jail. The Jail holds both pre-trial detainees and convicted prisoners (collectively referred to throughout this Notice as "prisoners").

Jail officials have stated that approximately 40% of Santa Rita Jail's population is on the mental health caseload, and have estimated that approximately 20–25% of the population has a serious mental illness. Mental health services at the Jail are provided by BHCS, through its Criminal Justice Mental Health arm.

IV. ALAMEDA COUNTY VIOLATES INDIVIDUALS' RIGHT TO RECEIVE SERVICES IN THE MOST INTEGRATED SETTING UNDER TITLE II OF THE ADA

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1) (2012). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2) (2012). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities when it provided that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2012). Accordingly, the "ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them." *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." *See* 28 C.F.R. § 35.130(d) (2019); *see also* 42 U.S.C. § 12101(a)(2), (b)(1). That is, under the ADA, public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). An integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B, at 708 (2018).

In *Olmstead v. L.C.*, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. 527 U.S. 581, 607 (1999). In so holding, the Court explained that unnecessary institutional placement “perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Id.* at 600.

The ADA’s integration mandate applies both to people who are currently institutionalized and to people who are at serious risk of institutionalization. *Steimel v. Wernert*, 823 F.3d 902, 913 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321–22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1115–18 (9th Cir. 2011), *opinion amended and superseded on denial of reh’g*, 697 F.3d 706 (9th Cir. 2012); *United States v. Mississippi*, 400 F. Supp. 3d 546, 553–55 (S.D. Miss. 2019). As the Tenth Circuit reasoned, the integration mandate “would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation.” *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003); *see also Pitts v. Greenstein*, No. 10-635-JJB-SR, 2011 WL 1897552, *3 (M.D. La. May 18, 2011) (“A State’s program violates the ADA’s integration mandate if it creates the *risk* of segregation; neither present nor inevitable segregation is required.”) (emphasis in original). A State’s failure to provide community services may create a serious risk of institutionalization. *Pashby*, 709 F.3d at 322; *see also Mississippi*, 400 F. Supp. 3d at 553–55 (upholding plaintiff’s *Olmstead* claim that when people with serious mental illness are discharged from state psychiatric hospitals, the state’s “ongoing lack of community-based services means they are at serious risk of re-institutionalization”).

A. Alameda County Subjects Adults with Mental Health Disabilities to Unnecessary Psychiatric Institutionalization and the Serious Risk of Psychiatric Institutionalization

Alameda County relies unnecessarily on segregated psychiatric institutions to serve its residents with mental health disabilities who need intensive treatment and long-term services and supports and who are eligible for public mental health services. Institutions such as John George and the sub-acute facilities in Alameda County isolate and segregate people with mental health disabilities from those without disabilities. *Cf., e.g., Benjamin v. Dep’t of Pub. Welfare*, 768 F. Supp. 2d 747, 750 (M.D. Pa. 2011) (individuals in facilities were segregated where they lived in units ranging from 16 to 20 people, primarily received services on the grounds of the facilities and had limited opportunities to interact with non-disabled peers); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 224 (E.D.N.Y. 2009) (finding that “many people with mental illness living together in [an adult home] setting with few or no nondisabled persons contributes to the segregation of [a]dult [h]ome residents from the community”), *judgment vacated on other grounds*, 675 F.3d 149 (2d Cir. 2012); *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 285 (E.D.N.Y. 2008) (denying motion to dismiss in case involving plaintiffs with mental illness who were institutionalized in nursing facilities). Residents of these facilities are exclusively people with

disabilities, and the facilities provide services nearly entirely within their walls. These institutions' doors are locked from the outside, and the facilities place restrictions on residents' ability to leave. Even short stays in these facilities isolate people from their friends and families and interrupt participation in community life.

Alameda County is distinct in California in that it has more beds per capita in long-term sub-acute psychiatric facilities than any other similarly sized California county, and these beds are nearly always full. The primary sub-acute facilities the County relies on to serve people with mental health disabilities are Villa Fairmont, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center, a nursing facility, which have a combined 187 beds. Depending on the facility, people may stay for months or live in these facilities for years. At Villa Fairmont, the average length of stay in 2017 was 156 days. Most people stay at Morton Bakar for nearly two years and the average length of stay at Gladman is between two-and-a-half and three years.

Outside of these sub-acute facilities, people with mental health disabilities in Alameda County experience shorter, but often repeated, stays at John George Psychiatric Hospital in order to get needed services. Based on the data provided by the County, an average of 1111 people in need of crisis stabilization are evaluated at John George PES each month and remain there for up to 72 hours. Of these, almost 240 people each month are then admitted into John George's acute inpatient units. The average length of stay is nine days in these units, and increasing, but many stays last weeks or even months. Between August 2017 and July 2019, 844 admissions lasted two weeks or more in John George's inpatient unit, and 236 were for 30 days or more. Alameda County's utilization of John George's inpatient unit is 6.3 times the statewide average in California for utilization of state and county psychiatric hospitals. One complainant wrote to us about her experiences at John George and told us that County authorities "concentrate [M]edicaid crazies like myself there, as opposed to using clinics in the community." She was taken there involuntarily by law enforcement from her home after she called them to report domestic abuse and then spent two weeks in "the closest thing to Hell I've encountered." She felt that, while there, she had no clear treatment or release plan; when she eventually was released, she did not receive medications or other assistance, except for a bus pass with a single fare.

A high number of people cycle through John George again and again. Nearly 1600 people experienced four or more crisis stabilization admissions to John George's PES during the two-year period from August 2017 to July 2019.⁷ During the same period, over 1000 people experienced at least two admissions to the inpatient units. In fiscal year 2019, nearly 11% of individuals discharged from John George's inpatient unit were readmitted within just 14 days. This rate, which already far exceeds both national averages for state hospitals and statewide averages, appears to be increasing.

A history of admissions to John George—which alone is disruptive to people's lives and can put people at risk of losing jobs and housing—in turn often becomes the gateway to

⁷ The County similarly reported in 2016 that roughly 17.5% of all emergency room admissions to John George came from "high utilizers": people with more than four emergency admissions in the previous 12 months.

segregating people for longer periods in the sub-acute facilities. John George directly refers people needing longer-term services to the sub-acute facilities. Between 2012 and 2017, more than 10% of admissions to John George's inpatient units resulted in a placement in a sub-acute facility within 14 days of discharge. The County itself plays a direct role in institutional placements through its monthly Acute Care Coordination Committee meeting. In this meeting, representatives from John George, the sub-acute facilities, and community providers discuss individuals who have cycled through hospitals, and sometimes also jail, in an attempt to place these individuals in the sub-acute facilities or, for those who have been lingering at the sub-acute facilities, into a board and care home. However, few are connected with intensive community services through this process.

As discussed in Section IV.B–D, our investigation determined that nearly all of the people who are placed in the sub-acute facilities or in John George's inpatient units could have avoided or spent less time in these psychiatric institutions with appropriate community-based services, and few would oppose such services, rendering Alameda County's reliance upon psychiatric institutions unnecessary. But because Alameda County does not make appropriate community-based services available in sufficient capacity, people have little choice but to enter these psychiatric institutions to get the help they need.

People with mental health disabilities incarcerated at the Santa Rita Jail face further serious risk of institutionalization in a psychiatric facility upon their release from the Jail. Some people are sent directly to John George upon release from the Jail, and others make their way to the hospital soon after, because of a lack of community-based mental health services or because the County fails to connect them to those services that do exist. Between 2012 and 2017, there were more than 4200 instances when a person released from Santa Rita Jail was seen at John George PES within just 30 days. Of the people who spent time in John George's inpatient unit between 2012 and 2017, 41% had previously been incarcerated in Santa Rita Jail. Of those with four or more inpatient stays at John George, 53% had spent time in the Jail.

As discussed further in Sections V–VII, Santa Rita Jail denies prisoners adequate mental health treatment, isolates people with serious mental illness for prolonged periods in restrictive housing, and severely limits access to pre-release programming and transition services for this population. These conditions contribute to people with serious mental illness being sent repeatedly for brief stints to John George while incarcerated and often leads to institutionalization upon release. The inadequate discharge planning the County provides to prisoners with mental health disabilities at the Jail compounds this problem. The County's discharge and treatment planning often fails to anticipate a person's needs in advance of release and almost never includes goals for community stabilization. According to Jail mental health staff and our expert's review, prisoners commonly receive, at most, bridge medications and a list of resources. Although Alameda County BHCS is responsible for mental health treatment at the Jail, the County does not ensure that community providers meet with prisoners before their release to coordinate treatment. Because of these practices, people being released from jail, a time when they are particularly vulnerable, often do not successfully connect with community services. A lack of successful connection to community services leads to housing instability and

a lack of effective mental health treatment. This results in an increased risk of additional mental health crisis and eventual placement at John George and the sub-acute facilities.

Alameda County further places people at serious risk of psychiatric institutionalization due to its lack of community-based behavioral health crisis services. Instead of providing community crisis services by trained mental health clinicians, such as mobile crisis services and crisis residential services, that are effective in preventing unnecessary hospitalizations, the County relies heavily on law enforcement to respond to crises. The Alameda County Board of Supervisors' Mental Health Board observed in 2015 that "Police officers in the field responding to individuals with mental illness have few options other than bringing them to Santa Rita or John George. Although they may have received Crisis Intervention Training, without adequate diversion resources, police officers must frequently use John George and/or Santa Rita Jail as their only option."⁸ We heard from multiple stakeholders, including those who had themselves experienced a mental health crisis, that it is typically law enforcement who respond to psychiatric emergencies and that there is a degree of chance with respect to whether one is taken to jail or the hospital. Multiple reports have found that the lack of access to community-based mental health services—including crisis services, diversion mechanisms, long-term community supports, and re-entry discharge planning—may all contribute to people with mental health disabilities encountering law enforcement and ultimately becoming hospitalized or incarcerated in Santa Rita Jail. Our experts' findings and national studies also support this conclusion.⁹

The death of A.A.¹⁰ illustrates the problems that can occur due to the lack of community-based mental health services, including crisis services. A.A. was experiencing a mental health crisis in early June 2019. After a brief psychiatric hospitalization, nurses told his parents on discharge to call 911 and ask for police if he needed further help, and that he would be brought back in for mental health treatment. Days later, A.A. was still in crisis, and his parents called 911, asking for help. A.A.'s father told the police who responded that A.A. was not a danger and that he needed to be taken for mental health treatment. This would have been an appropriate situation in which to bring in community-based crisis services or call a mobile crisis team, but it appears that this did not occur. Instead, police arrested A.A., and, as described in more detail below, he was taken to Santa Rita Jail, where he sustained severe injuries and later died. A.A.'s parents have publicly expressed deep regrets that they ever sought assistance from police for their son.¹¹

Another person's experience similarly illustrates how the lack of effective community-based services and a history of repeated institutionalization can also result in engagement with the criminal justice system. B.B. was well known to BHCS—she had more than 100 "episodes"

⁸ ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014–2015 at 7 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.

⁹ In fact, California law specifically permits pre-trial diversion to mental health treatment for individuals with mental illness where the mental illness played a significant factor in the commission of the charged offense, excluding certain violent and serious charges, CAL. PENAL CODE § 1001.36 (West 2020), but without community-based treatment options, this law may have little impact on diversion.

¹⁰ To protect the identity of people, we use coded initials.

¹¹ Despite multiple requests, Alameda County did not provide records related to A.A.'s death.

dating back to 2002. In 2016, without access to intensive community-based services, B.B. experienced a mental health crisis, attempted to admit herself to John George, and was ultimately arrested for trespassing after John George denied her admission without contacting a mobile crisis team or otherwise connecting her to services. B.B. was rearrested a few months later, but her mental health deteriorated and she was forensically admitted to a state psychiatric hospital for nearly two years before being released back to Santa Rita Jail in July 2019.

B. People with Mental Health Disabilities in Alameda County Can Be Appropriately and Effectively Served in the Community

People with mental health disabilities who are institutionalized or at serious risk of institutionalization at John George or a sub-acute facility in Alameda County could avoid placement in psychiatric institutions with appropriate integrated, community-based services, if such services were available. Many established, evidence-based practices exist that are proven to support people with serious mental illness or other mental health disabilities in their own homes and community-based settings, and to reduce needless psychiatric institutionalization. However, Alameda County has not appropriately implemented these practices, and services are in too short supply. It is the County's failure to provide evidence-based, community-based treatment, including crisis services and processes to divert people from psychiatric institutionalization, that results in and perpetuates the cycle of needless institutionalization described above.

1. People Cycling Through Psychiatric Institutions Are Appropriate for Community-Based Services

Most of the people who cycle in and out of John George and the sub-acute facilities in Alameda County could be provided appropriate mental health treatment in the community. At two points during the Department's investigation, our consultant, a national expert in the provision of community-based treatment to people with serious mental illness, conducted a review of people in John George's inpatient unit. Both times, our expert found that nearly all of the individuals there would have avoided hospitalization altogether or spent less time in the hospital had they been provided appropriate community-based treatment and received professionally adequate discharge planning to connect with those services.

People regularly stay longer than is needed at John George. On any given day at John George, a significant portion of the residents have been determined by John George professionals to be appropriate to leave but remain in the hospital because they are awaiting a placement elsewhere. On July 31, 2019, 24 of the 69 inpatient beds—or 35%—were occupied by individuals whom John George had determined no longer met criteria for an inpatient stay. In the year between August 2018 and July 2019, 123 people spent two weeks or more institutionalized at John George after they were cleared for discharge, simply because there was nowhere for them to go. Instead, they were held at John George, waiting for an opening in an intensive community-based mental health program, or for space at one of the sub-acute facilities—discussed below. John George staff estimated that in a given week, about 10 of their inpatient residents who are ready for discharge are of enough concern to be discussed at the

weekly Acute Care Coordination Committee meeting in order to locate a community placement; each week, the resources are found to support only about half of them. Staff reported that in some cases, people have waited in the inpatient unit for months for a placement, simply because there were no community resources available to support them outside of the hospital. Similarly, the County has estimated that 75% of people placed on involuntary holds at John George do not even meet medical necessity to be there. This is likely because, as one John George administrator put it, the “dearth of resources” in the community lands far too many people in their institution, again and again.

People living in the sub-acute facilities could also largely live in their own homes and communities with appropriate services. Facility staff themselves stated that many of the people living at these facilities could live in the community with appropriate services, and this opinion was echoed by stakeholders in various roles in the County. Our expert agreed that Alameda County overly relies on the sub-acute facilities instead of community-based treatment. Our expert reviewed a sample of people at one sub-acute facility, Villa Fairmont, and concluded that, like those at John George, nearly all would have avoided admission or could have spent less time in the facility, had they been provided appropriate community-based treatment. Yet many are stuck, waiting for slots in community service programs that simply do not exist or that are inadequate to meet their needs.

Our expert found that people served by BHCS are often at serious risk of psychiatric institutionalization because of a lack of available community supports. Having interviewed individuals in and at risk of entry to many of the psychiatric institutions in Alameda County, our expert confirmed that the people he met in Alameda County’s institutions were no different from people he had served or observed receiving services successfully in their own homes around the country.

2. Alameda County Fails to Provide Adequate Community-Based Services that Could Prevent Needless Psychiatric Institutionalization

It is well-established that an appropriate array of evidence-based services can enable people with serious mental illness or other mental health disabilities to avoid psychiatric institutionalization and live safely in integrated, community-based settings. The County has implemented some critical community-based services, but it has not fully funded them to ensure they are available in sufficient capacity, adequate intensity, and with fidelity to evidence-based practices so as to prevent individuals from cycling through psychiatric institutional stays.

Community-based mental health services and practices are necessary to enable individuals with mental health disabilities to live in the community. These are critical, evidence-based practices that can be individually tailored to the needs of each person and minimize costly, unnecessary, and repeated psychiatric institutionalization. These services are appropriate for Alameda County residents who have serious mental illness and are currently in or at serious risk of entering psychiatric institutions and, if fully developed in Alameda County, would prevent unnecessary institutionalization. These services are also proven to reduce arrests and incarceration and could thus further help to break the cycle of unnecessary psychiatric

institutionalization and incarceration. These services or their equivalents are provided in John George and the sub-acute facilities, but do not currently exist in sufficient supply or intensity in the community. These services include the following:

- **Crisis Services:** Community-based crisis supports are a crucial component of a system that prevents needless psychiatric institutionalization. These services include crisis hotlines, mobile crisis teams, crisis apartments, and walk-in crisis centers. For example, mobile crisis is an evidence-based intervention that is available 24 hours a day to respond rapidly to people experiencing a mental health crisis at their homes or at whatever location they may be experiencing the crisis. These services are proven to decrease psychiatric hospitalizations, arrest rates, and incarceration. However, as of our last visit to Alameda County, there were just two mobile crisis programs, which do not operate at all times. Instead, law enforcement officers alone typically handle mental health crisis calls.¹² In our expert's review of individuals at John George and Villa Fairmont, he found that none had had access to the kind of mobile crisis services that could have diverted them from admission. County leadership has recognized the important role of mobile crisis and the gaps in this service in Alameda County and is in the process of expanding mobile crisis response. At the time of our last visit, the County described plans to add six new mobile crisis teams, one of which would include an EMT to conduct medical clearance so that individuals in crisis could be taken to a location other than John George or Santa Rita Jail, expanding the options that currently are used by existing mobile crisis teams. This is among the most promising plans for improvement in the County. However, even if the County creates all of the crisis teams as planned, it will not have mobile crisis services available 24 hours a day, mobile crisis response will not be available in all areas of the County, and only one team will be able to conduct medical clearances.

Similarly, crisis services should also include alternatives to hospitalization such as crisis residential programs or crisis apartments, which typically contain a few beds in a home-like environment with full-time staff. These programs are intended to allow people to stabilize in these settings and avoid going to the hospital. The County has a few crisis residential programs, but people typically come to those settings from an acute setting, typically John George, instead of using them to avoid hospitalization in the first place. This is counter to the purpose of having a crisis residential program and uses up beds that could otherwise be used as a diversion or alternative to hospitalization.¹³

¹² In 74% of the involuntary holds (also known as 5150 holds) conducted by Alameda County Sheriff's Office that we reviewed, the individual was neither threatening nor violent. In 88% of these incidents, no restraints were used. And this does not include mental health crisis calls that did not rise to the level of severity that resulted in an involuntary hold.

¹³ In fact, the entire behavioral health system seems to be permeated by a step-down philosophy, requiring individuals to graduate out of more restrictive care to gradually less restrictive settings, which does not comport with the ADA's requirement that people receive community-based services when they are appropriate. Standards in the field today, which align with the requirements of the ADA, reject the step-down philosophy. Professional standards instead dictate that individuals are best supported in their own homes with intensive, appropriate community-based services.

To be effective, community-based crisis services must also include and be paired with mechanisms specifically designed to divert people with mental health disabilities from psychiatric institutions and the criminal justice system, which are notably absent in Alameda County. For example, the County has acknowledged that law enforcement overutilizes involuntary holds at John George due to the lack of alternative crisis resources or a formal mechanism at initial detention to connect people with mental health disabilities to community-based services, which would reduce the serious risk of subsequent psychiatric institutionalization.

- **Full Service Partnerships:** Assertive Community Treatment, or California’s model, called Full Service Partnerships, is designed to support service recipients with the highest mental health needs and most frequent hospitalizations to transition from institutions and live in the community. Full Service Partnerships provide a multidisciplinary team that is intended to help people stay in treatment, manage medication, address crises, secure and maintain housing and employment, and engage in their communities. Teams should be available 24 hours a day and be able to respond to crises and other needs on a flexible basis, including assisting in the coordination of services if a client enters or is at risk of entering an institutional setting. Both California and Alameda County have recognized that Full Service Partnerships reduce institutionalization, criminal justice involvement, and emergency room use, and community members in Alameda County have identified Full Service Partnerships as the most effective mental health service in the County. Alameda County administrators have acknowledged that the capacity is far from sufficient, although the County has not conducted an analysis of the actual need. One County administrator estimated the need to serve 4000 to 6000 people with the Full Service Partnership program. At the same time, Alameda County had funded capacity to serve only 850 adults with Full Service Partnerships and in practice serves fewer than 725 adults in a given month.¹⁴ Alameda County also operates a forensic Full Service Partnership that is designed to engage people with a history of significant criminal justice involvement. Yet, based on documents provided by the County, of the 290 people whom the County has identified to be eligible for this program, just 17 appear to have been connected with that service. Evidence we reviewed indicates that the County fails to effectively connect people with needed Full Service Partnership services and that, once connected, such services are often not provided in an intensity or with the flexibility needed to address crises and provide appropriate supports.
- **Permanent Supported Housing:** Permanent supported housing is an evidence-based mental health service that serves individuals with disabilities and provides flexible supports including medical, behavioral health, and services to support sobriety. Permanent supported housing promotes mental health recovery by enabling individuals to maintain housing and avoid the inherent stress of housing instability; by helping service recipients achieve maximum independence, positive health benefits, and overall higher

¹⁴ The County also offers another multidisciplinary team-based service, called Service Teams, which offers a lower-intensity of service and a higher client-to-staff ratio than Full Service Partnership teams.

quality of life; and by providing a stable place from which a person can engage with other services. It is a cost-effective service that is proven to reduce psychiatric institutionalization, as well as precursors to institutionalization including expensive hospitalizations, emergency room visits, incarceration, and, of course, homelessness. Alameda County BHCS acknowledges that there “is a direct link between housing and behavioral health.”¹⁵ However, Alameda County lacks sufficient supported housing capacity to meet the needs of individuals with mental health disabilities. In fiscal year 2017–2018, 10% of the people entering County programs for people with mental health disabilities—a total of 2702 unique individuals—were homeless.¹⁶ This number has steadily increased in recent years. Similarly, approximately 39% of all homeless individuals in the County self-reported a mental health condition that year.¹⁷ The County’s contractor to coordinate homelessness issues explained that these and other data points show “the considerable overlap between chronic homelessness and serious mental illness.” In 2018, Alameda County’s contractor estimated that the County needed to create an additional 2800 “permanent supportive housing” units to meet the need for this service. In 2019, there was an 8000-person waitlist for the County’s system to access housing services or subsidies, and only about a quarter of people with serious mental illness who attempt to join the waitlist are successful in even getting their names on the list. Unable to access this evidence-based service, many individuals go to board and care homes instead. Board and care homes provide some minimal care and supervision, but residents frequently lack access to needed services and meaningful community life; further, these facilities tend to be overcrowded and highly variable in quality.

- **Peer Support Services:** Peer support services are an evidence-based practice where trained and certified individuals or family members of individuals who have lived experience with mental health disabilities and receipt of mental health services provide supports. Peer supports are proven to help individuals with serious mental illness engage in treatment and to prevent or reduce hospitalization and incarceration. California’s Council on Mentally Ill Offenders has explained that peer support services “clearly stood out . . . as one of the most impactful and desired resources to reduce incarceration among those with mental illness and substance use disorders.”¹⁸ Multiple groups in Alameda County have recommended expanding peer support services throughout the service system. Nevertheless, we heard from several stakeholders that peer support services remain in too short supply in Alameda County.
- **Supported Employment Services:** Supported employment is an evidence-based service that assists people with serious mental illness to obtain and maintain competitive employment. Supported employment supports people with disabilities to live integrated lives in their communities. Alameda County has recognized the importance of supported

¹⁵ *Housing Service Office*, ALAMEDA CNTY. BEHAVIORAL HEALTH CARE SERV., <http://www.acbhcs.org/housing-services> (last visited Apr. 6, 2020).

¹⁶ EVERYONEHOME, PLAN TO END HOMELESSNESS: ALAMEDA COUNTY, CA: 2018 STRATEGIC UPDATE at 31 (2018), <https://everyonehome.org/wp-content/uploads/2018/12/EveryOne-Home-Strategic-Update-Report-Final.pdf>.

¹⁷ *Id.*

¹⁸ COUNCIL ON MENTALLY ILL OFFENDERS, 15TH ANNUAL REPORT at 17 (2016).

employment to support recovery for people with serious mental illness, but fewer than 530 people with serious mental illness received the County's supported employment services in fiscal year 2019.

- **Services for People with Co-occurring Diagnoses:** Community-based services to support people with serious mental illness who also have co-occurring diagnoses, such as intellectual disability, substance use disorder, or chronic illnesses, are important to help such individuals avoid placement in long-term institutional settings. John George staff explained that in recent years they have seen an increase in people with co-occurring intellectual and developmental disabilities, people with co-occurring substance use disorders, and older adults who may have age-related disabilities—all of whom have begun utilizing John George's acute services more because of a lack of services in the community to support their needs. Although there are evidence-based approaches that have proven to decrease hospital use for most people—for example, integrated dual diagnosis treatment—these services are largely unavailable in Alameda County.

3. Alameda County Fails to Identify and Connect People with the Community-Based Services Necessary to Avoid Needless Institutionalization

In order to avoid needless cycling through institutions, it is crucial that individuals with mental health disabilities have a way to access community-based mental health services. However, Alameda County does not utilize available opportunities to identify people—whether in the community or in institutional settings—who need to be connected to community-based services and to connect them to those services. In particular, Alameda County does not provide adequate discharge planning and transition services to individuals who are institutionalized in John George and the sub-acute facilities in order to connect them to community-based services.¹⁹ In a recent review of treatment plans at John George, our expert found that not one reflected professionally adequate discharge planning. Discharge planning at John George is often not informed by important clinical and practical considerations for the person, and there is inadequate communication between treatment providers. Treatment plans also fail to promote transition to the most integrated setting for the person or to anticipate key goals, opportunities, and important factors for transition.

In addition, the County fails to adequately connect people to the community-based services that could help them avoid institutionalization. For example, as noted above, while the County operates a forensic Full Service Partnership designed to engage people with intensive needs who have a history of significant criminal justice involvement, and has identified 290 people eligible for the program, as of September 2019, fewer than 20 of those individuals had been connected with that service. Similarly, the County has identified the individuals who utilize the most mental health services, as measured by the top 3% of its mental health spending. However, fewer than one-third of those individuals were connected to Full Service Partnerships

¹⁹ And, as discussed above, Alameda County does not adequately provide for the discharge and transition planning of prisoners who will be released from Santa Rita Jail. This further places people with mental health disabilities at serious risk of psychiatric institutionalization upon release.

as of September 2019, and as of that time, the County did not track people who were eligible for those services other than those eligible for forensic Full Service Partnerships, in order to facilitate these linkages. Furthermore, of the top ten mental health service utilizers, all ten were hospitalized during the year, and nine of the ten were in sub-acute facilities. Yet, only three of those ten individuals received Full Service Partnership services during that 12-month period, and only one was placed on a service team, all for seemingly brief periods. While the County has started the process to identify people who need more intensive services, it has failed to take the necessary steps to actually connect them.

The County's failure to successfully connect people to services is hampered by lack of community-based options. This is particularly true for people with co-occurring diagnoses, such as intellectual and developmental disabilities, substance use disorders, and physical health needs. Many people are discharged without adequate supports and services, resulting in frequent readmissions to John George or sub-acute facilities or contacts with the criminal justice system. One person who had received treatment several times at John George described discharge planning there as: "Here's a bus pass, now get the hell out." Others described similar experiences with discharge from John George.

John George staff confirmed many of these issues. Staff report that there are few good options when they discharge patients to the community. They told us that at times, people are discharged to shelters or other forms of homelessness. Without housing, people rapidly lose connection with providers or with transition staff, so that the only way to get services is to return again to John George. Additionally, staff reported challenges with informing County behavioral health services when their clients were at the hospital and a regular failure of service providers to meet with their clients when at John George. John George leadership admitted that being linked to community services upon discharge is the single highest correlate with success in the community.

C. Most People with Mental Health Disabilities in Psychiatric Facilities in Alameda County Do Not Oppose Community-Based Services

Most people with mental health disabilities in Alameda County psychiatric institutions do not oppose receiving community-based services. The majority of people who find themselves at John George or the sub-acute facilities are there involuntarily, or because they had no other way to get services they needed. In fact, Alameda County has the highest rate of involuntary holds of adults in the state—a rate that is three-and-a-half times the statewide average. In his assessment of individuals at John George and Villa Fairmont, our expert found that nearly all individuals reviewed or their guardians would very likely choose to live in the community if they were fully informed of and had access to appropriate community-based services. He found in his most recent review that there was no recorded evidence, for any individual reviewed, that the person or their guardian would oppose receiving services in the community. For many individuals and their guardians, emergency room or inpatient hospitalization, or in some cases incarceration, appeared to be the only option to get help. But, in our expert's view, when there are viable options for receiving treatment at home and in integrated settings, very few people or their guardians would choose options that restrict their freedom and segregate them.

Our interviews with individuals at John George and the sub-acute facilities confirmed this conclusion. Many told us of their desire to leave, or expressed interest in receiving services in the community. One man we met at John George, who had also been to Santa Rita Jail four or five times and was otherwise homeless as of the time of our interview, explained that he would like a program that would help him transition out of John George and find a place to live, and not just be discharged to the street. Another man at John George told us he “wanted to be anywhere else,” but that after he left John George the last time, he relapsed and needed help, and so he returned. A woman we met who was living at a sub-acute facility told us she wanted to go home, and maybe go to college, but knew she would need support to do so. “Who is going to support me and be with me?” she questioned. Another man at a sub-acute facility told us that he wanted to leave as soon as possible, but felt that nobody was helping him with this. Others echoed these sentiments. A staff member at one of the sub-acute facilities told us that residents who want to leave the sub-acute facility sometimes “act up” in order to be sent to John George or to jail, because they mistakenly believe that they would subsequently be released into the community after their stay in the hospital or jail.

D. Alameda County Can Make Reasonable Modifications to Prevent Unnecessary Psychiatric Institutionalization

Alameda County can reasonably modify its mental health service system to provide home- and community-based services to prevent unnecessary psychiatric institutionalization. The County already makes available a range of services that can support people with mental health disabilities in their own homes. As discussed above, community-based services, diversion programs, and professionally-adequate discharge planning are proven to be effective in preventing unnecessary psychiatric institutionalization. The County has taken some positive steps to address unnecessary psychiatric institutionalization, including, as of our last visit, the recent funding of 100 Full Service Partnership slots for people with a history of forensic involvement (although providers have had difficulty staffing these slots); the proposal to pilot 100 additional Full Service Partnership slots, combined with housing subsidies, for individuals who are homeless and have co-occurring physical health or substance use disorders; and the plan to significantly expand mobile crisis services. The County also conducts some limited in-reach to John George and Santa Rita Jail with the goal of helping people to connect with services upon discharge. While the supply of these services and scope of existing programs remain insufficient to meet the need, the County can modify and expand these services to serve all individuals who are, or are at serious risk of becoming, unnecessarily institutionalized; ensure that each person receives an appropriate intensity and frequency of services to meet their needs; and eliminate barriers that lead to unnecessary psychiatric institutionalization.

In addition, the County already conducted a Sequential Intercept Mapping process in 2017 and 2019 in which it identified the potential “intercepts,” such as arrest, where individuals with mental health disabilities come into contact with the criminal justice system, but can instead be identified and connected to community-based services. Alameda County has identified the resources and gaps that exist at these intercepts and is well-positioned to develop the needed mechanisms to use these intercepts to connect people who are at serious risk of psychiatric institutionalization with services, but has not done so yet.

Further, County leadership has acknowledged, and studies have repeatedly shown, that providing community-based services for people with serious mental illness is cost effective. Alameda County currently spends disproportionately on institutional services as compared to community-based services. For example, based on information provided by the County, annually each individual in the County's top 3% of mental health spending utilizers uses services costing an average of \$120,410 as of 2019. This group is largely made up of people who spend the majority of their time in a sub-acute facility or have four or more hospitalizations and accounts for 32% of all system costs. However, few of the people in this group received intensive community services, which are known to cost significantly less.²⁰ Even including costs for housing supports, serving these individuals in the community could dramatically reduce the costs for the County.

Alameda County can also maximize federal and state funding opportunities to develop community-based services. For example, most hospital and sub-acute stays are funded solely by County funds, while community-based services are typically eligible for federal Medicaid match dollars. Moreover, California provides a significant amount of funding through the Mental Health Services Act funds, which can be used for critical services such as Full Service Partnerships, permanent supported housing, and diversion programs. Yet Alameda County in recent years has left a significant amount of its MHSA funds unspent, and these are at risk of reverting to the state.

The lack of community-based services drives individuals with serious mental illness into costly psychiatric facilities, but it also can lead to costly incarceration. Alameda County spent \$177.2 million in fiscal year 2016–2017 on Santa Rita Jail, not including mental health services, with around 25% of its population having serious mental illness. The County has recognized both its significant reliance on the Jail for people with mental illness and that appropriate mental health treatment could address this problem. The Alameda County Board of Supervisors' Mental Health Board recognized in 2015 that "Santa Rita Jail has become a warehouse for people with mental illness."²¹ The Board further explained that "since there is nowhere to place [individuals with mental health disabilities], they languish in jail, often isolated in jail cells. We need to develop a system so that this population can be diverted out of the criminal justice system and into treatment."²² More recent County and external reports have echoed these conclusions. As discussed above, studies have shown that evidence-based community mental health services have been effective at reducing arrest rates and incarceration in California and across the country. For example, a 2010 study in California found that the probability of arrest dropped by 56% for

²⁰ See, e.g., SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CRISIS SERVICES: EFFECTIVENESS, COST-EFFECTIVENESS, AND FUNDING STRATEGIES (2014); SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., ASSERTIVE COMMUNITY TREATMENT: THE EVIDENCE (2008); SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., PERMANENT SUPPORTIVE HOUSING: THE EVIDENCE (2010); NATIONAL COUNCIL ON DISABILITY, HOME AND COMMUNITY-BASED SERVICES: CREATING SYSTEMS FOR SUCCESS AT HOME, AT WORK AND IN THE COMMUNITY (2015), <https://ncd.gov/publications/2015/02242015>.

²¹ ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014–2015 at 7 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.

²² *Id.*

individuals who were involved in Full Service Partnerships.²³ Thus, in implementing community-based services to prevent psychiatric institutionalization, the County will also likely reduce incarceration and, in the process, reduce its expenditures for incarceration. The Mental Health Board's Criminal Justice Subcommittee has reported to the Board of Supervisors that, according to national data, it costs two to three times more for a person with serious mental illness to be incarcerated compared to being housed and receiving treatment in the community, and that mental health programs that included housing led to fewer arrests and shorter jail stays among people with mental illness. Making the needed modifications may thus also result in a smaller population of prisoners with mental health needs at Santa Rita Jail, which could free up funds to support community-based mental health services and potentially ease the Jail's implementation of remedies to address the conditions we identify in Sections V-VII.

Alameda County government has long been on notice of its needless institutionalization of people with serious mental illness. In 2015, the Alameda County Board of Supervisors' Mental Health Board wrote of the "dire need" for intensive outpatient services to address the overcrowding and high readmission rates at John George, explaining that "John George remains the single most utilized point of entry into the County mental health care system."²⁴ The same report concluded that "[f]ar too many Alameda County residents with mental illness cycle in and out of Santa Rita Jail and John George Psychiatric Hospital," and called for a "comprehensive, integrated system which offers a continuum of care."²⁵ In a January 2016 presentation to the Board of Supervisors' Health Committee, BHCS identified several concerns around the lack of coordinated mental health and substance use services, insufficient service coordination across settings, and a lack of 24/7 crisis service coverage, resulting in psychiatric emergency room admissions. And several other County reports have similarly acknowledged these problems and the needed solutions.

As described at several points above, the County has begun to develop many of the needed services and programs: it offers too-limited mobile crisis services, crisis residential services, Full Service Partnership teams, peer support services, permanent supported housing, supported employment, and substance use disorder services, as described in Section IV.B.2. It has the framework to divert people from institutions and conduct discharge planning in institutions to help people access these community services. Yet the scope and supply of each of these services and programs falls short of the need, in many cases as acknowledged by the County, instead causing the County to rely on institutional services. Though the County could use existing and available resources to rebalance its service system, and although County officials have expressed goals of doing so, the County must complete this work to ensure an adequate array and capacity of community-based services, including crisis services, diversion programs, and appropriate discharge planning, in order to fulfill County residents' right to

²³ NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, BERKELEY, EVIDENCE ON THE EFFECTIVENESS OF FULL SERVICE PARTNERSHIP PROGRAMS IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM (2010), <https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.172.8620&rep=rep1&type=pdf>.

²⁴ ALAMEDA CNTY. MENTAL HEALTH BD., ANNUAL REPORT TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS, FISCAL YEAR 2014-2015 at 6 (2015), http://www.acbhcs.org/mhb/Resources/MHB_Annual_Report_2015.pdf.

²⁵ *Id.* at 7.

receive services in the most integrated setting. The minimum remedial measures necessary to achieve this goal are described in Section VIII.

V. MENTAL HEALTH CARE AT SANTA RITA JAIL IS INADEQUATE IN VIOLATION OF THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL HEALTH NEEDS

After making several trips to the Santa Rita Jail with our experts; speaking with Jail management, security staff, mental health staff, and hundreds of prisoners; and reviewing thousands of pages of documents, including numerous mental health and other records, the Department has reasonable cause to believe that the Jail fails to provide prisoners with serious mental health needs with adequate mental health care, in violation of their Eighth and Fourteenth Amendment rights.

As discussed above in Section III, Alameda County funds the Jail, which is administered and controlled by the Alameda County Sheriff's Office. The Jail has the capacity to hold approximately 4000 prisoners. During most of the period encompassed by our investigation, however, the actual prisoner count has been closer to 2400.²⁶ The Jail holds both pre-trial detainees and convicted prisoners. Approximately 85% of the Jail's population is pre-trial detainees.

While the population of the Jail is, by its very nature, constantly in flux, it includes a large number of individuals with serious mental health needs. Although the Jail does not specifically categorize prisoners as having "serious mental illness," Jail representatives have stated that approximately 40% of its population is on the mental health caseload.²⁷ And in our interviews with the Jail's chief psychiatrist and other key mental health staff, they estimated that approximately 20–25% of the population likely has a serious mental illness. For those in various specialized housing units, the numbers are likely even higher. According to the Jail's chief psychiatrist, for example, approximately 50% of the prisoners in the administrative segregation units²⁸—the most restrictive in the Jail, other than short-term "safety cells" used up to 72 hours for actively suicidal prisoners—have a serious mental illness. Our observations of prisoners we

²⁶ While the population at the Jail had declined to approximately 1800 prisoners in May 2020 due to changes to booking and release procedures that were instituted in response to the COVID-19 pandemic, the population has since rebounded to 2200 prisoners as of April 5, 2021. See *Covid-19 Update*, ALAMEDA CNTY. SHERIFF'S OFFICE, https://www.alamedacountysheriff.org/admin_covid19.php (visited June 19, 2020; visited April 6, 2021).

²⁷ This estimate may undercount the number of prisoners with mental health needs. A March 25, 2021, report by the California State Auditor found that the Jail fails to "conduct a mental health screening of every inmate, as state regulations require" and instead "only assesses those inmates who exhibit erratic behaviors or disclose a history of mental illness to jail staff." The report explained that the Jail therefore lacks "sufficient data regarding whether inmates have mental illnesses," information which is "critical" to "minimize the risk of violence, injury, or death." CALIFORNIA STATE AUDITOR REPORT 2020-102, PUBLIC SAFETY REALIGNMENT REPORT at 22-25 (March 2021).

²⁸ During the course of our investigation, the Jail changed its nomenclature in relation to these units, so that it now uses the term "Administrative Separation," or "Ad Sep," instead of "Administrative Segregation," or "Ad Seg." For the sake of consistency, we refer to these units as "administrative segregation."

interviewed in administrative segregation suggested that the chief psychiatrist's estimate was accurate, if not perhaps an undercount. As discussed in other sections of this Notice, many of the individuals with serious mental illness at the Jail cycle repeatedly in and out of the Jail, as well as in and out of John George and other institutional settings.

There is one primary unit at the Jail—Unit 9—for male prisoners with mental health needs with any security classification. While Jail officials refer to Unit 9 as a mental health unit, it largely functions not as a therapeutic setting but rather, in all but name, as a restrictive housing unit, because these prisoners are confined to their cells for the vast majority of the day, alone or with another prisoner.²⁹ Within Unit 9 are different pods, based on security classification. Most prisoners in these pods are placed in two-person cells and are locked in those cells for the vast majority of their waking hours. Jail records show that, depending on their pod, prisoners were limited to less than 1.5 to three hours out of their cells each day. And prisoners on most pods received yard time outdoors for as little as one hour per week, with many receiving no yard time.

Instead of going to the clinic for mental health care, or to a classroom for educational or other programming, prisoners in Unit 9 remain on the Unit. They have access to few group programs on the Unit, and are prohibited from attending the many other programs available to general population prisoners. Mental health staff meet with the prisoners on the Unit, at large tables in the day-room-type area. Prisoners on Unit 9 must wear different color uniforms from the rest of the population, which not only discloses sensitive health information, because staff and other prisoners know that the uniform signifies a mental health diagnosis, but also serves to stigmatize them and marginalize them.

Not all prisoners with serious mental health needs are housed on Unit 9. Women prisoners are housed in a different area of the facility, and there are also men with serious mental health needs housed throughout the facility. Significantly, a number of them are in administrative segregation, which is another form of restrictive housing. Prisoners in administrative segregation are, by policy, permitted at most only five hours outside of their cells per week. Our review of a sample of records revealed many receiving only one or two hours outside of their cells on given weeks, a fact repeatedly mentioned by prisoners in administrative segregation in our conversations with them. When prisoners are permitted to leave their cells, they do so alone—with no opportunity to interact with others—and are still confined to the common indoor pod space. They may not go outdoors.

²⁹ Restrictive housing, elsewhere sometimes referred to as solitary confinement, segregation, or isolation, is any type of detention that involves three basic elements: removal from the general prisoner population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another prisoner; and the inability to leave the room or cell for the vast majority of the day. *Porter v. Clarke*, 290 F. Supp. 3d 518, 528 (E.D. Va. 2018) (citing U.S. DEP'T OF JUSTICE, REPORT AND RECOMMENDATIONS CONCERNING THE USE OF RESTRICTIVE HOUSING at 3 (2016)); *see also, e.g., Wilkinson v. Austin*, 545 U.S. 209, 214, 223–24 (2005) (describing restrictive housing as limiting human contact for 23 hours per day); *Sweet v. Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990) (describing restrictive housing as being limited to a cell for 21 to 22 hours per day); *Sweet v. S.C. Dep't of Corr.*, 529 F.2d 854, 867 (4th Cir. 1975) (Butzner, J., concurring) (categorizing as restrictive housing being alone in a cell for 24 hours per day, save for two, one-hour periods a week for exercise and a shower).

The Eighth Amendment’s prohibition against cruel and unusual punishment requires jails to provide prisoners with adequate mental health care. *See Doty v. Cnty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994) (“[T]he requirements for mental health care are the same as those for physical health care needs.”); *see also Brown v. Plata*, 563 U.S. 493, 503 (2011) (prisoners “with serious mental illness” lacked access to adequate mental health care). The protections afforded pre-trial detainees under the Fourteenth Amendment are at least as great as a convicted prisoner’s Eighth Amendment rights. *See Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187–88 (9th Cir. 2002), *overruled on other grounds by Castro v. Cnty. of Los Angeles*, 833 F.3d 1060 (9th Cir. 2016). While a pre-trial detainee may be afforded greater protections, we have conducted our analysis under the Eighth Amendment standard, to which all prisoners at the Jail are at least entitled, because the populations are mixed at the Jail.

The rights of any prisoner under the Eighth Amendment are violated when “officials remain deliberately indifferent to their serious medical needs.” *Id.* at 1187 (internal quotation marks omitted). The analysis examines if inadequate medical or mental health care creates a “substantial risk of serious harm” to prisoners, incorporating the possibility of future harm as well as present harm. *See id.* at 1188 (applying “substantial risk of serious harm” language in the Eighth Amendment medical care context); *see also Helling v. McKinney*, 509 U.S. 25, 33 (1993) (“That the Eighth Amendment protects against future harm to prisoners is not a novel proposition.”).

The existence of serious systematic deficiencies can demonstrate that jail officials are deliberately indifferent to prisoners’ medical needs, in violation of the Constitution. *See Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995) (“[C]ourts have traditionally held that deliberate indifference can be shown by proving either a pattern of negligent acts or serious systemic deficiencies in the prison’s health care program.”); *Casey v. Lewis*, 834 F. Supp. 1477, 1543 (D. Ariz. 1993) (“In cases in which the system’s constitutionality is at issue, deliberate indifference to the serious medical needs of prisoners may also be ‘evidenced by repeated examples of negligent acts’ . . . or by ‘proving there are such systemic and gross deficiencies in staffing, facilities, equipment or procedures that the inmate population is effectively denied access to adequate medical care.’”) (internal citation omitted). Furthermore, a system-wide policy or practice that leads to a substantial risk of serious harm may be considered holistically to demonstrate a constitutional violation. *See Brown*, 563 U.S. at 505 n.3 (noting that in assertion of system-wide deficiencies in medical and mental health care, there was no need to consider whether specific instances violate the Constitution, because the state of medical and mental health care “taken as a whole” created a constitutional violation).

A. Many Prisoners at the Jail Have Serious Mental Health Needs, Requiring Treatment

Prisoners with serious mental health needs require treatment in order to ensure that their illnesses are not exacerbated. *See Madrid*, 889 F. Supp. at 1205–06 (“For inmates with serious or painful symptoms, delays lasting days or even weeks can cause unnecessary suffering, exacerbate illness, and have life-threatening medical consequences.”). As acknowledged by Jail staff, at least 20–25% of prisoners in the Jail have serious mental illness. By not adequately

addressing these prisoners' mental health needs, the Jail places them at significant risk of harm. At least in part as a result of the Jail's failure to address their needs, and as described in more detail below, these prisoners' mental health often deteriorates; they may engage in self-harm, and many are transferred to John George for acute mental health care. Many former prisoners are admitted to John George or other psychiatric institutions, without ever receiving adequate mental health treatment that could avert these admissions and break this pattern of cycling repeatedly into segregated psychiatric institutions. Of the charts our expert reviewed, over 20% showed that the prisoner had to be transferred to John George while in the Jail, and many more showed stays at John George either prior to booking or after release. Of 21 prisoners known to have died in the Jail or from injuries or other causes sustained in the Jail between January 12, 2017, when we opened our investigation and 2020, at least 13 either had apparent indicators of serious mental illness or died due to suicide.

B. Prisoners with Serious Mental Health Needs Are Subject to a Substantial Risk of Serious Harm as a Result of Inadequate Mental Health Care

The Jail's inadequate mental health care places prisoners with serious mental health needs at substantial risk of harm. The Jail's mental health program is inadequate because it fails to provide essential components that have been identified by courts as being minimally necessary for such a program, including adequate psychotherapy and individualized treatment plans that include close supervision of the prisoner. *See, e.g., Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995); *see also Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1188 (M.D. Ala. 2017); *Madrid*, 889 F. Supp. at 1256–58; *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part and rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982). While a denial of any one of these factors alone may not necessarily amount to a constitutional violation, courts have examined these factors together to evaluate the constitutional adequacy of a correctional facility's mental health program.

1. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of a Lack of Individualized Treatment, Including Inadequate Psychotherapy and Programming

The failure to treat mental illness can lead to a substantial risk of serious harm, including decompensation and suicidal ideation, constituting a serious medical need under the Eighth Amendment. *See Conn v. City of Reno*, 572 F.3d 1047, 1054–56 (9th Cir. 2009), *judgment vacated on other grounds by Connick v. Thompson*, 563 U.S. 51 (2011); *Madrid*, 889 F. Supp. at 1222. Courts have found mental health care insufficient when use of psychotropic medications supplants the use of mental health therapy. *See, e.g., Braggs*, 257 F. Supp. 3d at 1188 (“The ‘basic’ mental-health care that States must provide if needed by a prisoner includes not only medication but also psychotherapeutic treatment.”) (citation omitted); *Balla*, 595 F. Supp. at 1577 (“[P]rescription of [psychotropic] drugs cannot supplant the necessity of psychiatric counseling.”). Without therapy and programs that might, for example, help them learn cognitive or emotional skills, plan for recovery from substance use disorder, and make healthy life choices,

prisoners with serious mental health needs are at risk of deterioration and eventual re-institutionalization upon their release from incarceration.

The Jail, however, provides little to no individualized treatment, including psychotherapy, to prisoners with serious mental health needs. Instead, mental health care on Unit 9—the unit specifically designated for people with mental health needs—is generally limited to medication administration, screenings for suicidal ideation, and brief conversations with clinicians. Our expert found these conversations to be insufficiently frequent, as well as too brief. In addition, these conversations are usually not held in therapeutic environments, but rather “cell side,” or in day rooms within earshot of other prisoners and of security staff. As the Alameda County Sheriff’s Office itself has previously acknowledged: “For those housed in high security units, the vast majority of these meetings [for therapy or counseling] take place in the dining area of the housing unit, providing little to no privacy, in an environment not designed for this type of activity.”³⁰ Prisoners are often reluctant to disclose sensitive information necessary to treatment where that information can easily be overheard by staff and other inmates. “[C]ell-front check-ins are insufficient as counseling and do not constitute actual mental-health treatment,” as they fail to provide a therapeutic environment. *Braggs*, 257 F. Supp. 3d at 1210; see also *Robinson v. Purcell*, No. 2:14-CV-0790, 2019 WL 1330874, at *6 (E.D. Cal. Mar. 25, 2019) (finding “cell-door consultations posed risks to plaintiff’s mental health” because of the need to speak softly for privacy and the impediment plaintiff faced to “speak[ing] freely” due to the “non-confidential nature of these visits”). Prisoners receiving cell-side visits are often reluctant to speak freely, and therefore do not receive the treatment they need, and are thus at risk of further harm and increased risk of poor outcomes such as self-harm, according to our expert. During their brief conversations, clinicians generally encourage prisoners to take medication, rather than utilizing any therapeutic techniques. Further, the Jail provides no group therapy (only a sole educational class) to prisoners on Unit 9. Jail clinicians often are unable to provide even a minimally adequate level of care to the large number of prisoners who need it, resulting in serious harm, including suicide. See *Conn*, 591 F.3d at 1095 (“A heightened suicide risk or an attempted suicide is a serious medical need.”). One of the most critical components of a minimally adequate mental health treatment program is the “identification, treatment, and supervision of inmates with suicidal tendencies.” *Ruiz*, 503 F. Supp. at 1339. Suicide watches at the Jail—known as “IOL status” (referring to an intensive observation log)—feature unduly harsh conditions, including a prohibition on access to socks, underwear, hygiene products, sheets, reading material, and the commissary. Such punitive conditions are known to discourage prisoners from reporting suicidality.

From 2015 through 2019, there were at least 14 suicides in the Jail, which equates to a rate of suicides that is more than twice the national average. While there were no suicides in 2020, two other suicides occurred at the Jail in the first four months of 2021. In one instance in 2017, L.L., a 29-year-old former Marine, who had previously spent time at both the Jail and John George, hanged himself in administrative segregation 18 days after entering the Jail. Despite his

³⁰ ALAMEDA CNTY. SHERIFF’S OFFICE, MENTAL HEALTH SERVICES IN SANTA RITA JAIL at 9 (2015), http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_10_8_15/PUBLIC%20PROTECTION/Regular%20Calendar/Mental_Health_Services_Santa_Rita_Jail.pdf.

history of previous suicide attempts, and the fact that he had been hospitalized two months prior at John George for suicidal ideations, L.L. was only briefly placed on Inmate Observation Log (IOL) status, a form of suicide watch employed by the Jail, before being removed from observation later that same day by mental health staff and placed in administrative segregation. The doctor who made this decision stated that this was appropriate because L.L. was not expressing suicidal ideation at the time of his intake and was being cooperative. L.L. received no follow-up mental health evaluation between the time of his intake and his suicide only a few weeks later. Another example involves 20-year-old A.A., also described above, who police brought to Santa Rita Jail while he was experiencing a mental health crisis. A.A.'s parents reportedly informed the police that he was not a danger and was in need of mental health treatment. A.A.'s parents say deputies ignored their requests that their son receive a mental health evaluation. A lieutenant allegedly ordered A.A. chained to a cell door, in violation of the Sheriff's office restraint policy, while he was still experiencing severe symptoms. Left unattended, A.A. appears to have attempted to strangle himself with the chains, and later died.³¹

Other prisoners have suffered harm as a result of the Jail's inadequate provision of mental health care. C.C., a 38-year-old male prisoner with a history of bipolar disorder, was incarcerated on January 8, 2019, on a charge of narcotics possession. Although he was assigned to Unit 9 upon intake, he did not receive an initial evaluation until nine days after he was admitted, and then only after his sister called the Jail to inform them that her brother was connected to a community provider, receives injections of Haldol (a psychotropic medication), and "decompensates quickly without medication." C.C. started on Haldol on January 22, 2019, but a clinician's note indicated that he was not seen that day due to overbooking. During a medical evaluation the next day, C.C. reported that he felt like he was in a "dream state," "fired up," and "mildly hallucinating." It also appeared that he was having seizures. Because he reported no thoughts of self-harm, he was not placed on IOL status. The next day however, C.C. was "acting strange, shaking, sweating, and appearing confused." He was observed banging his head on the wall and had a cut on his lip and forehead. When the mental health clinician saw him, he was lying on the floor of his cell naked, picking at the floor, and talking to himself. C.C. was sent to John George later that day, and subsequently transferred from John George to Highland Hospital, where it was ultimately determined that he had several high impact hip fractures.

D.D., a 22-year-old with schizophrenia and over 600 interactions with the County's behavioral health system, including multiple incarcerations at the Jail, and with a history of bipolar disorder was incarcerated on February 22, 2019. He was placed on IOL "for muteness and safety" after he refused to respond to medical or mental health questions. Clinicians did not follow up with D.D. until four days later. Three days after that, on March 1, 2019, a deputy reported to a clinician that D.D. had flooded his cell the day before and was naked, talking and laughing to himself. Despite this behavior, there is no record of any specific therapeutic treatment for D.D., other than a clinician's note that the clinician spoke with D.D. about "coping strategies." The clinician made several cell-side visits while D.D. was on IOL, noting that nothing could be seen because there was no light available to see into the cell. Despite his long

³¹ Despite multiple requests, Alameda County did not provide records related to this incident.

history of mental health needs, and behaviors that presented a clear management problem on the unit, D.D. received only limited cell-side visits, and was not prioritized to receive therapy.

The lapses in mental health treatment for prisoners with serious mental health needs are even more acute for such prisoners in administrative segregation. Those prisoners generally speak with mental health staff infrequently, and only through their cell doors, which, as noted, raises privacy concerns.

The Jail's mental health program lacks meaningful access to substance use disorder treatment, a deficiency that is particularly acute because prisoners with serious mental health needs have a high rate of co-occurring substance use disorders. Over 70% of the charts our expert reviewed indicated that the prisoner had significant substance use problems, sometimes reflecting the use of multiple substances. Several prisoners were noted to be in distress from opioid withdrawal at the time of their mental health assessments in the Jail. But very few charts contained any mention of treatment plans, interventions, or referrals related to those disorders. Typically, the most that mental health staff provides these prisoners is some information in the form of handouts, and in some cases a single educational class, rather than any treatment.

Having enough mental health professionals is an essential part of any constitutionally adequate correctional mental health program. Mental health staff must be employed in numbers sufficient to identify and treat prisoners who have treatable mental illness in an individualized manner. *See Cabrales v. Cnty. of Los Angeles*, 864 F.2d 1454, 1460–61 (9th Cir. 1988) (upholding district court's determination that understaffing of mental health personnel such that prisoners only could receive 12 minutes of care per month created constitutionally inadequate care), *judgment vacated on other grounds*, 490 U.S. 1087 (1989); *Coleman*, 912 F. Supp. at 1298; *Madrid*, 889 F. Supp. at 1256–58; *Balla*, 595 F. Supp. at 1577.

Several factors contribute to the lack of adequate mental health coverage at the Jail. First, when there are not sufficient security personnel present, mental health staff are hampered in their ability to see prisoners. In records we reviewed, it was not unusual to see notes from mental health clinicians documenting this problem. One note regarding a prisoner in administrative segregation, stated: "Writer spoke with [prisoner] at cell door due to shortage of available deputies in the [housing unit]." In another example, a clinician wrote about a prisoner with schizophrenia and schizoaffective disorder who had previously been at John George, Napa State Hospital, and multiple other inpatient settings: "Writer interviewed [prisoner] at the door in H[ousing] U[nit] 2 for follow up d[ue to] shortage of deputies. [Prisoner] repeatedly requested to be taken out to the tables, even after multiple explanations from writer and Sergeant . . . that there was not enough staffing in the HU to do so." In fact, in over 85% of the charts our expert reviewed for this issue, there was a notation of a deputy shortage, resulting in limitations on the ability of mental health staff to adequately assess prisoners.

Second, on Unit 9, in a restriction imposed by security staff, mental health staff are permitted only a two-hour window during each weekday in which to see any prisoners for treatment. Because they have to fit visits with all of the individuals on their caseloads into a two-hour window, mental health staff are not able to spend sufficient time treating prisoners with

serious mental health needs. In fact, as they explained to us, they are only able to spend approximately 10 to 15 minutes at a time with each prisoner on their caseloads. Further, mental health staff members with whom we spoke informed us that they do not have the time to run treatment groups or therapeutic programs. This is borne out by notes in records such as, “unable to see inmate due to caseload,” or “today this clinician was overbooked.” Finally, the Jail does not have sufficient numbers of mental health practitioners for the population it serves, as the Sheriff himself has noted publicly.

2. Prisoners with Serious Mental Health Needs Are Subject to Harm Because of Inadequate Treatment Planning, Including Discharge Planning

The Jail fails to provide individualized treatment plans to prisoners with serious mental health needs, which represents a substantial deviation from a constitutionally sound mental health care program. *See, e.g., Sharp v. Weston*, 233 F.3d 1166, 1168–69, 1169 n.2 (9th Cir. 2000) (upholding denial of request to lift an injunction that included individualized treatment plans as a requirement in providing constitutionally adequate mental health care); *see also Braggs*, 257 F. Supp. 3d at 1206 n.34 (explaining that treatment planning is part of a minimally adequate mental health care system). Treatment plans should be developed, implemented, and monitored by treatment teams to provide adequate focus, purpose, and direction for the delivery of service. Our expert observed that clinicians’ notes in the overwhelming majority of the charts she reviewed merely indicate whether or not a prisoner is stable, and clinicians often provide seriously mentally ill prisoners nothing more than handouts that list coping skills or describe deep breathing techniques that may help reduce stress.

In addition, the Jail should provide bridge medications and transition planning. *See Charles v. Orange Co.*, 925 F.3d 73, 84–85 (2d Cir. 2019) (finding plausible the allegation that discharge planning, including interim medication and referrals, “is an essential part of in-custody care”); *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (state has constitutional duty to provide medication to outgoing prisoner in a supply sufficient “to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply”); *United States v. County of Los Angeles*, No. CV 15-05903-DDP, 2016 WL 2885855, at * 7, n. 7 (C.D. Cal. May 17, 2016) (finding that *Wakefield* extends to discharge planning for mentally ill inmates as required to provide them medical care after release from custody, and noting that “[i]f anything, a public entity may be more responsible for mental health treatment where the incarceration itself has aggravated or exacerbated the harmful symptoms of mental illness”); *Matysik v. Cnty. of Santa Clara*, No. 16-CV-06223-LHK, 2018 WL 732724, at *12 (N.D. Cal. Feb. 6, 2018) (“[T]here is evidence from which a jury could conclude that Defendants’ failure to adopt policies requiring greater coordination related to the release of mentally disabled inmates amounted to a policy or custom [amounting] to deliberate indifference.”). The Jail typically does not provide access to sufficient medication and a connection to needed care upon release for prisoners with serious mental health needs.

The Jail also excludes prisoners with serious mental health needs from existing transition services. The Jail has developed a transitional center where prisoners in general population can meet community providers and a program, called Operation My Home Town, which connects

soon-to-be-released prisoners to community-based programs assisting with housing, employment, drug and alcohol treatment, and other needs. However, prisoners with serious mental health needs on Unit 9 or in administrative segregation do not have access to these discharge services. These prisoners are among those with the greatest need for such services, in order to ensure that they receive needed mental health treatment in the community. But they often receive little more than a sheet of paper that lists programs in the community.

When prisoners are not provided with discharge planning that connects them to community providers, it is unsurprising that they frequently cycle back to the hospital or the Jail. One such prisoner is E.E., an administrative segregation prisoner who has a history of schizoaffective disorder and polysubstance use disorder and, when not incarcerated, has been connected with a mental health provider or admitted to the hospital at least 135 times. E.E. was in and out of the Jail 13 times during the 13-month period from August 2018 to August 2019. During those 13 incarcerations, the Jail’s limited efforts to prepare E.E. for reentry into the community were inconsistent and incomplete. For example, in June 2019, E.E. himself—not his clinician—suggested that he go to a substance use treatment program upon discharge. However, instead of connecting him to the program, Jail staff simply provided bridge medications and a prescription, and spoke with E.E. about the importance of medication compliance to prevent re-arrest. E.E. was back at the Jail a month later. Despite his extensive contacts with the Jail and BHCS, there is no indication that the Jail made any meaningful effort to connect E.E. with community mental health services.

The lack of discharge planning contributes to the cycling we so often observed, as individuals with serious mental health needs are drawn deeper into the criminal justice and public mental health systems through relapse, re-arrest, and re-institutionalization, with fewer and fewer opportunities to stabilize in the community. One prisoner’s mental health notes from July 2019 explain that the prisoner was made aware of the “B[ay] A[rea] C[ommunity] S[ervices] Re-entry program” but “does not appear to have engaged.” Several lines down in the notes, the clinician writes that this prisoner “has been incarcerated at [the Jail] 15 times since 2015.” If the Jail did more than simply making the prisoner aware of community services—if, for instance, it reached out to providers and set up appointments—the prisoner would have been more likely to have engaged in treatment that could reduce his likelihood of repeated hospitalization or incarceration.

C. Officials at the Jail Have Known of the Risk to Prisoner Health and Safety Posed by Inadequate Mental Health Care and Disregarded It

Jail officials have been put on notice that inadequacies in the Jail’s mental health system pose a substantial risk of serious harm to prisoners. The Jail has failed to take steps to eliminate these risks, evincing deliberate indifference to prisoner health and safety. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (holding that a prison official may be liable under the Eighth Amendment if he “knows of and disregards an excessive risk to inmate health or safety”).

There are numerous sources that should have put Jail officials on notice of the risks posed by their deficient mental health care system. Alameda County has long known of the problems related to the provision of mental health care to prisoners with serious mental health needs. In

July 2017, a public presentation was given to the Alameda County Board of Supervisors Health Committee on the need to decrease the incarceration of those with mental illness in the County. The Alameda County Mental Health Advisory Board’s Criminal Justice Subcommittee investigation³² noted the “revolving door between John George [and] Alameda County jails.”³³ The Criminal Justice Subcommittee identified factors that contributed to this situation including, among other things: the Jail’s inadequate discharge planning and coordination of services; frequent inadequate access to psychiatrists; and inadequate substance use disorder treatment.

In addition, lawsuits alleging inadequate mental health care at the Jail have put officials on notice of the risks to prisoner health and safety. *Cf. Disability Rights Mont., Inc. v. Batista*, 930 F.3d 1090, 1099 (9th Cir. 2019) (finding that two prior lawsuits “complaining about factually similar conditions at the prison” supported finding of deliberate indifference) (citing *Lemire v. Cal. Dep’t of Corr. & Rehab.*, 726 F.3d 1062, 1078 (9th Cir. 2013) (concluding that plaintiffs stated a claim for deliberate indifference where “litigation specifically alerted prison officials to the acute problem of inmate suicides”)). For instance, *Babu v. County of Alameda*, a federal district court case filed in December 2018, concerns the very subject of this Notice—deficiencies in mental health care provided by the Alameda County Sheriff’s Office. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 22, 2020), ECF No. 111-1. In the Complaint’s first paragraph, it states, “The Alameda County Jail system is broken, especially when it comes to the way it treats people with psychiatric disabilities. . . . Alameda County relies almost entirely on the unconstitutional use of isolation to manage prisoners, including prisoners with significant . . . mental health needs, resulting in horrific suffering.”³⁴ Although the Jail has recently reported its commitment to improve mental health care as part of the ongoing settlement negotiation process in *Babu*, it is not clear what, if any, remedial measures have been put in place, whether they have been incorporated into the Jail’s policies and procedures, or whether any measures actually put in place will prove durable. Likewise, Disability Rights California, the federally-mandated protection and advocacy entity for California, issued a letter to Alameda County in November 2019 alleging, after an investigation, that “people with mental health disabilities regularly cycle in and out of . . . the jail system,” and noting that “people with mental health disabilities held in jail face dangerous and damaging isolation conditions and inadequate access to programming or meaningful mental health treatment.”³⁵

³² The Criminal Justice Subcommittee conducted interviews with Oakland Police Department officers, BART Crisis Intervention counselors, social workers, program directors, and program managers to gather information on gaps within the County system. The Criminal Justice Subcommittee also compared the situation in Alameda County with national statistics on the relationship between mental illness and the criminal justice system.

³³ BRIAN BLOOM & DR. NOHA ABOELETA, DECREASING INCARCERATION OF THE MENTALLY ILL IN ALAMEDA COUNTY at 4 (2017), http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_7_24_17/GENERAL%20ADMINISTRATI%20ON/Regular%20Calendar/Community_Mental_Health_7_24_17.pdf.

³⁴ Complaint at ¶ 1, *Babu v. Cnty. of Alameda*, No. 5:18-cv-07677 (N.D. Cal. Dec. 21, 2018), ECF No. 111-1.

³⁵ Letter from Disability Rights Cal., to Karyn Tribble, LSCW Dir., Alameda Cnty. Behavioral Health and Services, and Donna Ziegler, Counsel, Alameda Cnty. (Nov. 1, 2019), <https://www.afsc.org/sites/default/files/documents/2019-11-01%20DRC%20Findings%20Letter%20%20Access%20Requests%20Alameda%20Cty%20-%20Signed%20%281%29.pdf>.

Finally, numerous media reports have raised concerns about the provision of mental health care to prisoners with serious mental health needs at the Jail. The Department's investigation has also provided Jail officials with notice of deficiencies in mental health care. Department attorneys and staff, accompanied by experts, visited the Jail several times in 2017, and again in 2019. At the conclusion of these visits, we provided Jail officials with exit briefings, during which our experts shared their preliminary observations. Our experts expressed their opinions that mental health care for prisoners with serious mental health needs was deficient, and specified the various areas in which such care is inadequate, as described above. Nevertheless, most of the conditions we identified in 2017 were still present when we returned in 2019.

VI. THE JAIL'S USE OF PROLONGED RESTRICTIVE HOUSING UNDER CURRENT CONDITIONS, INCLUDING THE FAILURE TO PROVIDE ADEQUATE MENTAL HEALTH CARE, VIOLATES THE CONSTITUTIONAL RIGHTS OF PRISONERS WITH SERIOUS MENTAL ILLNESS

The Jail's use of restrictive housing for prisoners with serious mental illness in current conditions—in which prisoners can spend months, if not longer, locked in their cells, with only three to five hours out of cell per week, and with little to no mental health treatment, therapy, and programming—places prisoners with serious mental illness at a substantial risk of serious harm in violation of the Eighth and Fourteenth Amendments. *See Disability Rights Mont.*, 930 F.3d at 1099 (finding plausible Eighth Amendment claim that placing prisoners with serious mental illness in restrictive housing of 22 to 24 hours per day for months poses substantial risk of serious harm); *Palakovic v. Wetzel*, 854 F.3d 209, 226 (3d Cir. 2017) (holding that, “in light of the increasingly obvious reality that extended stays in solitary confinement can cause serious damage to mental health,” there was a plausible claim that placing prisoner with history of suicidality in restrictive housing for multiple 30-day stints violated the Eighth Amendment); *Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 946 (N.D. Cal. 2015) (“While housed in segregation, the mentally ill are especially vulnerable, and their mental health symptoms—including depression, psychosis, and self-harm—are especially likely to grow more severe.”); *see also Braggs*, 257 F. Supp. 3d at 1247 (noting the “consensus on the substantial risk of harm of decompensation for these mostly severely mentally ill prisoners” from segregation); *Madrid*, 889 F. Supp. at 1265 (using prolonged restrictive housing on prisoners who are, because of their serious mental illness, “at a particularly high risk for suffering very serious or severe injury to their mental health” is “the mental equivalent of putting an asthmatic in a place with little air to breathe”); *Coleman*, 912 F. Supp. at 1320–21 (adopting finding that restrictive housing can “cause further decompensation” to prisoners with mental illness); *Casey*, 834 F. Supp. at 1549 (finding that an extensive use of lockdown in place of mental health care “clearly rises to the level of deliberate indifference to the serious mental health needs of the inmates and violates their constitutional rights to be free from cruel and unusual punishment”).

As discussed above, prisoners at the Jail with serious mental illness are regularly placed in administrative segregation, where they spend almost every hour of their days locked in their cells, alone or with one cellmate, with little to no treatment, therapy, or programming. When they do get out, each prisoner is alone (or with their cellmate only), so they do not have any

opportunities for social interaction. Jail mental health staff have estimated that approximately 50% of the prisoners in administrative segregation have serious mental illness. As a result, these prisoners are at increased risk of physical self-harm, extreme mental distress, and unnecessary suffering. In fact, we have seen evidence of such harms, as discussed further below, including prisoners swallowing objects, not eating, smearing or eating feces, banging their heads against the wall, and attempting or completing suicide.

The Alameda County Sheriff has acknowledged that one hour per day of out-of-cell time is not sufficient. “We do not like to keep people in those cells for any length of time,” he has said.³⁶ Yet, despite his statements, until very recently the Jail continued to keep individuals locked down with less than one hour out of cell each day for months at a time.³⁷ In fact, at the time of our last visit, in July 2019, there were 75 prisoners in administrative segregation who had been there for over 90 days, at least 75% of whom had indications of serious mental illness. Thirteen of those prisoners with indications of serious mental illness had been in administrative segregation for more than a year.

Jail officials say that prisoners are placed in administrative segregation if they cannot co-exist with other prisoners, are violent, or need protection, among other reasons. However, our review of classification records for prisoners placed in administrative segregation revealed many instances of prisoners being assigned to such housing for reasons that seemed directly related to their serious mental illness and not due to Jail officials’ stated reasons. For example, F.F. had a history of suicide attempts in administrative segregation when a classification deputy approved F.F.’s request to be transferred to a less restrictive pod. The deputy understood that the move could help F.F.’s mental health: “Having a cellmate might help [F.F.] cope with being incarcerated [sic],” he wrote. But several weeks later, F.F. was returned to administrative segregation, because of his serious mental illness. The classification deputy explained that F.F. was being re-classified to administrative segregation “due to” his flag as “mental”. The deputy made this recommendation despite the fact that the behavioral health professional who had just evaluated F.F. recommended against the transfer, indicating instead that F.F. should be housed in the less restrictive behavioral health unit. Over an approximately three-month period, two behavioral health professionals made five separate recommendations that F.F. be moved to a less restrictive unit. Each time, they were overruled by classification deputies. Their reasons often explicitly cited F.F.’s mental illness. “Due to [F.F.’s] recent mental instability,” a deputy wrote, for example, “he will remain in [administrative segregation] at this time.”

Another example is G.G., an individual who was sent to John George at least twice during his incarceration at the Jail, and who reported to the Jail that he had previously been housed in minimum security. His classification report from February 2019 from the Glenn Dyer

³⁶ Lisa Fernandez, *Death Rate at Santa Rita Exceeds Nation’s Largest Jail System as Critics Call for Reform*, KTVU (Oct. 1, 2019) <https://www.ktvu.com/news/death-rate-at-santa-rita-exceeds-nations-largest-jail-system-as-critics-call-for-reform>.

³⁷ We note that, as part of the ongoing settlement negotiation process in the *Babu* case, the Jail reportedly has taken steps to increase out-of-cell time for prisoners. We have not yet seen evidence of how much more time prisoners may get, or how widespread the change is, and there is no evidence that this is memorialized in any policy. Moreover, it is not clear whether such remedial measures will prove durable.

Jail, which was operated by the Alameda County Sheriff's Office until it closed in 2019, notes that he "suffers from bipolar [disorder] and is on heavy psychiatric medication that [the Glenn Dyer Jail] doesn't carry. The nurse said that if he missed more than one dose of his [medication] he is likely to have a serious mental breakdown." After several weeks at the Glenn Dyer Jail, G.A. was observed "visibly shaking," "making the sign of the cross," and "displaying bizarre" behavior, and was therefore placed in administrative segregation. A few weeks later, when he was transferred to the Jail, a classification deputy acknowledged that G.G. had been housed in administrative segregation "due to acting strangely during his classification interview"—in other words, for reasons related to his mental health status. The deputy suggested that G.G. "may be suitable for . . . the behavioral health unit." Although two mental health professionals agreed with that assessment and recommended on at least four separate occasions that G.G. be transferred to the behavioral health unit, he remained in administrative segregation. At the time of our visit to the Jail in July 2019, he had not been reclassified.

A. Prisoners with Serious Mental Illness Are Subject to a Substantial Risk of Serious Harm as a Result of the Jail's Use of Restrictive Housing

The Jail's practice of subjecting prisoners with serious mental illness to prolonged periods of restrictive housing places these prisoners at substantial risk of serious harm. As described above, as of our last visit, prisoners in administrative segregation were, by policy, permitted only five hours outside of their cells per week at most, and our review of a sample of records revealed many receiving only one or two hours outside of their cells on any given week.

The lack of access to adequate mental health care is especially harmful for prisoners who are suicidal. Instead of receiving the constitutionally adequate mental health care required, such as intensive therapeutic interventions, they receive minimal engagement from limited interactions with mental health staff. Notably, despite the known harms of prolonged restrictive housing for people with serious mental illness, at least six of the prisoners who have died by suicide at the Jail since January 1, 2014, were in restrictive housing at the time of their suicide.³⁸

One such example is H.H. He was arrested on April 4, 2018, and booked into the Jail early the next morning. During his initial screening, he was observed to have "delusional thoughts," and as a result he was referred to mental health staff. While awaiting re-classification, H.H. was found with fecal matter smeared on his face, and he stated to a deputy that he wanted to be killed or would kill himself. He was moved to a safety cell and put on an IOL. The following day, April 6, a mental health clinician determined that H.H. was no longer suicidal, and he was moved from a safety cell to administrative segregation. There, on April 8, H.H. was found with a bed sheet tied around his neck and tied to another sheet that was wrapped around the top bunk. When a deputy entered his cell, he found H.H. unresponsive, with pale skin. The cell was flooded with water and fecal matter, which had also been spread onto the floor, walls,

³⁸ In addition, in February 2021, an individual in the Jail's quarantine unit for newly booked prisoners died by suicide. The County and the Sheriff's Office have reported that newly-booked individuals at the Jail must complete a 14-day quarantine upon intake, and that on average, those individuals receive approximately one hour of out-of-cell time per week. *Babu v. Cnty. of Alameda*, 5:18-cv-07677 (N.D. Cal. Apr. 7, 2021), ECF 239 at 7.

and window. A fellow prisoner reported that in the hours leading up to his suicide, H.H.'s requests to see mental health staff were ignored. In addition, although according to Jail policy H.H. was supposed to be observed every 30 minutes, he had not been observed for over an hour, during which time he took his own life.

Other individuals suffer a variety of other significant harms. Indeed, over half of the episodes of self-injurious behavior that our expert reviewed occurred while prisoners were in restrictive housing. For example, I.I., a prisoner in restrictive housing with serious mental illness, smeared his feces, wrote words on the walls with his feces, and even ate his feces. He suffered delusions, believing himself to be Jesus Christ; engaged in head banging; and tried—unsuccessfully—to hang himself. One clinician hypothesized that I.I. may have been in a “safer placement” in a mental health unit in another jail, but noted that the Jail “does not have a mental health unit,” apologizing to I.I. for this fact and “encourag[ing] him to try his best to manage in” administrative segregation while the clinician tried to help him get “to a quieter pod.”

Other examples of people who were harmed include J.J., whose chart shows that he told a clinician that he had instructed his wife not to visit him because he was “losing [his] mind” in administrative segregation; F.F., who attempted to suffocate himself on several occasions, including by wrapping clothes around his neck and putting a bag over his head; and K.K., who swallowed pencils, a razor, a screw, and a comb. One prisoner in administrative segregation who had returned from a short stay at John George less than two months earlier was “refusing to lockdown, naked, urinating all over . . . , putting his bread in the urine then eating it, sticking his finger up his rectum and threatening to kill himself by taking pills.” The experiences of these prisoners mirror that of the many prisoners who told us during our visits to the Jail about “going crazy” and “flipping out” in restrictive housing, due to the isolation they experienced. Chart notes confirm that the Jail’s mental health professionals believe restrictive housing exacerbates prisoners’ mental health issues. As one psychiatrist noted about a prisoner who reported a history of schizophrenia, “Unfortunately patient appears to be doing worse, compared to initial evaluation. This may be due to continuing to be in administrative segregation.”

B. Officials at the Jail Have Known of, and Disregarded, the Substantial Risk of Serious Harm of Placing Individuals with Serious Mental Illness in Restrictive Housing

Prisoners with serious mental illness in restrictive housing have died by suicide, attempted suicide, or otherwise harmed themselves, as discussed above. These incidents—most of which were known to Jail officials—should have put Jail officials on notice that they were putting prisoners with serious mental illness at a substantial risk of serious harm by placing them in restrictive housing for prolonged periods. Moreover, as discussed above, mental health clinicians and other Jail staff specifically raised concerns about whether placement in restrictive housing, such as administrative segregation, was appropriate for prisoners with serious mental illness, further putting officials on notice of the risk to these prisoners.

Following our 2017 visits, the Jail made some changes to its restrictive housing practices, apparently in part in response to the concerns expressed by our experts. Most notably, the Jail

instituted a “Maximum Separation” or “Max Sep” program, which represents a step-down from administrative segregation, allowing prisoners more time out of cell, and allowing them to be out with other prisoners. Nevertheless, the “Max Sep” program is available only to a small percentage of those in administrative segregation. The Jail did not reasonably respond to reduce the risk of serious harm to prisoners with serious mental illness until the very recent—and limited—steps taken as part of the *Babu* negotiations, *see supra* note 37, evincing deliberate indifference to prisoner health and safety.

VII. THE JAIL’S TREATMENT OF PRISONERS WITH MENTAL HEALTH DISABILITIES VIOLATES THE AMERICANS WITH DISABILITIES ACT

Title II of the ADA provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132; *see also Pierce v. Cnty. of Orange*, 526 F.3d 1190, 1214 (9th Cir. 2008). To establish a Title II claim, one “must show: (1) he is a ‘qualified individual with a disability’; (2) he was either excluded from participation in or denied the benefits of a public entity’s services, programs, or activities, or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability.” *Duvall v. Cnty. of Kitsap*, 260 F.3d 1124, 1135 (9th Cir. 2001) (citation omitted). Title II has been found to “unmistakably” cover correctional institutions. *See Pa. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 209–10 (1998) (applying Title II in the prison context); *Bell v. Williams*, No. 18-CV-01245-SI, 2019 WL 2358971, at *3 (N.D. Cal. June 4, 2019) (applying Title II in the jail context); *see also Pierce*, 526 F.3d at 1214 (noting that Title II applies to county jails’ “services, programs and activities for detainees”). The ADA offers the same protections to prisoners with disabilities whether those disabilities stem from physical or mental impairments. 42 U.S.C. § 12102. Thus, prisoners at the Jail with mental health disabilities are entitled to this protection. Further, the ADA applies to prisoners even if they are not in the general population. “A prisoner’s misconduct does not strip him of his right to reasonable accommodations, and a prison’s obligation to comply with the ADA and the RA [Rehabilitation Act] does not disappear when inmates are placed in a segregated housing unit, regardless of the reason for which they are housed there.” *Furgess v. Pa. Dep’t of Corr.*, 933 F.3d 285, 291 (3d Cir. 2019).

Some prisoners are placed in administrative segregation or other restrictive housing due to their mental health disabilities, and all prisoners in Unit 9 are placed there precisely due to their mental health disabilities. Yet, prisoners at the Jail who are on Unit 9 or in administrative segregation do not receive the same programming that is available to prisoners in general population. For example, the Alameda County Sheriff’s Office provides an array of programs to many prisoners in general population at the Jail, including, educational programs, art therapy, culinary arts, computer coding, job readiness training, financial literacy, and hospitality. And the Jail’s transition center allows many prisoners in general population to receive additional services from community-based organizations in areas such as education, employment, housing, and substance use disorder. But none of these programs and services are available to prisoners with mental health disabilities placed on Unit 9 or in administrative segregation. The Jail provides just one program, “Breaking the Chains,” on Unit 9, and it is limited to the topic of substance use

disorder. As discussed above, Jail officials place prisoners with mental health disabilities in Unit 9, the “mental health” unit, precisely because they have a serious mental illness. As also discussed above, the Jail often places other prisoners with mental health disabilities in administrative segregation for reasons that are directly related to their mental illness, as, for example, with F.F. and G.G., discussed in Section VI, *supra*.

Thus, but for their mental health disabilities, prisoners in Unit 9 and those prisoners placed in administrative segregation due to their mental health disabilities would be able to access the programming provided to the general population. For example, approximately 41% of the stays on Unit 9 over a 19-month period that we examined were classified as “Mental Min.” This means that these individuals would have been classified as minimum custody, and housed accordingly, with the attendant access to programming, but for their “mental health” classification. Thus, by virtue only of their mental health disabilities, they were placed in a housing unit where they were denied access to programs that they otherwise would have been able to access, as minimum custody prisoners.

Denying prisoners with a mental health disability equal access to programming and services available to those without disabilities violates Title II of the ADA. *See Love v. Westville Corr. Ctr.*, 103 F.3d 558, 561 (7th Cir. 1996) (affirming conclusion that prison officials intentionally discriminated against an inmate in violation of the ADA when they excluded him from prison programs and services on account of his disability).

VIII. MINIMUM REMEDIAL MEASURES

To remedy the constitutional and statutory violations identified in this Notice, we recommend that the County implement, at minimum, the remedial measures listed below.

A. Providing Mental Health Services in the Most Integrated Setting

1. Provide evidence-based community-based services in the most integrated setting that are effective at meeting the needs of eligible adults with mental health disabilities in and at serious risk of entering psychiatric institutions in Alameda County and preventing them from unnecessary institutionalization, including:
 - a. Implement a comprehensive crisis response system, including an array of integrated crisis residential services, in sufficient capacity to serve adults with mental health disabilities in the most integrated setting and effective mobile crisis services that can respond to individuals wherever they experience crises and that works with law enforcement where appropriate to de-escalate crises and prevent unnecessary arrest and detention, involuntary commitment, or hospitalization.
 - b. Implement a sufficient number of Full Service Partnership teams that can provide sufficiently intensive community services to those who need them.
 - c. Implement a sufficient quantity of scattered-site, permanent supported housing slots to ensure adults with mental health disabilities can maintain housing in integrated settings.

- d. Implement sufficient community-based services including case management, personal care services to assist with activities of daily living, and supported employment services in the amount, frequency, and duration needed by adults with mental health disabilities in Alameda County.
 - e. Implement peer support services provided by trained and certified peers with lived experience with mental illness in sufficient quantity to be integrated in all aspects of the mental health service system.
 - f. Implement sufficient community-based services that can appropriately support people who have co-occurring diagnoses, such as intellectual disability, substance use disorder, or chronic illnesses.
2. Provide transition and discharge planning, beginning upon admission, to all eligible adults with mental health disabilities in psychiatric institutions in Alameda County.
 3. Provide transition and discharge planning, beginning upon admission, for prisoners with mental health disabilities in Santa Rita Jail to prevent needless psychiatric institutionalization for those individuals following release from Jail.
 4. Identify eligible individuals who may be at serious risk of psychiatric institutionalization and connect them with appropriate community-based services, including by using the crisis services described above, and by utilizing identified intercepts where individuals with mental health disabilities are known to come into contact with County services or the criminal justice system.
 5. Ensure that community-based services and supports are designed to engage and support individuals with mental health disabilities who may be involved in the criminal justice system.
 6. Implement systems, including through close coordination between Alameda County BHCS, Alameda County Sheriff's Office and Santa Rita Jail, that ensure people with mental health disabilities can initiate or maintain connections with community-based services while incarcerated and transition seamlessly into such services upon release.

B. Jail Mental Health Care

1. Ensure that prisoners with serious mental illness receive timely treatment from mental health professionals as clinically appropriate, in a setting that provides privacy.
2. Ensure that appropriate, individualized treatment plans are developed for prisoners with serious mental illness, and implement procedures whereby treatment plans are regularly reviewed to ensure that they are being followed.

3. Ensure that all prisoners with serious mental illness receive regular, consistent therapy and counseling, in group and individual settings, as clinically appropriate.
4. Ensure that prisoners at risk of suicide receive appropriate mental health care. The Jail's suicide prevention program should include:
 - a. Individual assessments of prisoners to determine whether and when they should be placed on some form of suicide watch, the individualized conditions of that watch, and whether and when they should be removed from that watch; and
 - b. Conditions in suicide watch placements that are therapeutic, rather than punitive.
5. Provide transition and discharge planning to prisoners with serious mental illness, including services for prisoners in need of further treatment at the time of discharge to the community. These services should include the following:
 - a. Arranging an appointment with community mental health providers for all prisoners with serious mental illness and ensuring, to the extent possible, that prisoners meet with that community mental health provider prior to or at the time of discharge to facilitate a warm handoff;
 - b. Providing a supply of bridge medications to prisoners sufficient to last until a prescription can be refilled; and
 - c. Arranging with local pharmacies to have prisoners' prescriptions renewed to ensure that they have an adequate supply to last through their next scheduled appointment with a mental health professional.

C. Restrictive Housing in the Jail

1. Ensure that prisoners with serious mental illness are not placed in restrictive housing for prolonged periods, absent exceptional circumstances, and review prisoners in restrictive housing periodically to ensure that restrictive housing remains appropriate for them.
2. Ensure that if a prisoner shows credible signs of decompensation in restrictive housing, the prisoner's mental health needs are assessed by a mental health professional and promptly addressed.
3. Ensure that prisoners expressing suicidality are not placed in restrictive housing and instead are provided clinically appropriate mental health care.
4. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to prisoners with serious mental illness, and take appropriate corrective action.

D. Jail Compliance with the Americans with Disabilities Act

1. Ensure that prisoners with mental health disabilities have the opportunity to participate in and benefit from services (including transition services), programs, and activities available to prisoners without disabilities consistent with significant health or safety concerns.

IX. CONCLUSION

We have reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office violate the ADA and engage in a pattern or practice of constitutional violations in the conditions at Santa Rita Jail and that Alameda County violates the ADA in its provision of public mental health services. The remedies we propose are narrowly tailored to correct the conditions found during our investigation and seek to address changes to policies, practices, training, supervision and accountability systems necessary for the County to overcome existing deficiencies and to come into compliance with the Constitution and the ADA. We look forward to working cooperatively with the County to identify appropriate responses to the violations have identified.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if County officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.

Report of the Independent Reviewer
In the Matter of
Disability Rights California, the United States Department of Justice
and
The County of Alameda and Alameda County Behavioral Health
Department

Case: 3:20-cv-05256-CRB

Covering the Period of January 31, 2024, through July 31, 2024

Submitted By: Karen Baylor, Ph.D., LMFT
August 2024

INTRODUCTION

Alameda County entered into a Settlement Agreement with Disability Rights California (DRC), and the United States Department of Justice (DOJ) which became effective on January 31, 2024. The Settlement Agreement is focused on Alameda County and the Alameda County Behavioral Health Department (ACBHD) to provide community mental health services for individuals with serious mental illness to reduce institutionalization and/or criminal justice involvement and to improve the individuals ability to secure and maintain stable permanent housing in the most integrated and appropriate settings.

The Settlement Agreement requires an Independent Reviewer to review relevant facts and assess the County's progress in implementing the Settlement Agreement. The Independent Reviewer is to write a report on the County's progress after six, fourteen, twenty, twenty-five, and thirty-one months after the effective date of the Settlement Agreement.

This is the first initial report and was submitted to the parties only five months after the effective date of the Settlement Agreement. The Settlement Agreement's definition of Substantial Compliance refers to substantial compliance for a period of no less than six (6) months and the on-site review occurred after four months of the Effective Date and the initial report was produced after five months of the Effective Date. There are no substantial compliance ratings for this initial report. which reflects the time period and *not* an indication of ACBHD's implementation of the Settlement Agreement.

As this is the initial report, time was spent on understanding the service delivery system for ACBHD. The report reflects as assessment of the County's progress for the previous five months but identifies any areas where work is in progress or still needs to be completed. This report also includes recommendations to facilitate or sustain substantial compliance.

A draft of this report was submitted to the parties on July 1, 2024. Per the Settlement Agreement, the Independent Reviewer is to provide a draft of the report at least thirty (30) days prior to the finalization of the report. The parties have fifteen (15) days to provide comments and responses to the Independent Reviewer for consideration. The finalized report is submitted to the parties and made public, with any redactions necessary under California or Federal Law. The Independent Reviewer and the parties agreed to extend the review period by an additional seven days. The Independent Reviewer was also granted an extension by an additional seven days with the final report being due on August 7, 2024.

The Settlement Agreement identified the following five service commitments:

1. Crisis Services
2. Full Service Partnerships
3. Service Teams (Intensive Case Management)

First Six Months Report August 7, 2024

4. Outreach, Engagement, Linkages, and Discharge Planning
5. Culturally Responsive Services

This report will outline the requirements in each of the service commitments along with a discussion of the County's progress and implementation of these five areas.

METHODOLOGY

The process began with a Zoom meeting on February 14, 2024, with the Independent Reviewer and DRC and the DOJ. It was decided at that meeting to meet every other week in order to keep the parties apprised of the activities of the Independent Reviewer, County progress, and to identify any challenges or barriers.

Next, the County invited the Independent Reviewer to have an on-site meeting with the Alameda County Behavioral Health Department (ACBHD) management team. That meeting occurred on February 21, 2024, in Oakland, California. The Independent Reviewer was given an overview of the service delivery system, met the management team, and discussed the role of the Independent Reviewer. It was also decided that the Independent Reviewer would meet monthly with the two Deputy Directors of ACBHD in order to discuss progress and any barriers or challenges. A secure ShareFile was also established by ACHBD in order for the County to upload documents, data and other requested documents, that could be reviewed by the Independent Reviewer.

A list of policies and procedures was requested from ACBHD on February 29, 2024, and a list of data was requested on March 21, 2024. A list of additional documents was requested on March 21, 2024, and a request for follow-up documents was sent on May 21, 2024. During the months of February through May, the County has uploaded policies and procedures, protocols, data, contracts, portions of 16 individual client records (clinical assessment and progress notes), and other related information to the ACBHD ShareFile. All these documents were reviewed and helped form the interview questions for the on-site review.

The Independent Reviewer developed a protocol for every service commitment in the Settlement Agreement. A chart was developed that included all of the service commitments in the Settlement Agreement and a list of possible sources of evidence such as policy and procedures, operations manuals, sample of client records, data and data analysis, and interviews of both ACBHD staff and community-based provider staff. This protocol is an organized tool and was utilized as the foundation for the determination of proof of practice for the ratings of compliance for every service commitment. The protocol was shared with both the DOJ/DRC and ACBHD. Feedback from both parties was incorporated into the final protocol and both parties agreed with the use of the protocol.

The Independent Reviewer conducted an on-site review in Alameda County from May 7, 2024, through May 10, 2024. During that on-site review the Independent Reviewer

interviewed County staff, toured five contract providers and interviewed their staff, and met with ACBHD's Senior Executive Team. The Independent Reviewer did speak to some clients when on a tour of a facility, but no formal interviews were conducted with clients.

There are a few limitations to this report that need to be noted. Only two client records for each of the following service areas were reviewed: ACCESS, crisis residential treatment, full-service partnerships, service teams, and psychiatric inpatient. It is difficult to draw any conclusions or recommendations based on the low number of client records reviewed. There were no formal client interviews conducted for this initial report. This was due to the time frame and conducting interviews with clients will be a priority for the next review. The on-site review occurred only four months after the effective date of the Settlement Agreement. That timeframe did not give the County much time to implement changes. This initial period was also used to understand ACBHD's service delivery system and all the programs and providers utilized to provide specialty mental health services. Additional information will be gathered for future reports which is noted throughout this report. Therefore, this report is a baseline of where the County currently is with implementation of the Settlement Agreement based on the information available to the Independent Reviewer, and information in this report will be compared with the information gathered for future reports.

Throughout the five months of this process, the Independent Reviewer has had the cooperation of the staff from the Alameda County Behavioral Health Department. They have been collaborative and very responsive to requests for information that has been needed to perform the review functions. The Independent Reviewer would especially like to acknowledge the assistance provided by James Wagner, LMFT, LPC, Deputy Director, Clinical Operations and Vanessa Baker, LMFT, Deputy Director, Plan Administration.

OVERVIEW OF THE SERVICE DELIVERY SYSTEM

ACBHD is considered a Mental Health Plan and contracts with the State Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries. ACBHD is under the Alameda County Health (ACH) within the County structure. ACBHD contracts 79 percent of the specialty mental health services through contracts with community based organizations. ACBHD contracts for inpatient and psychiatric emergency services which are provided by John George Psychiatric Hospital which is under Alameda Health Systems. ACBHD is responsible for administration of the Mental Health Services Act which includes the provision of Full Service Partnership (FSP) services.

The ACBHD has a Behavioral Health Director, a Deputy Director of Clinical Operations, a Deputy Director of Plan Administration, and a Chief Medical Officer which comprises the Senior Executive Team. ACBHD has three main divisions which are as follows:

1. Clinical Operations which include Adults and Older Adults Systems of Care, Child and Young Adult Systems of Care, Substance Use Continuum of Care, and Forensic, Diversion, and Re-entry Services
2. Office of the Medical Director which includes Chief Nursing Officer and Crisis System of Care
3. Plan Administration which includes Quality Management, Finance, MHSA management and data analytics.

The Director/Office of Health Equity also reports to the ACBHD Director and has a smaller division than the three mentioned above. Workforce, education and training is also a unit that reports directly to the ACBHD Director.

SUMMARY OF RATINGS

The five service commitment areas are from the finalized Settlement Agreement. As discussed in the Methodology section above, the ratings in this first-round report are based on an initial set of evidence. This evidence is comprised of documentation, protocols, contracts, data, client records and other related documents, received from ACBHD and from initial interviews with staff, and community-based provider staff. These interviews occurred during a one-week on-site visit in May 2024. As mentioned in the Methodology section above, there were limitations to the initial review and more documentation and evidence of compliance will be requested in future reports, which is noted throughout the report.

Determination of compliance with the Settlement Agreement results in a rating as follows: Substantial Compliance (SC), Partial Compliance (PC), Non-Compliance (NC), and Not Applicable (NA). This rating was added to the protocol and a full list of the ratings is in Attachment 1.

The Settlement Agreement states:

“For the purposes of this Agreement, substantial compliance will mean something less than strict or literal compliance. Substantial compliance is achieved if (1) any violations of the Agreement are minor or occasional and are not systemic, and (2) substantial compliance is sustained or otherwise demonstrated to be durable. Substantial compliance refers to substantial compliance for a period of no less than six (6) months. Non-compliance with or due to mere technicalities, or isolated or temporary failure to comply during a period of otherwise sustained substantial compliance, will not constitute failure to sustain substantial compliance.”

The Partial Compliance and Not Applicable ratings are not defined by the Settlement Agreement. For purposes of rating the County’s compliance with the Settlement Agreement, the Independent Reviewer adopts the following definitions:

Partial Compliance: a provision was rated Partial Compliance when there was any evidence that steps had been taken toward implementation or that implementation had begun. Partial Compliance includes a range of potential progress toward Substantial Compliance, from taking preliminary steps to near-completion of implementation. Partial Compliance was also given when a part of the service commitment was met but not all of the requirements were met.

Non-Compliance: a provision was rated Non-Compliance when there was no evidence that steps had been taken toward implementation.

Not Applicable: a provision was rated Not Applicable when it was not yet required to be implemented by the Settlement Agreement, where the Independent Reviewer has not yet begun to review or has not yet gathered sufficient evidence to determine the rating.

The ratings were determined by a review of the documents provided from ACBHD, public documents, and interviews with both ACBHD staff and community-based provider staff. It was important to see a requirement in a document such as the policy and procedure but also to see the requirement in practice. It is also important that the requirement is occurring in practice but also that it is sustained and in a durable manner. A rating was provided when there were several sources of evidence to the requirement.

The following is a summary table of the overall ratings regarding compliance to the Settlement Agreement. Since the Settlement Agreement’s definition of Substantial compliance refers to substantial compliance for a period of no less than six (6) months and the on-site review occurred after four months of the Effective Date and the initial report was produced after five months of the Effective Date, there are no substantial compliance ratings for this initial report. It is a reflection of the time period and not an indication of ACBHD’s implementation of the Settlement Agreement.

Summary of Rating Per Service Commitment

SERVICE COMMITMENT	SC*	PC	NC	NA	TOTAL
1. Crisis Services	-	13	0	7	20
2. Full Service Partnership	-	10	0	6	16
3. Service Teams (Intensive Case Management)	-	3	0	1	4
4. Outreach, Engagement, Linkages, and Discharge Planning	-	16	0	10	26
5. Culturally Responsive Services	-	3	0	3	6
Totals	0	45	0	27	72

**Due to the temporal limitations of this report, a rating of substantial compliance was not possible.*

Percentage of Each Rating at the First Six Months

Ratings	Percent
Substantial Compliance	0*
Partial Compliance	62.5%
Non-Compliance	0
Not Applicable	37.5%
Total	100%

** Due to the temporal limitations of this report, a rating of substantial compliance was not possible.*

CRISIS SERVICES

The Settlement Agreement outlines the service components under crisis services which include the County providing a county wide crisis system and expanding crisis intervention services. In Alameda County, crises services are organized under the Chief Medical Officer. There is an Interim Crisis Services System of Care Director who reports directly to the Chief Medical Officer. The Independent Reviewer was able to interview this Acting Director, the Chief Medical Officer, the Crisis Services Division Director, ACCESS staff and Mobile Crisis staff.

Requirement: *The County will continue to offer a countywide crisis system and expand crisis intervention services.*

The County contracts with providers for crisis intervention services and crisis support services, Crisis Residential Treatment (CRT), and Psychiatric Emergency Services (PES). The crisis services system of care includes the following:

- Prevention and early intervention which includes outreach and engagement teams, and referral, education and training
- Crisis intervention services which include crisis support services and mobile crisis teams
- Crisis stabilization which includes services at either a crisis stabilization unit (CSU) or at a crisis residential treatment facility
- Post crisis follow-up which include Crisis Connect/Post Crisis Follow-up Team.

Crisis services are provided by County staff and through contracts with community-based providers. Specifically, the County provides or contracts with the following for services:

- ACBHD Crisis System of Care works closely with the ACCESS staff and provides mobile crisis services

- Crisis Stabilization Units which are provided through a contract with Amber House (Bay Area Community Services/BACS) and John George Psychiatric Emergency Services (PES) with plans to open another CSU in Hayward
- Crisis Residential Treatment which includes contracts with Amber House (BACS), Woodroe Place (BACS), and Jay Mahler (Telecare)
- Acute services through John George Psychiatric Hospital and Herrick Hospital
- Sub-acute services which include contracts with Villa Fairmont, Gladman, and Morton Bakar.

The chart below indicates the number of crises calls and the location of the call for Fiscal Year 2022-23.

Region	Crisis City	Number of Calls
1. North	Alameda	129
1. North	Albany	24
1. North	Berkeley	286
1. North	Emeryville	54
1. North	Oakland	3511
1. North	Piedmont	17
2. Central	Castro Valley	104
2. Central	Hayward	1083
2. Central	San Leandro	726
2. Central	San Lorenzo	56
3. South	Fremont	334
3. South	Newark	84
3. South	Union City	153
4. East	Dublin	75
4. East	Livermore	130
4. East	Pleasanton	77
5. Out of County	Out of County	807
6. Unknown	Unknown	25

ACBHD provided this data, and the chart indicates that the calls are received from all over the county but most of the crisis calls are from Oakland and Hayward. This data point should be combined with the mobile crisis assessment to determine the need for expanded services.

Requirement: *Maintain a 24/7 crisis hotline. The crisis hotline will provide screening and de-escalation services on a 24/7 basis.*

*No later than **18 months** after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis.*

The ACCESS line is operated 24/7 as is required by the State Department of Health Care Services (DHCS). The County staff answer the ACCESS line from 8:30am to 5pm, Monday through Friday. ACBHD contracts Crisis Support Services for coverage of the telephone line after hours, weekends and holidays. Crisis Support Services will write up a referral for treatment services and then the County ACCESS team will follow up on the referral the next morning but does not provide any crisis services. ACBHD staff reported that if a crisis occurs after business hours, Crisis Support Services will call 911 or the Community Assessment and Transport Team (CATT).

The ACCESS staff reported that they utilize their clinical judgement regarding where to refer clients for services. There is a decision tree that crisis services use when out in the field to determine the appropriate level of care.

The MHPA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states that one of the reoccurring themes in the community listening session was “Address the response time in systems such as ACCESS” (Page 66).

Requirement: *The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available), to ensure there is “no wrong door” for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmlines to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.*

The Interim Director of Crisis Services System of Care reported that the process has started with communication with 988 but that has not been implemented. Although the level of coordination will continue to deepen as plans are implemented, coordination has already begun. ACBHD and Crisis Support Services of Alameda/988 regularly host the quarterly 988 collaborative meetings with 911, law enforcement, fire department, all mobile crisis teams, Emergency Medical Services (EMS), and other community-based providers. In addition, ACBHD hosts a 988 conference annually each September. ACBHD also meets monthly with EMS to discuss high utilizers of the services and develop plans to provide the appropriate level of care. ACBHD receives a monthly report of 988 calls along with documentation of planned and provided interventions. ACBHD provided 988 data which included date and time of the call, call duration, any safety risks, reason for the call, and the intervention.

The Interim Director also stated that 911 continues to be an entry point into the system and that 911 Dispatchers can directly request that a mobile crisis team respond to an emergency. Additional entry points include 911, 988, or the crisis main telephone number (510-891-5600).

ACBHD did report the demographics on the calls they received which are as follows: age, sex, ethnicity, preferred language, and location of the caller. ACBHD also collects the following data: average wait time for the call to be answered, number of abandoned calls, and average time spent on the call. In addition, the Crisis System of Care implemented the cloud-based telephone system, Fire 9, which will allow ACBHD to track the number of calls, hold times, and the time of the call. A report will be developed and generated to track the crisis contacts and the assignment to an FSP, Service Team of to a community-based provider. The Independent Reviewer will monitor this system and the report for subsequent reports.

ACBHD provided a copy of the warm hand-off procedure from a contracted community-based provider. The procedure requires the community-based provider staff contact the client within 24 hours of receiving the referral and offer an intake/assessment appointment within one week of receiving the referral.

Requirement: *The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.*

ACBHD has a contract with the Indigo Project to develop and conduct a Mobile Crisis Assessment of the needs and gaps in mobile crisis coverage. It is not clear how ACBHD deploys their mobile crisis teams and which team should respond to a particular crisis. It seems to be based on availability and location of the crisis in the county. ACBHD currently does not collect MCT response times. However, it is important for the Indigo Project to complete their work and more on this requirement will be discussed in future reports.

Requirement: *Provide mobile crisis response services on a county-wide basis. Mobile crisis teams will provide a timely in-person response to resolve crises as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.*

ACBHD reported that it operates a total of 14 mobile crisis teams¹ with the following three different models for mobile crisis services:

- Mobile Crisis Teams (MCT) that includes two clinicians and law enforcement, if needed. This team is available Monday through Friday, from 8am to 6pm. This team can respond to requests from the general public, 988, and 911. ACBHD has three of these teams.

¹ There are a number of cities in Alameda County that also operate their own mobile Crisis Assessment Teams. An example of this is the MACRO program that operates in Oakland and is housed in the fire department. The ACBHD reported that peers and EMT's are a part of the County's crisis services.

- Mobile Engagement Teams (MET) that pairs a clinician with a police officer in Oakland and operates from Monday to Thursday, from 8am to 3pm. The Hayward MET operates from Monday to Thursday, from 8am to 4pm. These teams respond to 911/988 generated and Crisis System of Care mental health calls. ACBHD has two of these teams
- Community Assessment and Transport Team (CATT) that pairs a clinician with an Emergency Medical Technician. This team focuses on crisis intervention and medical clearance. This service operates 7 days a week, from 7am to 11pm. ACBHD has nine of these teams.

Per the Settlement Agreement, mobile crisis is to provide timely response. While data collection and analysis are not required by the Settlement Agreement, it may be helpful for the ACBHD to monitor the timeliness of the response from a quality assurance perspective. Monitoring data on response time is also well-established in the field as an important performance metric for mobile crisis services.² A number of mobile crisis staff reported that when the mobile crisis team is already responding to a crisis, there is no other option than to contact 911 who can then contact one of the city's mobile crisis teams. Mobile Crisis staff also reported that the team in Oakland can be very busy with multiple requests for mobile crisis services, and they only have one team to respond to the crisis calls. This staff also reported that they know not to contact MCT on Wednesday afternoon because that is when MCT has their staff meetings which occur twice a month, but other city mobile crisis teams or CATT may be contacted during this time. ACBHD staff stated in interviews that the purpose of MCT is to reduce interaction with law enforcement and to reduce inpatient admissions. ACBHD also provided their telehealth policy and procedure.

The MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states that one of the reoccurring themes in the community listening session was "Expand mobile crisis teams" (Page 66).

Data collected by ACBHD on mobile crisis services include the following: number of clients, response and outcome of the call. Response time and other outcome data for mobile crisis services is currently not collected. While the Settlement Agreement does not describe specific data points for which data collection is required, this data would be useful to the ACBHD management team from a quality assurance perspective. It is necessary data for the County to assess its mobile crisis services effectiveness and important for the Independent Reviewer to reach a rating conclusion.

² [National Guidelines for Behavioral Health Crisis Care \(samhsa.gov\)](https://www.samhsa.gov) at page 50-51.

The number of clients served during the Fiscal Year (FY) 2022 -23 was 2074. The chart below shows the number of involuntary holds (5150) during the same time period and some clients may have had more than one episode:

Service	Clients	Episodes
5150 by clinician	13	13
5150 by Police	3	3
5150 Danger to Others	238	271
5150 Danger to Self	255	267
Gravely Disabled	241	271

This chart indicates that the highest number of 5150's during the fiscal year was danger to others and gravely disabled closely followed by danger to self. A client may have one or more episodes during the fiscal year which is why the number of clients does not exactly match the number of episodes. This data will be used as the baseline for comparison in future reports.

It is noteworthy that ACBHD received a grant from DHCS from the Behavioral Health Continuum Infrastructure Program (BHCIP) to upgrade communication devices for existing mobile crisis teams, fund marketing materials, and increase capacity for outreach and engagement teams who provide post crisis follow up services. This grant was awarded in May 2024.

Requirement: *Mobile crisis services shall be provided with the purposes of reducing, to the greatest extent possible, interactions with law enforcement during a mental health crisis, reducing 5150 and John George psychiatric emergency services (“PES”) placement rates, and increasing use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkage to services).*

Evidence was found regarding the purpose of mobile crisis services. The Independent Reviewer interviewed mobile crisis staff and the crisis system of care management staff and reviewed mobile crisis program information. The Independent Reviewer has requested a ride-along with the mobile crisis staff at the next on-site review. Results of the ride-along will be discussed in the next report.

Requirement: *The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams, and agrees to maintain this as a minimum capacity.*

As described above, the County now has 14 mobile crisis teams. Future reports will continue to monitor the number of mobile crisis teams to ensure that ACBHD retains minimum capacity. The results of the mobile crisis assessment may influence this and will be included in the next report.

Requirement: *The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than **one year** after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide*

mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”). The Mobile Crisis Assessment will be informed by and will appropriately take into account (i) community and stakeholder input; and (ii) all necessary data and information sufficient to assess the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.

The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer (see section III.1.a of this Agreement) for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the Mobile Crisis Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final Mobile Crisis Assessment will promptly be made available to the public.

Based on the County’s Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.

The Settlement also requires the County to conduct an assessment of the needs and gaps in mobile crisis coverage. This requirement is not yet due to be completed.

ACBHD has a contract with the Indigo Project to develop and conduct a Mobile Crisis Assessment of the needs and gaps in mobile crisis coverage. The Indigo Project submitted a draft of the methodology for this assessment in May 2024. This draft was submitted to DOJ and DRC for their feedback on May 14, 2024. Feedback from the Independent Reviewer and DOJ and DRC was submitted to ACBHD on May 28, 2024. A more in-depth analysis of this assessment will be included in the next report from the Independent Reviewer. But the Independent Reviewer wishes to acknowledge ACBHD for starting this assessment process early in order to meet the established deadline in the Settlement Agreement.

Requirement: *FSPs will provide crisis intervention as set forth in section II2.m in this Agreement.*

During this review period, the Independent Reviewer undertook the following activities to determine compliance with FSPs providing crisis intervention services:

- Review of ACBHD’s FSP policy and procedures,
- Review of community-based provider contracts scope of work, and
- Interviews with community-based provider staff and supervisors.

All of the above indicated that FSP provides crisis intervention services. The Independent Reviewer will continue to assess to ensure the requirement is occurring in practice and sustained in a durable manner.

Requirement: *Each mobile crisis team shall include at least one mental health clinician.*

As described above, the Mobile Crisis Teams includes two clinicians, Mobile Engagement Teams pairs a clinician with a police officer, and Community Assessment and Transport Team (CATT) pairs a clinician with an Emergency Medical Technician.

Requirement: *Trained peer support specialists shall be part of the County’s crisis services team and shall be included in outreach and engagement functions.*

ACBH reported that peers and EMT’s are a part of the County’s crisis services. Specifically, ACBH reported that peers and people with lived experience are part of their Outreach and Engagement Teams (O&E). The Independent Reviewer will explore this more fully in future reports to ensure the requirement is occurring in practice and is sustained in a durable manner.

Requirement: *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.*

The current number of CRT beds is outlined in the chart below.

CRT Facility	Community-Based Provider	Number of Beds
Amber House	BACS	16
Woodroe House	BACS	16
Jay Mahler	Telecare	16
TOTAL		48

While ACBHD has met this requirement, it has to be sustained for six months per the Settlement Agreement. The Independent Reviewer will verify the sustainability and durability of this requirement in the next report.

Requirement: *Within two years of the Effective Date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based provider(s) to add a mixture of 25 additional CRT and/or peer-respite beds.*

ACBHD reported that two additional CRTs will be opened in the future. ACBHD plans to contract for an additional 32 beds with Telecare and La Familia, which will bring the total number of CRT beds to 80 beds.

Requirement: *A purpose of CRT facilities and peer-respite homes is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization. They are intended to be used by people experiencing or recovering from a crisis due to their mental health disability for short-term stays and provide support to avoid escalation of a crisis. CRT facilities and peer-respite homes are unlocked.*

During the on-site review, the Independent Reviewer was able to tour Amber House which has the CRT on the bottom floor and crisis residential on the top floor. The Independent Reviewer was able to review client records who had received CRT services, community-based contracts scope of work and the community-based

providers Operation Manual. There was evidence found that the goal of CRT facilities is to de-escalate or avoid a crisis and reduce unnecessary hospitalization. The Independent Reviewer was not able to tour the one peer-respite facility but will for subsequent reports.

Requirement: *Peer staff will be on-site 24-7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.*

ACBHD reported that the County only has one peer respite home that opened in 2020 named Sally's Place. ACBHD reported that the facility is unlocked and has peers on site. ACBHD staff did report that the telephones at Sally's Place are often not answered, and that the facility usually is full. MHS Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026 included in the program description that it is staffed by peers and that it operates 24 hours a day in a homelike environment. The report also included one of the challenges is that Sally's Place has continuously received referrals that exceed the established bed capacity (Page 334).

The Independent Reviewer was not able to tour the one peer-respite facility but will for subsequent reports.

Requirement: *Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.*

The Independent Reviewer was able to review client records of clients who had received CRT services, community-based contracts scope of work and the community-based providers Operation Manual. Both ACBHD staff and community-based provider staff confirmed that housing is not a condition for admission to a CRT. The Independent Reviewer will verify the sustainability and durability of this requirement in the next report.

Requirement: *CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis teams.*

Admissions to a CRT may be made directly by MCT. The Independent Reviewer did receive a tour of Amber House and interviewed the staff to confirm this. Evidence was also found in the Operating Manual of the community-based providers. The Independent Reviewer was also provided with client records of clients who had received CRT services. There was evidence to support admissions directly from mobile crisis teams. However, the Independent Reviewer was not able to tour the one peer-respite facility but will for subsequent reports.

Data collected in FY 2022-23 by ACBHD includes total number of clients (663) who received CRT services, length of stay and the following outcomes listed in chart below.

Outcome	Number of Clients	Percentage
Admitted to hospital	48	7%
Connected to CBS	140	21%
Discharged to other facilities	130	20%
Detention to Santa Rita Jail	20	3%

This data will be used as the baseline for comparison in future reports. It is important to note that the chart indicated outcomes for about half of the clients served. More information regarding outcomes will be provided in subsequent reports.

Requirement: *The County’s crisis system will be designed to prevent unnecessary hospitalizations, IMD admissions, law enforcement interactions, and incarceration.*

The Independent Reviewer interviewed ACBHD staff, community-based provider staff, reviewed policy and procedures and community-based Operations Manual, indicating that the crisis services are designed in the manner stated. However, it seems that the services are not provided in a coordinated fashion. Crisis intervention services are offered during business hours and a contract provider provides coverage overnight, weekends and holidays but they contact 911 or CATT for any crisis intervention services. It is also not clear which model of mobile crisis teams should respond to a particular crisis. It seems to be based on availability and location of the crisis in the county. There are outcome data that the county currently does not collect such as mobile crisis teams response times, except for the CATT team. ACBHD also identified the need to expand CSU, CRT, peer respite, and mobile crisis teams and that ACBHD is waiting for completion of the mobile crisis assessment before being able to expand services. In future reports, the Independent Reviewer will assess additional evidence to ensure services are designed to achieve the outcomes described in the above requirement.

Summary of Crisis Services Findings

As stated previously, no substantial compliance was given for this initial report since the Settlement Agreement requires substantial compliance for six months and this report was produced only five months after the Effective Date of the Settlement Agreements.

Overall, there are twenty service commitments in the Crisis Services component of the Settlement Agreement. ACBHD received partial compliance for thirteen service commitments and a not applicable rating for seven service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Partial Compliance for the following requirements:

1. *The County does offer county wide crisis system.* Partial compliance was given so that the Independent Reviewer can assess whether the County’s compliance is sustained in subsequent reviews.
2. *The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911,*

FSP warmlines, and 988 (when and if such coordination is available) to ensure there is “no wrong door” for accessing appropriate crisis services. There is evidence that steps have been taken and there is progress towards substantial compliance.

3. *Provide mobile crisis response services on a county-wide basis.* There are several requirements included and there is evidence that steps have been taken and there is progress towards substantial compliance.
4. *Mobile crisis services shall be provided with the purposes of reducing, to the greatest extent possible, interactions with law enforcement during a mental health crisis, reducing 5150 and John George psychiatric emergency services (“PES”) placement rates, and increasing use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkage to services).* There is evidence that steps have been taken and there is progress towards substantial compliance. The Independent Reviewer requested a ride-along with mobile crisis during the next on-site review.
5. *The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams and agrees to maintain this as a minimum capacity.* While ACBHD currently has 14 mobile crisis teams, it is important for the Independent Review to see that this is maintained. In addition, the results of the mobile crisis assessment may influence this and will be included in the next report.
6. *FSPs will provide crisis intervention as set forth in section 112.m in this Agreement.* There is evidence to support this but in order to obtain substantial compliance, it has to be in practice for six months and the on-site review occurred only after four months.
7. *Each mobile crisis team shall include at least one mental health clinician.* There is evidence to support this but in order to obtain substantial compliance, it has to be in practice for six months and the on-site review occurred only after four months.
8. *Trained peer support specialists shall be part of the County’s crisis services team and shall be included in outreach and engagement functions.* This rating was given because the Independent Reviewer needs to explore this more fully in future reports.
9. *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.* While ACBHD currently contracts for 48 CRT beds, it has to be maintained and the on-site review occurred only after four months. The Independent Reviewer will verify this requirement again in subsequent reports.
10. *A purpose of CRT facilities and peer-respite homes is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization.* There was evidence of the purpose of the CRT facilities and peer-respite homes. The Independent Reviewer was not able to tour the peer-respite home during the first on-site review but plans to do so in a subsequent review.
11. *Individuals shall not be required to have identified housing as a condition of admission to a CRT facility. While there is evidence to support this requirement, it has to be in practice for six months and the on-site review occurred only after four months.* The Independent Reviewer will verify this requirement again in subsequent reports

12. *CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis teams.* There was evidence to support admissions directly from mobile crisis teams. However, the Independent Reviewer was not able to tour the one peer-respite facility but will for subsequent reports.

ACBHD achieved Not Applicable for the following:

1. *With the Maintain a 24/7 crisis hotline is the following requirement: No later than **18 months** after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis.*
2. *The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.* The rating was given due to ACBHD waiting for the completion and implementation of the Mobile Crisis Assessment which is due in the future.
3. *The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than **one year** after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”).*
4. *The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer.*
5. *Based on the County’s Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.*
6. *Within **two years** of the effective date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based provider(s) to add a mixture of 25 additional CRT and/or peer-respite beds.*
7. *Peer staff will be on-site 24-7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.* The Independent Reviewer was not able to tour the peer-respite home during the first on-site review.

FULL SERVICE PARTNERSHIPS

Full Service Partnerships (FSP) services are defined in California Code of Regulations, Title 9, Section 3620 which defines the Full Spectrum of Community Services necessary to attain the clients treatment goals. FSP services are intended to be flexible and provided at a level of intensity and location that meets the client’s needs. FSP services are intended to reduce hospitalization, utilization of emergency health care, and criminal justice involvement. FSP services in Alameda County are provided through contracts with community-based providers.

FSP services were assessed for this initial report through interviews with ACBHD staff, community-based provider staff and the supervisor of FSP programs, reviewing the contracts between ACBHD and the community-based providers and reviewing two client records of clients receiving FSP service. These client records were selected randomly by ACBHD and provided to the Independent Reviewer. During this first review period, the Independent Reviewer was not able to review additional records or to conduct a broad sampling across the various ACBHD client populations to identify systemic patterns. In addition, the Independent Reviewer was not able to interview clients receiving FSP services to confirm that they receive services consistent with the requirements but plans to do so in subsequent on-site reviews.

Requirement: *The County offers FSPs through community-based providers that provide services under the Community Services and Supports (“CSS”) service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10.*

*Within **two years** from the effective date, the County will add 100 FSP slots for adults and transition aged youth for a total of 1,105 FSP slots for that population. The County will utilize the FSP slots that are added under this Agreement to serve individuals 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.*

ACBHD contracts with community-based providers for the provision of FSP services. ACBHD provided the contract’s scope of work and through interviews with ACBHD staff and community-based provider staff, this part of the requirement was confirmed.

Requirement: *Within **one year** from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the “FSP Assessment”).*

Requirement: *The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to:*

- i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services;*
- ii. Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment, and length of time from identification to enrollment;*
- iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups;*

and iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.

Requirement: *The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before finalizing the County's FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.*

Requirement: *Based on the County's FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.*

ACBHD has contracted with the Indigo Project to conduct an FSP assessment to identify needs and gaps for individuals ages 16 and older. Indigo Project submitted a draft of the design and methodology of the assessment to the Independent Reviewer on March 29, 2024. The Independent Reviewer sent the draft to DOJ and DRC on April 1, 2024, and they returned the draft with their comments and edits on May 2, 2024. A meeting was held on June 14, 2024, with Indigo, ACBHD, and the Independent Reviewer to discuss the edits and to finalize the design and methodology. The implementation and results of this assessment will be discussed in subsequent reports.

Requirement: *As used in this Agreement, one "slot" (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time. FSP will provide services necessary to attain the goals identified in each FSP recipients' Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1).*

While evidence was found regarding the definition of one slot, the Independent Reviewer needs to review more client records and other information regarding the ISSP to determine if FSPs are in fact providing the services necessary.

Requirement: *Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person's individualized goals and the Full Spectrum of Community Services necessary to attain those goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual.*

The Independent Reviewer reviewed ACBHD’s policies and procedures for FSP and reviewed two client records. FSP client records listed the issues that the client identified, individualized goals, and the client’s treatment plan or problem list were consistent with the assessment. The client records indicated that the issues identified were being addressed. But the Independent Reviewer was not able to fully review the ISSP requirements, given the small number of client records, and plans to review additional client records. In addition, the Independent Reviewer was not able to interview clients receiving FSP services to confirm that they receive services consistent with the requirements but plans to do so in subsequent on-site reviews to ensure the requirement is occurring in practice and is sustained in a durable manner.

Requirement: *Services provided through FSPs will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals’ needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.*

The Independent Reviewer reviewed ACBHD’s policies and procedures for FSP and reviewed two client records. Client records indicated that the services were being provided in multiple ways. However, the client records indicated that the services were not as frequently provided as indicated in the client’s treatment plan. For example, in one client’s record, the treatment intervention was to occur weekly, but the progress notes indicated that the intervention was being conducted every other week. The client record indicated that the client was only working on their activities of daily living with no immediate plans for discharge. This was a very small sample of client charts for review, so it is difficult to draw conclusions about the overall service delivery system. An additional sampling of client records will be completed in subsequent reviews to ensure the requirement is occurring in practice and is being sustained in a durable manner.

The chart below indicates the top six locations where FSP services were provided for the Fiscal Year 2022-23.

Treatment Location	# Clients	% of Visits
Field	1,072	41.2%
Home	815	23.8%
Phone	1,073	20.9%
Office	1,128	14.3%
Telehealth	549	3.6%
Inpatient	286	2.4%

This chart indicates that the majority of services are being provided in the field and at home as is appropriate for FSP services. This data will be compared to data collected in the future.

Requirement: *FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals’ ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.*

The Independent Reviewer reviewed ACBHD’s policies and procedures for FSP, reviewed two client records, and interviewed community-based provider staff. All indicated that services are designed to reduce hospitalization, utilization of emergency health care services, reduce criminal justice involvement, and improve individuals’ ability to secure and maintain stable permanent housing.

The chart below is ACBHD outcomes for FSP clients related to housing for discharges during Fiscal Year 2022 to 2023.

Housing Status	At Admission	Percent Admission	At Discharge	Percent Discharge
Independent	73	31%	72	30%
Unknown or other	45	19%	54	23%
Homeless	56	24%	48	20%
Group Housing	45	19%	32	14%
Medical Facility	8	3%	13	5%
Justice Related	4	2%	12	5%
Rehabilitation	6	3%	6	3%

This chart indicates that the largest percentage of clients who received FSP services were discharged to independent living. Over forty percent were discharged to an unknown place or were homeless. While this seems to be a high percentage, it also speaks to the housing issues in Alameda County. There also seems to be a slight increase in the number of justice related clients from admission to discharge. The Independent Reviewer will examine this more fully in subsequent reports to ensure the requirement is occurring in practice and is being sustained in a durable manner. This data will be used as the baseline for comparison in future reports.

Requirement: *FSP programs will be implemented using high fidelity to the Assertive Community Treatment (“ACT”) evidence-based practice, including that: (i) FSP programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals; (ii) FSP teams operate at a 1:10 mental health staff to client ratio.*

During this review period, the Independent Reviewer undertook the following activities to determine compliance with the above FSP-related services:

- Toured two community-based providers of FSP services, one for adults and one for Transitional Aged Youth (TAY),
- Interviewed 15 community-based provider staff and supervisors from two FSP community-based providers visited,
- Reviewed ACBHD's FSP policy and procedures,
- Reviewed ACBHD community-based provider contracts scope of work for the provision of FSP services,
- Reviewed ACBHD's ACT training materials.

The MHSA Annual Plan Update (Draft) for FY24/25 describes the difference between FSP and the ACT model as follows:

“In California, Full Service Partnership (FSP) programs are intended to be the most intensive level of publicly-funded outpatient treatment programs (in addition to Laura’s Law, or Assisted Outpatient Treatment/AOT programs). Some counties, like Alameda, base their FSP service models on the ACT evidence-based model that operates nationally; this model is the highest intensity service level for outpatient services. FSP ACT model programs are team structured with a staff to partner ratio of 10:1 and provide coordinated comprehensive services that support and promote recovery” (Page 80).

Community based providers staff reported that ACBHD conducts a fidelity assessment to the ACT model annually. ACBHD staff and community-based provider staff reported that the FSP program design in Alameda County is based on the ACT model. For the next report, the Independent Reviewer will include documentation of ACBHD’s fidelity review results.

The ACBHD Deputy Director of Clinical Operations reported that the staff to client ratio for FSP is 1 to 10. This was also confirmed by the provider’s contract’s scope of work and by interviews with community-based provider staff.

However, the Independent Reviewer was unable to confirm through records sampling, data analysis, and individual client interviews that FSP programs are being implemented using high fidelity to the ACT evidence-based practice. Review of the initial client records discussed above indicated that services are not being provided with the frequency required under ACT high fidelity standards, or that multidisciplinary teams are providing the treatment, rehabilitation, and support services that clients need to achieve their goals. In future reports, the Independent Reviewer will assess additional evidence, including data, individual client interviews, and client records sampling, to ensure the requirement is occurring in practice and is being sustained in a durable manner.

Requirement: *FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than **eighteen (18) months** after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served*

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by an FSP receives crisis intervention from another ACBHD contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.

FSP services are intended to provide crisis intervention services. During this review period, the Independent Reviewer undertook the following activities to determine compliance with the above FSP-related requirements:

- Review of ACBHD's FSP policy and procedures,
- Review of community-based provider contracts scope of work, and
- Interviews with community-based provider staff and supervisors.

In future reports, the Independent Reviewer will assess additional evidence, including data, individual client interviews, and client records sampling, to ensure the requirement is occurring in practice and is being sustained in a durable manner.

Requirement: *FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.*

FSP services are to include the provision of or the arrangement for Individual Placement and Support (IPS) services. The interviews with community-based provider staff and supervisor indicated that this was being conducted, ACBHD provided two client records where IPS services were provided, and it was evident from the client records that employment services were being provided. Community-based provider staff reported that ACBHD conducts a fidelity assessment to the IPS annually. The Independent Reviewer has not yet reviewed the fidelity assessment or results but will do so in subsequent reports.

Requirement: Housing: *The Parties recognize that permanent, integrated, stable housing with Housing First principles is critical to improving treatment engagement and supporting recovery. (i) FSP clients will receive a housing needs assessment, and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency's Coordinated Entry System ("CES"), or through other County and community resources.*

FSP participants are to receive a housing assessment and be referred to the Health Agency Services Coordinated Entry System (CES). No evidence was found in the client record of a formal housing assessment or of a referral to CES. However, evidence of housing needs and wishes of the client was found in the client record. In future reports, the Independent Reviewer will assess additional evidence, including data, policy and procedures, individual client interviews, and client records sampling, to ensure the requirement which includes temporary and permanent housing, is occurring in practice and is being sustained in a durable manner.

Requirement: *As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.*

The MHSA Annual Plan Update (Draft) for FY24/25 states that CES began in 2017, underwent significant changes that started in FY 2022 and was fully implemented in FY 2023. The Housing Solution for Health Program (Alameda County Health Care Services Agency Office of Homeless Care and Coordination (OHCC)) Housing Services Office (HSO) and multiple subcontractors) stated in the report:

“Ongoing collaboration and coordination will be needed to ensure the maximum effectiveness of CES. Much larger investments in affordable and supportive housing are needed by multiple levels of government to ensure individuals with serious mental illness have a place to call home” (Page 106).

ACBHD Senior Executive Team stated that FSP clients are to receive priority from CES. The Independent Reviewer was not able to interview the housing staff during this initial review period but will consider doing so in subsequent on-site reviews. At this initial review, it is difficult to determine if this is the practice by CES.

Requirement: *If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.*

Requirement: *Permanent housing provided under this section II.2.o will be provided in the least restrictive and most integrated setting that is appropriate to meet individuals’ needs and preferences. (v). Nothing in this section II.2.o is intended to override an FSP client’s preferences.*

The Independent Reviewer heard in numerous interviews with ACBHD staff and community-based provider staff that housing is a challenging issue in Alameda County. In addition, the MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states a reoccurring theme in the community listening session was “address basic needs such as insecure housing” (Page 65). The report also states that housing and homelessness ranks as the number one concern for adults and older adults (Page 87).

During the community input period for this MHSA report, community members were asked to complete a 21-question survey. The following barriers to accessing mental health services from the survey were identified:

1. Resources, ranging from basic needs such as food and housing to behavioral and mental healthcare treatment, are in short supply.
2. If these resources are somehow available, then accessing them can be an arduous and difficult process.

3. Their responses speak to an overloaded, unfriendly system that does not currently meet their needs;
4. They also speak to a desire for a more friendly, efficient, and transparent method to access care.

The ACBHD Senior Executive Team reported that the County Housing Department used to be under ACBHD, but it was moved to the Office of the Health Agency Director. The Senior Executive Team reported that this change has been a challenge in serving their clients. The County does have a number of coordinated housing resource centers located throughout the county. ACBHD provided documentation of housing training from the Alameda County Office of Homeless Care and Coordination. In addition, the loss of Board and Care homes in the County and the subsequent loss of those beds, has also had an impact the housing situation. Community-based providers also reported on the difficulty in finding housing for their clients. One example provided was there is an affordable housing list but it has a minimum salary requirements which their clients cannot meet and thus do not have access to that housing.

Great Hope FSP (Adobe Services) reported the following in the MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026 regarding barriers to services:

“Difficulty in securing units under the changing Fair Market Rates (FMR). There was a decline in available and viable units within Alameda County. Landlords unwillingness to work with subsidized housing was also a challenge, discriminatory language or behaviors with landlords towards subsidized housing recipients was a contributing factor” (Page 132).

Strides Program (Telecare) reported the following challenges in the MHSA Annual Plan Update (Draft) for FY 24/25:

“FY22/23 was a time of great uncertainty due to the stressors of the global pandemic (increasing COVID outbreaks again), housing insecurity, increased risk of substance use, increase of hate crimes directed at vulnerable populations, increased cost of living, especially for housing and food. While all these factors impact our partners, the most challenging in the past year include the dangerous risk of overdose and death due to fentanyl and other street drugs, as well as increasingly complex psychiatric / medical presentations with our clients and the shortage of appropriate, supportive housing resources available.” (Page 137).

The MHSA Annual Plan Update (Draft) for FY24/25, identifies several recurring themes in numerous listening sessions. One theme identified was “housing continuum”. The plan lists the following strategies and solutions:

- “Increase prevention and early intervention programs to avoid homelessness.
- Provide safe/welcoming places with direct services and housing for those with mental health challenges, aiming to prevent additional trauma.

- Provide emergency housing lasting a minimum of 6 months, followed by long-term supportive housing.
- Support housing interventions with additional funding for operational support to meet the needs of the community that include comprehensive and wraparound services.
- Establish accountability and check-and-balance mechanisms in housing programs and services.
- Ensure transparency in decision-making processes related to housing” (Page 54).

Given the challenges in providing housing, both temporary and permanent, the Independent Reviewer expects the implementation of housing-related settlement provisions to require continued effort, including coordination across all relevant County entities including those that fund and support the development of affordable housing and/or have the authority to prioritize the delivery of existing housing to the population covered by the settlement. The Independent Reviewer notes that the County’s activities with respect to housing are confined to obligations with respect to FSP clients. It is noteworthy that ACBHD was just awarded \$14,040,909 from DHCS for Round 3 of the Behavioral Health Bridge Housing Program. The Independent Reviewer will examine the issue of both temporary housing and permanent housing in subsequent reports.

Summary of Full Service Partnership Findings

As stated previously, no substantial compliance was given for this initial report since the Settlement Agreement requires substantial compliance for six months and this report was produced only five months after the Effective Date of the Settlement Agreements. There were no non-compliant ratings given in this section.

Overall, there are sixteen service commitments in the Full Service Partnership section. There were ten service commitments that received a rating of partial compliance and six service commitments that were not applicable. There were no non-compliant ratings given in this section.

ACBHD achieved Partial Compliance for the following requirements:

1. *As used in this Agreement, one “slot” (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time. FSP will provide services necessary to attain the goals identified in each FSP recipients’ Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1). The Independent Reviewer needs to review more client records and other information regarding the ISSP.*
2. *Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person’s individualized goals and the Full Spectrum of Community Services necessary to attain those*

goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual. The Independent Reviewer needs to review more client records and interview clients regarding the ISSP.

3. *Services provided through FSPs will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals' needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.* While there was evidence regarding the flexibility of services, the Independent Reviewer needs to review more client records and interview clients.
4. *FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.* While there was evidence regarding the design of services, the Independent Reviewer needs to review more client records and interview clients.
5. *FSP programs will be implemented using high fidelity to the Assertive Community Treatment ("ACT") evidence-based practice, including that: (i) FSP programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals; (ii) FSP teams operate at a 1:10 mental health staff to client ratio.* While there was evidence regarding the use of the ACT model, the Independent Reviewer needs to review more client records and interview clients.
6. *FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.* While there was evidence of employment service being provided, the Independent Reviewer has not yet reviewed the fidelity assessment or results but will do so in subsequent reports.
7. *Housing: FSP clients will receive a housing need assessment and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency's Coordinated Entry System ("CES"), or through other County and community resources.* The Independent Reviewer may need to interview CES staff, interview FSP clients, and review a random sample of client records, for subsequent reports.
8. *As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.* The Independent Reviewer was not able to interview the housing staff

during this initial review period but plans to do so in subsequent on-site reviews. At this initial review, it is difficult to determine if this is the practice by CES.

9. *If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.* Given the challenges in providing housing, both temporary and permanent, the Independent Reviewer may need to continue to examine the issue of both temporary housing and permanent housing in subsequent reports.
10. *Permanent housing provided under this section II.2.o will be provided in the least restrictive and most integrated setting that is appropriate to meet individuals' needs and preferences. (v). Nothing in this section II.2.o is intended to override an FSP client's preferences.* Given the challenges in providing housing, both temporary and permanent, the Independent Reviewer may need to continue to examine the issue of both temporary housing and permanent housing in subsequent reports.

ACBHD achieved Not Applicable for the following:

1. *The County offers FSPs through community-based providers that provide services under the Community Services and Supports ("CSS") service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10. Within **two years** from the effective date, the County will add 100 FSP slots for adults and transition aged youth for a total of 1,105 FSP slots for that population.*
2. *Within **one year** from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the "FSP Assessment").*
3. *The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process.*
4. *The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment.*
5. *Based on the County's FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.*
6. *FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than **eighteen (18) months** after the Effective Date, the*

County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBHD contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.

SERVICE TEAMS (INTENSIVE CASE MANAGEMENT)

Service Teams are intended to provide services to adults with serious mental illness to decrease or diminish mental health symptoms in order for them to integrate into the community and avoid patterns of psychiatric hospitalization. Service teams are intended to serve adults ages 18 and above who have high utilization of emergency and/or urgent behavioral health systems.

Service Teams were assessed for this initial report through interviews with ACBHD staff, community-based provider staff and supervisors, reviewing the contracts between ACBHD and the community-based providers, reviewing policies and procedures, reviewing outcomes data provided by ACBHD, and reviewing two client records of individuals receiving Service Team services. During this first review period, the Independent Reviewer was not able to review additional records or to conduct a broad sampling across the various ACBHD client populations to identify systemic patterns. In addition, the Independent Reviewer was not able to interview clients receiving Service Team services to confirm that they receive services consistent with the requirements.

Requirement: *The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.*

ACBHD contracts with thirteen community-based providers for Service Teams for a total of 2,228 slots. The Independent Reviewer will verify the sustainability and durability of this requirement in the next report.

Requirement: *The County will explore community needs and opportunities for expanding Service Teams as appropriate.*

The FSP assessment will review data related to Service Team utilization. Service Team capacity and opportunity for expansion will be explored as appropriate.

Requirement: *Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and will be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.*

Data provided by ACBHD indicated that for FY 2022-23, the frequency of contacts was 2.9 contacts per month. Evidence was found in the contracts with community-based providers, policy and procedures, review of client records, and interviews with community-based provider staff and supervisors that a variety of services are provided to assist the client in attaining autonomy, and the services are provided in appropriate locations. A review of the contracts with community-based providers listed out the following services to be provided under Service Teams: mental health services, case management/brokerage, crisis intervention, and medication support.

ACBHD provided the following outcomes data for these clients in the chart below. Of clients who completed six consecutive months during the 12-month fiscal year, there was a 78 percent reduction in psychiatric hospital or crisis stabilization unit per the data provided by ACBHD. While this is not current data and it is unclear why the two fiscal years were combined, the Independent Review will continue to monitor the outcomes for future years and will provide a comparison in subsequent reports.

Discharge Years	Discharge	Percent Change Incarceration	Percent Change Hospital Days	Percent Change in ED Days
FY20/21 and FY21/22	916	-74%	-84%	-13%

Requirement: *Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.*

Evidence was found in the contracts with community-based providers, policy and procedures, review of client records, and interviews with community-based provider staff and supervisors that assistance with housing needs is provided. However, the Independent Reviewer was unable to confirm through broad records sampling and direct client interviews that Service Teams are receiving support and assistance to access temporary and permanent housing.

Summary of Service Team Findings

As stated previously, no substantial compliance was given for this initial report since the Settlement Agreement requires substantial compliance for six months and this report was produced only five months after the Effective Date of the Settlement Agreements.

Overall, there are four service commitments in the Service Teams (Intensive Case Management) component of the Settlement Agreement. ACBHD received partial compliance for three service commitments and not applicable for only one service commitment. There were no non-compliant ratings given in this section.

ACBHD achieved Partial Compliance for the following requirements:

1. *The County will maintain 2,168 slots to provide intensive case management through Service Teams.* While ACBHD contracts with thirteen community-based providers for Service Teams for a total of 2,228 slots, it is important to see that slots are maintained for more than six months.
2. *Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and will be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.* The Independent Reviewer needs to review more client records and interview clients who have received these services.
3. *Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.* The Independent Reviewer may need to interview CES staff, interview clients and review more client records for subsequent reports.

ACBHD achieved Not Applicable for the following requirement:

1. *The County will explore community needs and opportunities for expanding Service Teams as appropriate.* The FSP Assessment will include Service Teams utilization data and the due date for this is in the future.

OUTREACH, ENGAGEMENT, LINKAGES, AND DISCHARGE PLANNING

The Settlement Agreement outlines service components related to outreach, engagement, linkages, and discharge planning. Among other services, the services under this section relate to connecting individuals with the services they need to avoid unnecessary institutionalization and incarceration, and discharge planning from facilities such as John George Psychiatric Hospital, Santa Rita jail, and Villa Fairmont Rehabilitation Center.

Requirement: *The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.*

The first service commitment in this service component is to maintain a 24/7 telephonic ACCESS Line. This is also a DHCS requirement, and DHCS conducted test calls to the ACCESS line during their triennial review. The seven test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The results of the last triennial review were for FY 2022-23, DHCS made 7 test calls with the following results:

- In Compliance – 5 calls
- Partial Compliance – 2 calls

Partial compliance was given by DHCS since the County did not provide information about how to access specialty mental health services to the caller.

The MHSA Annual Plan Update (Draft) for FY24/25, identifies a number of recurring themes as identified by numerous listening sessions. One theme identified was “access, coordination and navigation to services” (Page 398).

Requirement: *The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS or its successor, in order to facilitate prompt and appropriate connection to services following an eligible individual’s contact with ACCESS.*

ACCESS staff collect demographic information, current symptoms, and historical information from the caller and then utilize a screening tool to determine eligibility for services. ACCESS teams do not complete the formal clinical assessment. Currently, ACCESS writes up a referral and sends that referral to the community-based provider who then contacts the client to schedule an intake appointment. The community-based providers reported that they then complete the clinical assessment. No evidence was found on real-time appointment scheduling, and no data on the timeliness, number, and location of assessments completed. However, the County is making meaningful efforts, which at present involve technological and other back-end improvements that would be the foundation for the system changes and data collection.

ACBHD currently has a pilot underway with Pathways to Wellness where ACCESS coordinates a call with Pathways to Wellness staff and connects the client to Pathways to Wellness in real time. The pilot is in its first year and data will be collected on the efficacy of this pilot.

The Independent Reviewer will assess additional evidence and provide more information on the progress of these efforts in subsequent reports.

Requirement: *When an individual with serious mental illness (1) is identified by the County through section 11.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBHD contracted entity for behavioral health services, the County or an ACBHD contracted community provider will determine the person’s eligibility for community-based behavioral health services and, unless the person can no longer be contacted or declines further contact, will provide a complete clinical assessment of the individual’s need for community-based behavioral health services (an “assessment”).*

The Independent Reviewer reviewed the following:

- Two client records,
- Policy and procedures,

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- Contracts with community-based providers and
- Interviewed ACCESS staff.

Evidence was found regarding partial compliance with this requirement. However, the Independent Reviewer will need to review additional client records and will report on this in subsequent reports to ensure the requirement is being implemented in practice and in a sustained and durable manner.

Requirement: *Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services. As discussed above, the County uses ACCESS to determine eligibility for community-based behavioral health services, and ACCESS refers individuals out to community-based providers for the clinical assessment.*

ACCESS determines eligibility of the individual and then refers the case to the appropriate community-based provider. ACBHD staff interviews plus the on-site review confirmed that ACCESS does make appropriate referrals to community-based providers. Community-based provider staff reported that they assign the case to the appropriate staff member and then initiate services promptly. The Independent Reviewer reviewed two client records and verified that the clinical assessment was in the record and the appropriate level of care was determined during the assessment. However, the Independent Reviewer will need to review additional client records and will report on this in subsequent reports to ensure the requirement is being implemented in practice and in a sustained and durable manner.

Requirement: *This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.*

Interviews with ACCESS staff plus the on-site review confirmed that ACCESS does make appropriate referrals to community-based providers. ACBHD did provide a report on when assessments are completed by the community-based provider and the number of hours of service provided. The Independent Reviewer was not able to interview clients to determine the length of time from their initial contact to ACBHD to when the community-based provider contacted them to complete the intake and assessment.

Requirement: *Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations. Following a quality review, the County will take appropriate action, if any is indicated, based on the results of the quality review, and the results will inform the County's FSP Assessment under Section II.2.c.*

Community-based providers, ACBHD staff, and ACBHD Senior Executive Team reported that there have not been any situations where a FSP team or Service Team were not available to take a case. It is also not tracked in the Quality Improvement Work Plan, but the Settlement Agreement does not require this. Interviews with ACBHD staff and community-based providers conducted during the on-site review reported that they have always been able to accommodate the client's needs for either FSP or Service Team. ACBHD has reported that they conducted an internal meeting with Quality Improvement, ACCESS, Utilization Management, and Adult and Older Adult System of Care to review if any client was unable to be assigned to an FSP or Service Team and there were no incidents to report. In future reports, the Independent Reviewer will assess additional evidence to ensure the requirement is occurring in practice and is being sustained in a durable manner.

Requirement: *Within two (2) years of the effective date of the Agreement, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.*

This requirement will be discussed in subsequent reports.

Requirement: *The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. In order to do so, this system will focus on factors that include, among others, whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), frequent hospitalizations for mental health reasons, and/or frequent incarcerations (and, in the case of incarcerations, received behavioral health services during an incarceration). The County will connect such individuals, as needed, to FSPs, Service Teams, or other community-based services. The County will use a culturally responsive, peer driven approach that builds on the person's strengths and goals and seeks to address the individual's concerns regarding treatment (including service refusals). Outreach and engagement will include frequent, in person contact in the field in locations convenient to the person. Outreach and engagement will include using the Familiar Faces program to identify and connect with individuals who do not follow up regarding services after experiencing a crisis. Beginning no later than **six (6) months** after the Effective Date, the County will track progress in connecting individuals to needed services.*

The Adult and Older Adult System of Care Director reported that the County has an Outreach and Engagement (O&E) team. Mobile crisis staff reported that there are three community-based providers who provide outreach and engagement services. The O&E Team do engage with individuals that are not currently receiving any services. The Interim Crisis Services System of Care reported that there is a Geriatric Assessment Response Team (GART) that can receive referrals from the public, the calls will be

screened for both clinical needs and the consumer's health insurance coverage according to professional best practices.

The ACBHD contract for those community-based providers requires that the staff conduct the outreach in the client's natural environment. Evidence was found in policy and procedures along with interviews with community-based providers that individuals are connected to FSP, Service Teams or appropriate community-based services as needed. In future reports, the Independent Reviewer will assess additional evidence to ensure the requirement is occurring in practice and is being sustained in a durable manner.

ACBHD did provide their tracking log of high inpatient and subacute utilizers. The Independent Reviewer will need to follow up on ACBHD's system for tracking whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), and/or frequent incarcerations and, in the case of incarcerations, received behavioral health services during an incarceration.

ACBHD reported that Familiar Faces is a program that will conduct outreach and engagement activities, and this program went live in FY 2019-20. The Independent Reviewer will review this program in subsequent reports.

Requirement: *The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact, and will coordinate with these entities to rapidly connect individuals to those services as appropriate.*

Evidence was found of information and education provided to, or coordination with, criminal justice entities for rapid connection to community-based services. ACBHD provided examples of training and educational material that are used to educate providers about alternatives to incarceration, arrest and law enforcement contact. The Forensic, Diversion and Re-entry Services Director reported that there are multiple meetings with the Sheriff's Office.

Requirement: *The County will provide information and education to ACBHD-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.*

Evidence was found of information and education provided to, or coordination with, criminal justice entities for rapid connection to community-based services. ACBHD provided many examples of training material that are used to educate providers about available services. Some of these training topics were as follows: overview of working

with participants in the criminal justice field, ACT, crisis services, youth justice, and re-entry mental health programs. Interviews with community-based provider staff confirmed that there is coordination with ACBHD regarding rapid connection to community-based services as an alternative to hospitalization or incarceration. The Independent Reviewer will provide more information regarding this rapid connection process in a subsequent review.

Requirement: *The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).*

ACBHD has the following four In Home Outreach Teams (IHOT):

- One Transitional Age Youth (TAY) County-wide team and
- Three adult teams based on region.

The TAY IHOT team is comprised of a clinician, two peer providers, and one family member provider. The Adult IHOT teams are comprised of one licensed team lead, a case manager, a peer provider and a family member provider. All teams provide family members support and education. The purpose of IHOT is to outreach and engage individuals who have historically been difficult to engage into services. IHOT also provides linkages with services that address serious mental health issues and substance use. Law enforcement may refer to IHOT as described in the IHOT Operations Manual and in the ACBHD contract scope of work. In future reports, the Independent Reviewer will assess additional evidence to ensure the requirement is occurring in practice and is sustained in a durable manner.

IHOT (Adobe Services) reported the following challenges in the MHSA Annual Update (Draft) for FY 24/25:

“If the client is homeless, major challenges have been locating said client, or giving a referral from a source that has never met said client and cannot do a warm introduction or provide accurate whereabouts. Overall, given the short timeframe to introduce services and produce positive results can be unfeasible at times due to inadequate rapport building and clients' distrust in mental health resources and county systems, which often times stem from a history of involuntary hospitalization and/or incarceration. These factors can lead to the team struggling to find an ethical discharge plan and may result in clients being enrolled in the program outside of set timeframes” (Page 242).

Requirement: *The County will ensure that people with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within **two years** of the Effective Date.*

This requirement will be discussed in subsequent reports.

Requirement: *In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases (“IMDs”). “IMD” as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman*
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Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review (“UR”) pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual’s needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess appropriateness for discharge in light of community-based services appropriate to the individual.

This requirement will be discussed in subsequent reports.

Requirement: *Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual’s discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual’s needs, consistent with the individual’s preferences. As part of assisting individuals to transition to the most integrated setting appropriate, appropriate community-based services will be identified. Where applicable and with the individual’s (and, when relevant, his or her legal representative’s) consent, FSP and Service Team providers will participate in the discharge planning process.*

Discharge begins at intake per community-based provider staff interviewed, and per the ACBHD contract. ACBHD provided examples of contracts that require the placement be of a less-intensive level of care and includes the appropriate referrals to community-based providers. Community-based provider staff interviewed reported that they participate in the discharge planning process. Interview with Adult and Older Adult System of Care Director indicated that there is an acute care coordination meeting every week. The purpose of this meeting is to review cases and to monitor the client’s progress and transition to a different level of care, as appropriate. In future reports, the Independent Reviewer will assess additional evidence, including individual client interviews, and client records sampling, to ensure the requirement is occurring in practice and is sustained in a durable manner.

Requirement: *If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or designee) will be notified, and the County will work to arrange such services as promptly as possible.*

Community-based providers, ACBHD staff, and ACBHD Senior Executive Team reported that there have not been any situations where a FSP team or Service Teams were not available to take a case. While it is not required by the Settlement Agreement, this issue is not tracked in the Quality Improvement Work Plan where any of these situations could be monitored on a regular basis for a quality assurance perspective. Interviews with ACBHD staff and community-based providers conducted during the on-site review reported that they have always been able to accommodate the individual’s needs for either FSP or Service Team.

Requirement: *The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.*

Interview with Adult and Older Adult System of Care Director indicated that there is an acute care coordination meeting every week. The purpose of this meeting is to review cases and to monitor the client's progress and transition to a different level of care, as appropriate. In future reports, the Independent Reviewer will assess the notification process and how services are resumed upon discharge.

Requirement: *Linkages for Services Following Discharge from John George PES and Inpatient. The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5. The County will collaborate with John George to support John George's safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate, including through ACBHD's critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services.*

*Beginning no later than **eighteen (18) months** after the Effective Date, the County's role in this collaboration will include, to the fullest extent reasonably practicable: (1) using available data to promptly identify individuals registered by John George who are both (a) likely to be, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration, and (b) likely to be eligible for and in need of FSP or Service Team services; (2) upon identification, to the extent that the individual has not yet been discharged, promptly coordinate with John George to determine whether the individual is eligible for and in need of any such services; and (3) if the individual is eligible for and in need of any such services and to the extent that the individual has not yet been discharged, promptly connecting the individual to an FSP or Service Team to commence engagement, which may include participation in discharge planning and commencement of services upon the individual's discharge.*

Community-based providers, ACBHD staff, and ACBHD Senior Executive Team reported their relationship has improved with John George. The Adult and Older Adult System of Care Director reported that they now have access to John George's electronic health record which indicates progress, and they receive client updates twice a week now.

John George has three units for a total of 69 beds and an additional 11 beds for Psychiatric Emergency Services (PES) for a grand total of 80 beds. Overall, the ACBHD Senior Executive team and ACBHD staff reported that their relationship with John George Hospital has improved recently. ACBHD Senior Executive Team reported that ACBHD staff are invited to participate in the discharge process.

There are portions of this requirement that are not due to begin until eighteen months from the effective date of the Settlement Agreement and will be discussed in a subsequent report.

Requirement: *The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual's FSP or Service Team (if any) in the discharge planning process and, with respect to patients determined eligible for and in need of such services under section II.4.k.ii above, invite and actively include representatives of the County or a County-contracted community based service provider in the discharge planning process. To the fullest extent reasonably practicable and within the direct control of the County and its community-based service providers, and with the individual's consent, the County will ensure that: (1) representatives of the FSP or Service Team are included in the discharge planning process for those individuals who are assigned to or are clients of a County FSP or Service Team; and (2) representatives of the County or a County contracted community-based service provider are included in the discharge planning process for those individuals who are not assigned to an FSP or Service Team but who have been identified as eligible for an FSP or Service Team under section II.4.k.ii above. To the extent that John George routinely does not include such representatives in the discharge planning process, the County will seek to identify and reasonably address barriers to John George's inclusion of such representatives in discharge planning.*

The ACBHD Senior Executive Team and ACBHD staff reported that their relationship with John George Hospital has improved recently. ACBHD Senior Executive Team reported that ACBHD staff are invited to participate in the discharge process. The Senior Executive Team also reported that the goal is for prompt connection to community-based services. There are two Critical Care Managers that assist with acute inpatient care coordination between the following: acute and subacute, acute and crisis residential, inpatient and outpatient, and discharge planning. John George attends the weekly care coordination meeting and care conferences, as needed. The Independent Reviewer will follow up on the attendance and frequency of meetings regarding the discharge process.

The Adult and Older Adult System of Care Director reported that they are creating a transition team to engage with the client in the hospital and to assist with their transition back into the community. This new team is not operational yet. The Independent Reviewer will continue to monitor this requirement and will include this in subsequent reports.

The chart below is the number of clients served based on data during FY 2022-23.

Service Modality	Number of Episodes	Number of Clients
Crisis Stabilization	8,584	4,270
Hospital	2,304	1,564

Requirement: *Beginning no later than **eighteen (18) months** after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital to promptly identify individuals with serious mental illness who are discharged to the community and who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration in accordance with section II.4.e. and will comply with its obligations under section II.4.c.*

This requirement will be discussed in subsequent reports.

Requirement: *The County will use programs designed to reach individuals who do not follow up regarding services.*

The Adult and Older Adult System of Care Director reported that the County has an Outreach and Engagement(O&E) team. There are also three community-based providers who provide outreach and engagement services. One example is from BACS, a community-based provider, who has an Assertive Outreach Protocol for clients who do not engage or follow-up for services. This protocol requires the community-based provider staff to continue outreach and engagement efforts for minimum of 90 days from the last date of service. In future reports, the Independent Reviewer will assess additional evidence to ensure services are designed to achieve the outcomes described in the above requirement.

Requirement: *The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP’s or Service Team’s prompt resumption of services upon discharge.*

The Adult and Older Adult System of Care Director reported that they now have access to John George’s electronic health record, and they receive client updates twice a week now. Further, the new Transition of Care team will assist with notification of FSPs and Service Teams when their clients are at John George. The Independent Reviewer will monitor this requirement and will discuss this in subsequent reports.

Requirement: *Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v. County of Alameda Consent Decree (including section III.I, “Discharge Planning,” page 49:13-51:18). The County will ensure that ACBHD collaborates with the County Sheriff’s*

office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.

The Forensic, Diversion and Re-entry Services Director reported that there are multiple meetings with the Sherriff's Office. For example, leadership meets twice a month, re-entry staff meet weekly and suicide risk meets monthly. The Director reported that there are two dedicated FSP teams that are through contracts with community-based providers. There is also one re-entry team, and this team will refer to community-based services. The Director also described the Community Assessment, Referral and Engagement Services (C.A.R.E.S) program. This program diverts individuals away from jail and the criminal justice system and into supportive services and referrals are from law enforcement.

Requirement: *Beginning no later than **eighteen (18) months** after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.*

This requirement will be discussed in subsequent reports.

Requirement: *Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.*

The ACBHD Senior Executive Team and community-based staff and supervisor reported that there has not been a situation where services were not available. However, this requirement was not due during this reporting period, it will be discussed further in subsequent reports.

Requirement: *With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any, based on the results of the evaluation in section II.4.i.ii. and the quality reviews in section II.4.I.iii. Where appropriate, the results of the quality reviews under section II.4.I.iii will inform the County's FSP Assessment under section II.2.c.*

This requirement will be discussed in subsequent reports.

Requirement: *The County will use programs designed to reach individuals who do not follow up regarding services, consistent with section II.4.e.*

The Forensic, Diversion and Re-entry Services Director reported that there is one re-entry team who follows-up with these individuals. In future reports, the Independent Reviewer will assess additional evidence to ensure services are designed to achieve the outcomes described in the above requirement.

Summary of Outreach, Engagement, Linkages, and Discharge Planning Findings

As stated previously, no substantial compliance was given for this initial report since the Settlement Agreement requires substantial compliance for six months and this report was produced only five months after the Effective Date of the Settlement Agreements.

This is the largest service commitment in the Settlement Agreement. Overall, there are twenty-six service commitments in the Outreach, Engagement, Linkages and Discharge Planning component of the Settlement Agreement. ACBHD received partial compliance for sixteen service commitments and a rating of not applicable for ten service commitment. There were no non-compliant ratings given in this section.

ACBHD achieved Partial Compliance for the following requirements:

1. *The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.* There is evidence to support this requirement, but the Independent Reviewer needs to examine again after six months.
2. *The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS, in order to facilitate prompt and appropriate connection to services.* While the County is making meaningful efforts on this requirement, the Independent Reviewer will provide more information on the progress of these efforts in subsequent reports.
3. *When an individual with serious mental illness (1) is identified by the County through section II.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBHD contracted entity for behavioral health services, the County or an ACBHD contracted community provider will determine the person's eligibility for community-based behavioral health services and, will provide a complete clinical assessment.* The Independent Reviewer will need to review additional client records and other information for subsequent reports.
4. *Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services.* The Independent Reviewer will

need to review additional client records and other information for subsequent reports.

5. *This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.* The Independent Reviewer will need to review additional client records and other information for subsequent reports.
6. *The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.* Evidence was found on the collaboration and with providing education and training to the justice system. However, the Independent Reviewer will need to verify that this process is continuing and is maintained.
7. *The County will provide information and education to ACBHD-contracted behavioral health providers and will coordinate with these entities to rapidly connect individuals to those services as appropriate.* Evidence was found of information and education provided to, or coordination with, criminal justice entities for rapid connection to community-based services. But the Independent Reviewer will need to obtain additional information on the rapid connection process.
8. *The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).* While there is evidence of steps taken by ACBHD, the Independent Reviewer will need to interview IHOT staff for a subsequent report.
9. *Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual’s discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual’s needs, consistent with the individual’s preferences.* While there was evidence of discharge planning, the Independent Reviewer will need to examine this process more fully in subsequent reviews.
10. *If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or designee) will be notified, and the County will work to arrange such services as promptly, as possible.* There was evidence that ACBHD has always been able to provide FSP or Service Team services, the Independent Reviewer will request additional information on how ACBD tracks this requirement.
11. *The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.* While there

is evidence of care coordination occurring, the Independent Reviewer will need to explore this issue more fully in subsequent reports.

12. *The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual's FSP or Service Team (if any) in the discharge planning process and, invite and actively include representatives of the County or a County-contracted community based service provider in the discharge planning process.* There is evidence of the care coordination, the Independent Reviewer will continue to monitor this requirement and will report on it in subsequent reports.
13. *The County will use programs designed to reach individuals who do not follow up regarding services.* While there is evidence to support the follow up regarding services, the Independent Reviewer will need to interview the Outreach and Engagement Team in a subsequent report.
14. *The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP's or Service Team's prompt resumption of services upon discharge.* The Independent Reviewer will monitor this requirement and will discuss this in subsequent reports.
15. *The County will ensure that ACBHD collaborates with the community's office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.* There is evidence to support this requirement, the Independent Reviewer needs to examine this process for subsequent reports.
16. *The County will use programs designed to reach individuals who do not follow up regarding services, consistent with Section II.4.e.* While there is evidence to support compliance with this requirement, the Independent Reviewer will need to interview O&E staff for subsequent reports.

ACBHD achieved Not Applicable for the following:

1. *Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations.*
2. *Within **two (2) years** of the effective date of the Agreement requires ACBHD to, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.*
3. *The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons*

*related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. Beginning no later than **six (6) months** after the Effective Date, the County will track progress in connecting individuals to needed services.*

- 4. The County will ensure that individual's with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within **two years** of the Effective Date.*
- 5. In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases ("IMDs"). "IMD" as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within **12 months** of the effective date of this Agreement, the County will begin initial implementation of a utilization review ("UR") pilot program.*
- 6. The County will collaborate with John George to support John George's safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate. Beginning no later than **eighteen (18) months** after the Effective Date, the County's role in this collaboration will include, (1) using available data and likely to be eligible for FSP or Service Team services; (2) upon identification, promptly coordinate with John George; and (3) if the individual is eligible, promptly connecting the individual to an FSP or Service Team.*
- 7. Beginning no later than **eighteen (18) months** after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital.*
- 8. Beginning no later than **eighteen (18) months** after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.*
- 9. Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.*
- 10. With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any,*

based on the results of the evaluation in section and the quality reviews in section II.4.1.iii.

CULTURALLY RESPONSIVE SERVICES

The Settlement Agreement outlines the service components under Culturally Responsive Services which include the County continuing ensure that all services are culturally responsive and are person-centered. In Alameda County, Culturally Responsive Services is organized under the Office of Health Equity with a Director who reports directly to the Behavioral Health Director. The Independent Reviewer was able to interview this Director, the Behavioral Health Director and ACBHD's Senior Executive Team.

Requirement: *The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. The County will continue to provide and expand culturally responsive behavioral health services, including through community-based and peer-run organizations, and will continue to identify and implement culturally and linguistically appropriate and affirming strategies and practices to help reduce behavioral health disparities across racial, ethnic, cultural, and linguistic groups.*

ACBHD developed a strategic plan that was issued on April 22, 2024, with seven themes and strategic directions. There are two goals in this plan that are related to Culturally Responsive Services. The first goal is to uplift community assets for policy/program development and the second goal is to increase equitable care for communities facing the greatest inequities through outreach, recruitment, and programs and opportunities for improvement especially for diverse Asian, Black, and LGBTQIA2S+ communities.

ACBHD has a Cultural Competence Plan (CCP), 2023. The plan describes the following:

- Vision: We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.
- Mission: To support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.
- Values: Access, consumer and family empowerment, best practices, health and wellness, culturally responsive, and socially inclusive.

The MHSA Annual Plan Update (Draft) for Fiscal Year 2024 through 2025 includes the goal of being culturally responsive which is defined as follows:

“We honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service setting, treatment options, and in the processes, we use to engage our communities” (Page 10).

The MHSA Annual Plan Update (Draft) for FY24/25, identifies several recurring themes as identified by numerous listening sessions. One theme identified was “Access, Coordination and Navigation to Services”. The plan lists two strategies and solutions related to cultural competency which are as follows:

- Prioritize bilingual services to support multiple languages in the growing client base and improve accessibility for diverse communities.
- Implement culturally sensitive and appropriate outreach strategies to effectively engage diverse communities (Page 53).

Interviews with both ACBHD staff and community-based provider staff indicated that the services provided are culturally responsive and person centered. The Independent Reviewer was able to review a number of client records where the client’s goals are identified and were developed in a manner consistent with a person-centered approach. However, it is difficult to draw any substantial conclusions due to the small number of client records reviewed and the lack of formal client interviews.

The MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states that three of the reoccurring themes in the community listening session were as follows: “More services for the African American community across the lifespan; supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers and; and the need for increased language capacity” (Page 65).

Alameda has six threshold languages as defined by DHCS Information Notice #20-070. The most prevalent threshold language is Spanish. The CCP includes a snapshot of data from the FY2022-23, and the largest ethnic group served in their system are Other/Unknown and White, followed by Black or African American. The smallest group within their system of care is Alaska Native or American Indian. The CCP also states that there is a “high penetration rate among African Americans, who receive care in the most severe forms of mental health treatment. (Cultural Competency Plan, 2023, Page 8).

According to the External Quality Review Organization (EQRO) report for FY2023-24, African American and Asian/Pacific Islander members are the only racial/ethnic groups with penetration rates lower than statewide penetration rates. The EQRO report also provided a breakdown for each ethnicity and penetration rate as follows:

ACBHD Mental Health penetration rate of Members Served by Race/Ethnicity, Calendar Year 2022

Race/Ethnicity	Total Members Eligible	Number of Members Served	ACBHD Penetration Rate	Statewide Penetration Rate
Hispanic/Latino	137,869	5,005	3.63%	3.51%
Other	127,820	5,017	3.93%	3.57%
Asian/Pacific Islander	99,830	1,433	1.44%	1.91%
African American	70,740	4,937	6.98%	7.08%
White	44,728	2,483	5.55%	5.45%
Native American	1,066	74	6.94%	5.94%

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ACBHD also conducts a Cultural Responsiveness Committee (CRC) and the community-based providers also reported that the County staff, community-based providers staff, and stakeholders attend these meetings. The Independent Reviewer did review the minutes of the March 19, 2024, meeting which was facilitated by the Health Equity Policy and Systems Manager. During the meeting, the CCP is discussed along with announcements and upcoming events of interest.

In future reports, the Independent Reviewer will assess additional evidence, including data, individual client interviews, and client records sampling, to ensure the requirement is occurring in practice and is being sustained in a durable manner.

Requirement: *The County will continue to operate the Office of Health Equity within ACBHD, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBHD, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client centered care that considers the whole person and all their needs.*

ACBHD provided an organizational chart that indicates that the Director, Office of Health Equity reports directly to the ACBHD Director. The Independent Reviewer interviewed the Director, Office of Health Equity. This department also includes Ethnic Services, Peer Support Services and Family Empowerment Services. The department also oversees operations related to Patients’ Right Advocacy.

In December 2023, ACBHD conducted a listening session with the Executive Team at the LGBTQ Center in Oakland and learned more about the needs of its clients and the LGBTQ Community. This was reported in the MHSA Annual Plan Update (Draft) for FY 24/25 which included the following:

“They are seeing a need for more programs to address social isolation in the elderly population. The housing being developed is not created with LGBTQ concerns in mind and accommodations for the LGBTQ community are leading to displacement from new developments. Also, needs for LGBTQ people in homeless encampments need to be addressed due to rising threats and

violence. HIV is an ongoing problem that is receiving less resources but still needs to be addressed. Overall, the LGBTQ Center is looking to bring on a care navigator and would like to continue to participate in county programs” (Page 441).

Requirement: *No later than **fifteen (15) months** after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity’s public internet website setting forth aggregated data metrics on the populations served by ACBHD (including individual racial and ethnic groups broken down by geographic area within the County) and various communities’ service needs (including racial and ethnic groups’ needs for FSP, Service Team, and IHOT services in geographic areas within the County.*

ACBHD has already begun to work on the dashboard and expects to have it uploaded to their website by February 2025. Subsequent reports will address this further.

Requirement: *The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services in the County. The Health Equity Officer will periodically make recommendations to the Director of ACBHD on how to improve culturally responsive services in the County and coordinate with the County’s other diversity, equity, and inclusion programs and activities.*

This will be discussed in subsequent reports since this requirement is not due at this time.

Requirement: *The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County’s service delivery system. The African American Wellness Hub facility will serve as a hub and coordinating center for a variety of behavioral health services, community-based supports, and linkages for the Black/African American community in the County. The County will provide opportunities for community and stakeholder engagement over the course of this project to further the project’s focus on providing culturally inclusive, respectful, and relevant supports to the County’s Black/African American clients and community.*

The County is to support the African American Wellness Hub and the Health Equity Division Director reported that the County has found a building and they recently closed escrow on the building. ACBHD conducted community listening sessions in April and May of 2023. The African American Wellness Hub will serve as a focal point designed to preserve and actualize the core understanding and best practices of African American people with a focus on wellness. The County has dedicated \$19 Million

dollars towards this effort. The Independent Reviewer will continue to monitor this and report on the progress in subsequent reports.

Requirement: *The County has implemented and will continue to provide periodic and ongoing trainings to all ACBHD staff and ACBHD-contracted community-based providers regarding: culturally responsive services; trauma-informed care; inequities across race, ethnicity, sex, sexual orientation, gender identity, and disability; anti-racism and implicit bias. A primary intent of such trainings is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.*

Training is provided upon hire and throughout the year. The ACBHD Health Equity Division Director reported that training is under the purview of the Office of Ethnic Services within ACBHD Department in collaboration with the Workforce and Education Team. The Health Equity Division Director also reported that the County has a contract with ONTRACK to provide the CLAS training and offers training each month. For the community-based providers, the following language was found in their contract with ACBHD: “Contractor shall maintain staffing with professional experience and expertise in providing evidence-based, culturally, and linguistically appropriate services, particularly for any designated priority populations that Contractor has agreed to serve. Contractor shall ensure annual training of all applicable employees.”

The Independent Reviewer will request additional information such as training topics and number of attendees for subsequent reports.

Summary of Culturally Responsive Services Findings

As stated previously, no substantial compliance was given for this initial report since the Settlement Agreement requires substantial compliance for six months and this report was produced only five months after the Effective Date of the Settlement Agreements.

Overall, there are six service commitments in the Culturally Responsive Services component of the Settlement Agreement. ACBHD received partial compliance for three service commitments and a rating of not applicable for three service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Partial Compliance for the following requirements:

1. *The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. While there is evidence to support compliance with this requirement, the Independent Reviewer will continue to monitor the County’s ongoing efforts and will report on these efforts in subsequent reports.*
2. *The County will continue to operate the Office of Health Equity within D, will report to the Director of ACBHD, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders and to ensure clients receive high quality and client*

centered care that considers the whole person and all their needs. While there is evidence to support compliance with this requirement, the Independent Reviewer will need to continue to monitor the stakeholder engagement and will need to interview clients who have received services.

3. *The County has implemented and will continue to provide periodic and ongoing training to all ACBHD staff and ACBHD-contracted community-based providers. The primary intent of such training is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.* While there is evidence of the training provided, the Independent Reviewer will request additional information such as training topics and number of attendees for subsequent reports.

ACBHD achieved Not Applicable for the following:

1. No later than **fifteen (15) months** after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than **one month** before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website.
2. The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services in the County.
3. The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County's service delivery system. The County has found a building and they recently closed escrow on the building.

SUMMARY AND RECOMMENDATIONS

This is the first initial report from the Independent Reviewer regarding the Settlement Agreement between the County of Alameda and ACBHD with Disability Rights California (DRC), and the United States Department of Justice (DOJ) which became effective on January 31, 2024. ACBHD has been very cooperative in providing the information requested by the Independent Reviewer.

A rating of partial compliance was given in 62.5 percent of the service commitments and a rating of not applicable was given for 37.5 percent of the service commitments.

This is the first report on the progress towards compliance with the Settlement Agreement and there has not been enough time for the County and ACBHD to implement everything in the Settlement Agreement nor for the Independent Reviewer to

gather and review all of the necessary evidence. As stated previously, the Settlement Agreement defined substantial compliance when the requirement has been sustained and durable for a period of no less than six months. Because the on-site review occurred after four months of the effective date and the draft of this report was due in five months, no substantial compliance ratings were given. Therefore, it should be noted that in some cases, this is not a reflection of the County's compliance with the requirements.

The Independent Reviewer will continue to evaluate implementation of all provisions. The Independent Reviewer will also verify if the requirements were sustained after six months and durable in the next report for any of the partial compliance ratings given. The Independent Reviewer will also monitor the implementation of any of the requirements given a not applicable rating if the deadline is during the next report.

The next report is to be submitted 14 months after the effective date of the Settlement Agreement. The Independent Reviewer would like to focus the next on-site visit on a tour of John George, interviewing FSP participants, a ride along with the mobile crisis team, reviewing additional client records, and touring other ACBHD contracted community-based providers. The Independent Reviewer will also monitor the implementation and results of both the Mobile Crisis Assessment and the FSP assessment.

Recommendations:

1. ACBHD currently collects a lot of data, but data is not a requirement of the Settlement Agreement. However, reviewing data can indicate compliance with a requirement and thus plays an important role in the determination of compliance. The Independent Reviewer will work with ACBHD to identify appropriate and/or alternative sources of data and evidence and will examine if the data can be collected for future reports to ensure the requirements are occurring in practice and is being sustained in a durable manner.
2. ACBHD also identified the need to expand CSU, CRT, peer respite, and mobile crisis teams. ACBHD will continue to monitor the implementation of Prop1 as some of these facilities may qualify for funding. In addition, it will be important to review the results of the Mobile Crisis Assessment to assist with expansion of crisis services.
3. The crisis services continuum of care seems to be disjointed and not coordinated. Along with the findings of the mobile crisis assessment, ACBHD should consider ways to coordinate their services. This includes a determination for which model of mobile crisis should respond to particular types of crisis situations.

4. ACBHD should monitor FSP services to make sure that the services are provided with high fidelity to the ACT model and that the needed frequency, intensity, and quality of services is being provided. The FSP assessment and implementation of Prop1 may help with this issue.
5. The Settlement Agreement requires FSP participants to receive a housing assessment. ACBHD should consider developing a formal housing assessment with collaboration from their community-based providers, ACBHD could then collaborate with CES to make sure their clients are receiving priority from CES.
6. ACBHD should examine the possibility of implementing real time scheduling within their systems of care so that clients do not have to wait for a call back to receive access to services. ACBHD currently has a pilot underway with Pathways to Wellness where ACCESS coordinates a call with Pathways to Wellness staff and connects the client to Pathways to Wellness in real time. The pilot is in its first year and data will be collected on the efficacy of this pilot.
7. ACBHD should continue to work with John George and Santa Rita jail to ensure a warm hand-off to community based services. The new transition team should be able to assist with care coordination, but this team will not be implemented for another year.

Attachment 1: Ratings of Service Commitments

SERVICE COMMITMENT	RATING ³
1. Crisis Services	
1.a. The County will continue to offer a countywide crisis system and expand crisis intervention services.	PC
1.a.i. Maintain a 24/7 crisis hotline. The crisis hotline will provide screening and de-escalation services on a 24/7 basis. No later than 18 months after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis.	NA
1.a.i. (2) The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available), to ensure there is “no wrong door” for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmlines to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.	PC
1.a.i.(3) The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.	NA
1.a.ii.(1) Mobile crisis teams will provide a timely in-person response to resolve crisis as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.	PC
1.a.ii.(2) Mobile crisis services shall be provided with the purpose of reducing, to the greatest extent possible, interactions with law enforcement during mental health crisis, reducing 5150 and John Geoge psychiatric emergency services (PES) placement rates, and increasing the use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkages to services).	PC
1.a.ii.(3) The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams and agrees to maintain this as a minimum capacity.	PC
1.a.ii. (4) The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than one year after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”). The Mobile Crisis Assessment will be informed by and will appropriately take into account (i) community and stakeholder input; and (ii) all necessary data and information sufficient to assess the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.	NA
1.a.ii.(5)The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer (see section III.1.a of this Agreement) for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the Mobile Crisis Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final Mobile Crisis Assessment will promptly be made available to the public.	NA

³ Due to the temporal limitations of this report, a rating of substantial compliance was not yet possible. First Six Months Report August 7, 2024

1.a.ii.(6) Based on the County’s Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.	NA
1.a.ii.(7) FSPs will provide crisis intervention as set forth in section II2.m. in this Agreement.	PC
1.a.ii.(8) Each mobile crisis team shall include at least one mental health clinician.	PC
1.a.iii. Trained peer support specialist shall be part of the County’s crisis service team and shall be included in outreach and engagement functions.	PC
1.b.i. Maintain 45 crisis residential treatment (CRT) beds.	PC
1.b.ii. Within two years of the effective date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based providers to add a mixture of 25 additional CRT and/or peer-respite beds.	NA
1.b.iii. A purpose of CRT facilities and peer-respite is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization. CRT facilities and peer-respite homes are intended to be used by people experiencing or recovering from a crisis due to their mental health disability for short-term stays and to provide support to avoid escalation of a crisis. CRT facilities and peer-respite homes are unlocked.	PC
1.b.iv. Peer staff will be on-site 24/7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.	NA
1.b.v. Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.	PC
1.b.vi. CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis.	PC
1.c. The County’s crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.	PC
2. Full-Service Partnerships (FSP)	
2. a. and b. The County offers FSPs through community-based providers that provide services under the Community Services and Supports (“CSS”) service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10. Within two years from the effective date, the County will add 100 FSP slots for adults and transition aged youth for a total of 1,105 FSP slots for that population. The County will utilize the FSP slots that are added under this Agreement to serve individuals 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.	NA
2.c. Within one year from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the “FSP Assessment”).	NA
2.d. The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to: i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services; ii.	NA

Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment, and length of time from identification to enrollment; iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups; and iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.	
2.e. The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before finalizing the County's FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.	NA
2.f. Based on the County's FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.	NA
2.g. and h. As used in this Agreement, one "slot" (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time. FSP will provide services necessary to attain the goal identifies in each FSP recipients' Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1).	PC
2.i. Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person's individualized goals and the Full Spectrum of Community Services necessary to attain those goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual.	PC
2.j. Services provided through FSP will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals' needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.	PC
2.k. FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.	PC
2.l. FSP program will be implemented using high fidelity to the Assertive Community Treatment (ACT) evidence-based practice, including that: (i.) FSP	PC

programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals. (ii.) FSP teams operate at a 1:10 mental health staff to client ratio.	
2.m. FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than eighteen (18) months after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBH contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.	NA
2.n. FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.	PC
2.o. Housing: The Parties recognize that permanent, integrated, stable housing with Housing First principles is critical to improving treatment engagement and supporting recovery. (i.) FSP clients will receive a housing needs assessment, and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency's Coordinated Entry System ("CES"), or through other County and community resources.	PC
2.o.ii. As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.	PC
2.o.iii. If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this Agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.	PC
2.o.iv. and v. Permanent housing will be provided in the least restrictive and most integrated setting that is appropriate to meet the needs and preferences. Nothing in this section II.2.o is intended to override an FSP client's preferences.	PC
3. Service Teams (Intensive Case Management)	
3.a. The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.	PC
3.b. The County will explore community needs and opportunities for expanding Service Teams as appropriate.	NA
3.c. Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.	PC

3.d. Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.	PC
4. Outreach, Engagement, Linkages, and Discharge Planning	
4.a. The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.	PC
4.b. The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS or its successor, in order to facilitate prompt and appropriate connection to services following an eligible individual’s contact with ACCESS.	PC
4.c. When an individual with serious mental illness (1) is identified by the County through section II.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBH contracted entity for behavioral health services, the County or an ACBH contracted community provider will determine the person’s eligibility for community-based behavioral health services and, unless the person can no longer be contacted or declines further contact, will provide a complete clinical assessment of the individual’s need for community-based behavioral health services (an “assessment”).	PC
4.c.i. Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team’s caseload to commence the provision of services.	PC
4.c.ii. This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.	PC
4.c.iii. Beginning no later than 6 months after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations. Following a quality review, the County will take appropriate action, if any is indicated, based on the results of the quality review, and the results will inform the County’s FSP Assessment undersection II.2.c.	NA
4.d. Within two years of the effective date of the Agreement, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County’s behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.	NA
4.e The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. In order to do so, this system will focus on factors that include, among others, whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), frequent hospitalizations for mental health reasons, and/or frequent incarcerations (and, in the case of incarcerations, received behavioral health services during an incarceration). The County will connect such individuals, as needed, to FSPs, Service Teams, or other community-based services. The	NA

<p>County will use a culturally responsive, peer driven approach that builds on the person’s strengths and goals and seeks to address the individual’s concerns regarding treatment (including service refusals). Outreach and engagement will include frequent, in person contact in the field in locations convenient to the person. Outreach and engagement will include using the Familiar Faces program to identify and connect with individuals who do not follow up regarding services after experiencing a crisis. Beginning no later than six (6) months after the Effective Date, the County will track progress in connecting individuals to needed services.</p>	
<p>4.f The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.</p>	PC
<p>4.g. The County will provide information and education to ACBHD-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.</p>	PC
<p>4.h. The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).</p>	PC
<p>4.i. The County will ensure that people with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within two years of the Effective Date</p>	NA
<p>4.j.i and ii. In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases (“IMDs”). “IMD” as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review (“UR”) pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual’s needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess appropriateness for discharge in light of community-based services appropriate to the individual.</p>	NA
<p>4.j.iii. Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual’s discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual’s needs, consistent with the individual’s preferences. As part of assisting individuals to transition to the most integrated setting appropriate, appropriate community-based services will be identified. Where applicable and with the individual’s (and, when relevant, his or her legal representative’s) consent, FSP and Service Team providers will participate in the discharge planning process.</p>	PC
<p>4.j.iv. If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or</p>	PC

<p>designee) will be notified, and the County will work to arrange such services as promptly, as possible.</p>	
<p>4.j.v. The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.</p>	PC
<p>4.k.i. and ii. Linkages for Services Following Discharge from John George PES and Inpatient. (i.) The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5. (ii.) The County will collaborate with John George to support John George’s safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate, including through ACBH’s critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services. Beginning no later than eighteen (18) months after the Effective Date, the County’s role in this collaboration will include, to the fullest extent reasonably practicable: (1) using available data to promptly identify individuals registered by John George who are both (a) likely to be, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration, and (b) likely to be eligible for and in need of FSP or Service Team services; (2) upon identification, to the extent that the individual has not yet been discharged, promptly coordinate with John George to determine whether the individual is eligible for and in need of any such services; and (3) if the individual is eligible for and in need of any such services and to the extent that the individual has not yet been discharged, promptly connecting the individual to an FSP or Service Team to commence engagement, which may include participation in discharge planning and commencement of services upon the individual’s discharge.</p>	NA
<p>4.k.iii. The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual’s FSP or Service Team (if any) in the discharge planning process and, with respect to patients determined eligible for and in need of such services under section II.4.k.ii above, invite and actively include representatives of the County or a County-contracted community based service provider in the discharge planning process. To the fullest extent reasonably practicable and within the direct control of the County and its community-based service providers, and with the individual’s consent, the County will ensure that: (1) representatives of the FSP or Service Team are included in the discharge planning process for those individuals who are assigned to or are clients of a County FSP or Service Team; and (2) representatives of the County or a County contracted community-based service provider are included in the discharge planning process for those individuals who are not assigned to an FSP or Service Team but who have been identified as eligible for an FSP or Service Team under section II.4.k.ii above. To the extent that John George routinely does not include such representatives in the discharge planning process, the County will seek to identify and reasonably address barriers to John George’s inclusion of such representatives in discharge planning.</p>	PC

4.k.iv. Beginning no later than eighteen (18) months after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital to promptly identify individuals with serious mental illness who are discharged to the community and who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration in accordance with section II.4.e. and will comply with its obligations under section II.4.c.	NA
4.k.v. The County will use programs designed to reach individuals who do not follow up regarding services.	PC
4.k.vi. The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP's or Service Team's prompt resumption of services upon discharge.	PC
4.l.i. Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v. County of Alameda Consent Decree (including section III.I, "Discharge Planning," page 49:13-51:18). The County will ensure that ACBHD collaborates with the community's office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.	PC
4.l.ii Beginning no later than 18 months after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.	NA
4.l.iii. Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.	NA
4.l.iv. With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any, based on the results of the evaluation in section II.4.l.ii. and the quality reviews in section II.4.l.iii.. Where appropriate, the results of the quality reviews under section II.4.l.iii will inform the County's FSP Assessment under section II.2.c.	NA
4.l.v. The County will use programs designed to reach individuals who do not follow up regarding services, consistent with Section II.4.e.	PC
5. Culturally Responsive Services	

<p>5.a. The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. The County will continue to provide and expand culturally responsive behavioral health services, including through community-based and peer-run organizations, and will continue to identify and implement culturally and linguistically appropriate and affirming strategies and practices to help reduce behavioral health disparities across racial, ethnic, cultural, and linguistic groups.</p>	<p>PC</p>
<p>5.b. The County will continue to operate the Office of Health Equity within ACBH, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBH, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client-centered care that considers the whole person and all their needs.</p>	<p>PC</p>
<p>5.b.i. No later than fifteen months after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website setting forth aggregated data metrics on the populations served by ACBHD (including individual racial and ethnic groups broken down by geographic area within the County) and various communities' service needs (including racial and ethnic groups' needs for FSP, Service Team, and IHOT services in geographic areas within the County).</p>	<p>NA</p>
<p>5.b.ii. The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services in the County. The Health Equity Officer will periodically make recommendations to the Director of ACBH on how to improve culturally responsive services in the County and coordinate with the County's other diversity, equity, and inclusion programs and activities.</p>	<p>NA</p>
<p>5.c. The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County's service delivery system. The African American Wellness Hub facility will serve as a hub and coordinating center for a variety of behavioral health services, community-based supports, and linkages for the Black/African American community in the County. The County will provide opportunities for community and stakeholder engagement over the course of this project to further the project's focus on providing culturally inclusive, respectful, and relevant supports to the County's Black/African American clients and community.</p>	<p>NA</p>
<p>5.d. The County has implemented and will continue to provide periodic and ongoing trainings to all ACBHD staff and ACBHD-contracted community-based providers regarding: culturally responsive services; trauma-informed care; inequities across race, ethnicity, sex, sexual orientation, gender identity, and disability; anti-racism and implicit bias. A primary intent of such trainings is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.</p>	<p>PC</p>

Report of the Independent Reviewer
In the Matter of
Disability Rights California, the United States Department of Justice
and
The County of Alameda and Alameda County Behavioral Health
Department

Case: 3:20-cv-05256-CRB

Covering the Period of August 1, 2024, through March 31, 2025

Submitted By: Karen Baylor, Ph.D., LMFT
April 2025

INTRODUCTION

Alameda County entered into a Settlement Agreement with Disability Rights California (DRC), and the United States Department of Justice (DOJ) which became effective on January 31, 2024. The Settlement Agreement is focused on Alameda County and the Alameda County Behavioral Health Department (ACBHD) to provide community mental health services for individuals with serious mental illness to reduce institutionalization and/or criminal justice involvement and to improve the individuals ability to secure and maintain stable permanent housing in the most integrated and appropriate settings.

The Settlement Agreement requires an Independent Reviewer to review relevant facts and assess the County's progress in implementing the Settlement Agreement. The Independent Reviewer is to write a report on the County's progress after six, fourteen, twenty, twenty-five, and thirty-one months after the effective date of the Settlement Agreement.

The Settlement Agreement's definition of Substantial Compliance refers to substantial compliance for a period of no less than six (6) months. The first on-site review occurred after four months of the Effective Date of the Settlement Agreement and the second on-site review occurred ten months after the Effective Date. The second report reflects an assessment of the County's progress from the previous report and identifies any areas where work is in progress or still needs to be completed.

A draft of this report was submitted to the parties on February 28, 2025. Per the Settlement Agreement, the Independent Reviewer is to provide a draft of the report at least thirty (30) days prior to the finalization of the report. The parties have fifteen (15) days to provide comments and responses to the Independent Reviewer for consideration. The Independent Reviewer and the parties agreed to extend the review period by an additional seven days. The finalized report is submitted to the parties and made public, with any redactions necessary under California or Federal Law.

The Settlement Agreement identified the following five service commitments:

1. Crisis Services
2. Full Service Partnerships
3. Service Teams (Intensive Case Management)
4. Outreach, Engagement, Linkages, and Discharge Planning
5. Culturally Responsive Services

This report will outline the requirements in each of the service commitments along with a discussion of the ACBHD's progress and implementation of these five areas.

METHODOLOGY

Since the effective date of the Settlement Agreement, the Independent Reviewer has met every other week with the DOJ and DRC, every other week with Alameda County's counsel, and once a month with ACBHD Deputy Directors. This was done to keep the parties apprised of the activities of the Independent Reviewer, County progress, and to identify any challenges or barriers.

On October 7, 2024, the Independent Reviewer emailed ACBHD a request for documents, including client records, a list of staff and clients to be interviewed, and a list of facilities to be toured.

During the months of August 2024 through March 2025, the County uploaded documents to the file sharing site. All these documents were reviewed by the Independent Reviewer and helped form the Independent Reviewer's interview questions for the on-site review.

The Independent Reviewer requested a random sample of ten client records from the following service categories:

- ACCESS
- Adult Full Service Partnership (FSP)
- Service Teams
- John George Psychiatric Hospital
- Institutes for Mental Diseases (IMD)
- Clients recently released from Santa Rita Jail

The methodology for the random selection of client records was provided to the Independent Reviewer.

The Independent Reviewer utilized the initial report and the same protocol from the first review that was developed based on the Settlement Agreement with feedback from the parties. The parties previously agreed with the use of the protocol. This protocol included all the service commitments in the Settlement Agreement and a list of possible sources of evidence such as policy and procedures, operations manuals, sample of client records, data and data analysis, and interviews of both ACBHD staff and community-based provider staff, and client interviews. This protocol is an organized tool and was utilized as the foundation for the determination of proof of practice for the ratings of compliance for every service commitment.

The Independent Reviewer conducted an on-site review in Alameda County from December 3, 2024, through December 6, 2024. During that on-site review the Independent Reviewer interviewed County staff, toured five contract providers and interviewed 17 of their staff, interviewed 16 county staff, and interviewed eight clients.

Limitations of the second review included conducting the interview of clients over Zoom. ACBHD requested the community based provider to determine which clients were

available to be interviewed. The Independent Reviewer requested two interviews: one with Service Team clients and the other with Adult FSP clients. The session with the FSP clients was hard to hear due to a connectivity issue. It is also more difficult to engage clients over Zoom. The clients were also very positive about the services they were receiving and had no issues or complaints with their current provider.

During the December 2024 on-site review, ACBHD staff accommodated a schedule change, scheduling a tour of the new Forensic Peer Respite facility and rescheduling a tour of Sally's Place. Unfortunately, the La Familia staff had the wrong set of keys and were not able to open the doors of the facility. The Independent Reviewer was given a tour of the grounds and was able to look into the windows of the facility. This facility is scheduled to open in the first quarter of 2025 and another tour may be scheduled for a future on-site review. The tour of Sally's Place occurred on 1/22/2025.

Throughout this process, the Independent Reviewer has had the cooperation of the staff from the Alameda County Behavioral Health Department. They have been collaborative and very responsive to requests for information that has been needed to perform the review functions.

OVERVIEW OF THE SERVICE DELIVERY SYSTEM

ACBHD is considered a Mental Health Plan and contracts with the State Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries. ACBHD is under the Alameda County Health (ACH) within the County structure. ACBHD contracts 79 percent of the specialty mental health services through contracts with community based organizations. ACBHD contracts for inpatient and psychiatric emergency services which are provided by John George Psychiatric Hospital which is under Alameda Health Systems. ACBHD is responsible for administration of the Mental Health Services Act which includes the provision of Full Service Partnership (FSP) services. ACBHD served a total of 25,638 clients for fiscal year 2023 to 2024.

The organization of ACBHD remains the same from the previous report and there were no changes in the organizational structure.

SUMMARY OF RATINGS

The five service commitment areas are from the finalized Settlement Agreement. Each service commitment was given a rating based on the evidence that is comprised of documentation, protocols, contracts, data, client records and other related documents, received from ACBHD and from interviews with staff, clients, and community-based provider staff.

Determination of compliance with the Settlement Agreement results in a rating as follows: Substantial Compliance (SC), Partial Compliance (PC), Non-Compliance (NC), and Not Applicable (NA). This rating was added to the protocol and a full list of the ratings is in Attachment I.

The Settlement Agreement states:

“For the purposes of this Agreement, substantial compliance will mean something less than strict or literal compliance. Substantial compliance is achieved if (1) any violations of the Agreement are minor or occasional and are not systemic, and (2) substantial compliance is sustained or otherwise demonstrated to be durable. Substantial compliance refers to substantial compliance for a period of no less than six (6) months. Non-compliance with or due to mere technicalities, or isolated or temporary failure to comply during a period of otherwise sustained substantial compliance, will not constitute failure to sustain substantial compliance.” (Page 20)

The Partial Compliance, Non-Compliance, and Not Applicable ratings are not defined by the Settlement Agreement. For purposes of rating the County’s compliance with the Settlement Agreement, the Independent Reviewer adopts the following definitions:

Partial Compliance: a provision was rated Partial Compliance when there was any evidence that steps had been taken toward implementation or that implementation had begun. Partial Compliance includes a range of potential progress toward Substantial Compliance, from taking preliminary steps to near-completion of implementation. Partial Compliance was also given when a part of the service commitment was met but not all of the requirements were met. In other cases, a rating of Partial Compliance was given where the information and documentation requested and reviewed to date is consistent with a finding of compliance, but the Independent Reviewer has identified additional areas of inquiry to be explored in a subsequent reporting period to confirm substantial compliance.

Non-Compliance: a provision was rated Non-Compliance when there was no evidence that steps had been taken toward implementation

Not Applicable: a provision was rated Not Applicable when it was not yet required to be implemented by the Settlement Agreement, where the Independent Reviewer has not yet begun to review or has not yet gathered sufficient evidence to determine the rating.

It was important to see a requirement in a document such as the policy and procedure but also to see the requirement in practice. It is also important that the requirement occurs in practice but also that it is sustained and in a durable manner. A rating was provided when there were several sources of evidence regarding the requirement.

The following is a summary table of the overall ratings regarding compliance with the Settlement Agreement.

Summary of Rating Per Service Commitment for the Second Report

SERVICE COMMITMENT	SC	PC	NC	NA	TOTAL
1. Crisis Services	14	1	0	5	20
2. Full Service Partnership	2	8	0	6	16
3. Service Teams (Intensive Case Management)	2	1	0	1	4
4. Outreach, Engagement, Linkages, and Discharge Planning	8	6	0	12	26
5. Culturally Responsive Services	4	0	0	2	6
Totals	30	16	0	26	72

Percent of Each Rating for Reporting Period

Ratings	First Report	Second Report
Substantial Compliance	0*	42%
Partial Compliance	62.5%	22%
Non-Compliance	0	0
Not Applicable	37.5%	36%
Total	100%	100%

**Due to the temporal limitations of the initial report, a rating of substantial compliance was not possible.*

CRISIS SERVICES

The Settlement Agreement outlines the service components under crisis services which includes the County providing a county wide crises system and expanding crisis intervention services. In Alameda County, crises services are organized under the Chief Medical Officer. There is an Interim Crisis Services System of Care Director who reports directly to the Chief Medical Officer. During this review, the Independent Reviewer interviewed the Interim Director, the Crisis Services Division Director, ACCESS Supervisor, and Mobile Crisis staff.

Requirement: *The County will continue to offer a countywide crisis system and expand crisis intervention services* as follows: refers to the subsequent requirements which are discussed below.

The County continues to offer a countywide crisis system. The County continues to contract with providers for crisis intervention services and crisis support services, Crisis

Residential Treatment (CRT), and Psychiatric Emergency Services (PES). The crisis services system of care includes the following:

- Prevention and early intervention which includes outreach and engagement teams, and referral, education and training.
- Crisis intervention services which include crisis support services and mobile crisis teams.
- Crisis stabilization which includes services at either a crisis stabilization unit (CSU) or at a crisis residential treatment facility.
- Post crisis follow-up which include Crisis Connect/Post Crisis Follow-up Team.

Crisis services continue to be provided by County staff and through contracts with providers. Specifically, the County either provides or contracts with the following for services:

- ACBHD Crisis System of Care works closely with the ACCESS staff and provides mobile crisis services.
- Crisis Stabilization Units which are provided through a contract with Amber House (Bay Area Community Services/BACS) and John George Psychiatric Emergency Services (PES). There are plans with La Familia to open another CSU in Hayward in July 2027.
- Crisis Residential Treatment which includes contracts with Amber House (BACS), Woodroe Place (BACS), and Jay Mahler (Telecare).
- Acute services through John George Psychiatric Hospital and Herrick Hospital.

The chart below indicates the number of crises calls and the location of the call for Fiscal Year 2022-23 and Fiscal Year 2023-24.

Region	Crisis City	Number of Calls FY 22/23	Number of Calls FY23/24
1. North	Alameda	129	150
1. North	Albany	24	23
1. North	Berkeley	286	260
1. North	Emeryville	54	62
1. North	Oakland	3,511	4,080
1. North	Piedmont	17	18
2. Central	Castro Valley	104	108
2. Central	Hayward	1,083	1,164
2. Central	San Leandro	726	769
2. Central	San Lorenzo	56	109
3. South	Fremont	334	235
3. South	Newark	84	76
3. South	Union City	153	140

4. East	Dublin	75	109
4. East	Livermore	130	164
4. East	Pleasanton	77	76
5. Out of County	Out of County	807	834
6. Unknown	Unknown	25	24

The chart indicates that the calls are received from all over the county but most of the crisis calls continue to be from Oakland and Hayward.

Requirement: *Maintain a 24/7 crisis hotline. The crisis hotline will provide screening and de-escalation services on a 24/7 basis.*

No later than 18 months after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis.

Beginning no later than 18 months after the Effective Date, the crisis hotline will have a clinician available to support crisis hotline services 24/7.

The ACCESS line is operated 24/7 as is required by the State Department of Health Care Services (DHCS). The County staff answer the ACCESS line from 8:30am to 5pm, Monday through Friday. ACBHD contracts Crisis Support Services of Alameda County for coverage of the telephone line after hours, weekends and holidays. Crisis Support Services will write up a referral for treatment services and then the County ACCESS team will follow up on the referral the next morning but does not provide any crisis services. ACBHD staff reported that if a crisis occurs after business hours, Crisis Support Services will call 911 or the Community Assessment and Transport Team (CATT).

ACCESS staff determines eligibility for specialty mental health services at the time of the initial telephone call and the determination is based on medical necessity as defined by the State Department of Health Care Services. ACBHD’s policy titled “Adult/Older Adult Outpatient Level of Care Determination states the following: “Individuals new to ACBH services are initially assessed to determine if they meet medical necessity.” There is a decision tree that crisis services use when out in the field to determine the appropriate level of care.

The MHSa Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states that one of the reoccurring themes in the community listening session was “Address the response time in systems such as ACCESS” (Page 65).

There are two future deadlines in this requirement which will be discussed in future reports.

Requirement: *The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available), to ensure there is “no wrong door” for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmlines to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.*

Crisis Support Services of Alameda County operates the 988 system for the county. The Executive Director of Crisis Support Services reported that 988 is available in Alameda County and has telephone and text capability 24/7. The purpose of 988 is to provide crisis intervention and suicide prevention services. There is also a website titled *988 Alameda County* where an individual may receive support. 988 of Alameda County is an Accredited Crisis Center. The Annual Report from the Crisis Support Services of Alameda County for the Fiscal Year 2023-24, reported that they responded to 38,288 calls.

ACBHD and Crisis Support Services of Alameda/988 regularly host the quarterly 988 collaborative meetings with 911, law enforcement, fire department, all mobile crisis teams, Emergency Medical Services (EMS), and other community-based providers. In addition, ACBHD hosts a 988 conference annually each September. At the last conference, they had panels that included the following topics:

- Providing support after suicide loss
- Safety planning for non-clinicians supporting youth in crisis
- Assessing suicide risk
- Using phone and text collaborative approach to suicide
- Using client centered data collection to build rapport and improve assessment
- How to access mobile crisis teams.

ACBHD continues to meet monthly with EMS to discuss high utilizers of the services and develop plans to provide the appropriate level of care. ACBHD receives a monthly report of 988 calls along with documentation of planned and provided interventions. ACBHD provided 988 data which included date and time of the call, call duration, any safety risks, reason for the call, and the intervention for Fiscal Year 2023 to 2024.

The Interim Director also stated that 911 continues to be an entry point into the system and that 911 Dispatchers can directly request that a mobile crisis team respond to an emergency. The MET Team and the Mobile Crisis Team may be accessed by the crisis telephone number or by 911. The CATT Team may be accessed by 911 or 988. Referrals from 988 are directed to ACCESS. Additional entry points include 911, 988, or the crisis main telephone number (510-891-5600).

ACBHD did report the demographics on the calls they received which are as follows: age, sex, ethnicity, preferred language, and location of the caller for Fiscal Year 2023 to 2024. ACBHD also collects the following data: average wait time for the call to be answered, number of abandoned calls, and average time spent on the call. In addition, the Crisis System of Care implemented the cloud-based telephone system, Fire 9, which will allow ACBHD to track the number of calls, hold times, and the time of the call. A report will be developed this year to track the crisis contacts and the assignment to an FSP Team, Service Team, or to a community-based provider.

ACBHD provided a copy of the warm hand-off procedure from a contracted community-based provider. The procedure requires the community-based provider staff to contact the client within 24 hours of receiving the referral and offer an intake/assessment appointment within one week of receiving the referral. Another contract for a community based provider had the following requirement: "Assist individuals in a mental health crisis in obtaining the right services at the right time". The Independent Reviewer examined another contract with a community based provider that stated: "Upon receiving a referral from ACCESS, Contractor shall provide assertive outreach to secure treatment engagement." The Independent Reviewer also reviewed several morning reports from Crisis Services Hotline sent to ACCESS.

The Independent Reviewer needs to examine more fully ACBHD's protocols for conducting warm handoffs from the crisis line to FSP warmlines teams.

Requirement: *The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.*

ACBHD provided a number of power point presentations regarding crisis services, a description of mobile crisis services and data relating to the individuals served by mobile crisis. In interviews with the mobile crisis staff during the initial and the second on-site review, staff reported that the mobile crisis teams are deployed by geographical location. During the second on-site review, the Independent Reviewer was able to observe the mobile crisis staff listening into police scanners in order to be prepared for possible deployment. ACBHD provided the policy and procedure for the crisis services on-duty clinician protocol and mobile crisis team daily procedures. This policy and procedure outlines when a mobile crisis response is indicated and the utilization of the dispatch tool to determine the response. ACBHD also provided the Dispatch Screening Tool that is used which also includes the dispatch decision.

Requirement: *Provide mobile crisis response services on a county-wide basis. Mobile crisis teams will provide a timely in-person response to resolve crises as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.*

ACBHD reported that the number of mobile crisis teams has recently expanded from 14 teams to 17 teams¹, with the following three different models for mobile crisis services:

- Mobile Crisis Teams (MCT) that includes two clinicians and law enforcement, if needed. This team is available Monday through Friday, from 8am to 6pm. This team can respond to requests from the general public, 988, and 911. ACBHD has three of these teams.
- Mobile Engagement Teams (MET) that pairs a clinician with a police officer in Oakland and operates from Monday to Thursday, from 8am to 3pm. The Hayward MET operates from Monday to Thursday, from 8am to 4pm. These teams respond to 911/988 generated and Crisis System of Care mental health calls. ACBHD has two of these teams.
- Community Assessment and Transport Team (CATT) pairs a clinician with an Emergency Medical Technician. These teams focus on crisis intervention and medical clearance. This service operates 24 hours a day and 7 days a week. ACBHD has 12 of these teams.

CATT data reflect timely response and reported that the response time is 38.37 minutes, which is the 90th percentile despite varying conditions across the County. However, the Independent Reviewer previously heard complaints during on-site reviews that it can take a long time for mobile crisis to respond. Per the Settlement Agreement, mobile crisis is to provide timely response. The Independent Reviewer did review a recent contract with the CATT service that requires the community based provider to report response time to ACBHD. Monitoring data on response time is well-established in the field as an important performance metric for mobile crisis services.²

ACBHD staff continued to state during interviews that the purpose of MCT is to reduce interaction with law enforcement and to reduce inpatient admissions. ACBHD also provided their telehealth policy and procedure.

Data collected by ACBHD on mobile crisis services include the following: number of clients, response and outcome of the call. Response time and other outcome data for mobile crisis services is currently not collected. While the Settlement Agreement does not describe specific data points for which data collection is required, this data would be useful to the ACBHD management team from a quality assurance perspective.

The chart below shows the number of involuntary holds (5150) for the past two fiscal years and some clients may have had more than one episode:

¹ There are a number of cities in Alameda County that also operate their own mobile Crisis Assessment Teams. An example of this is the MACRO program that operates in Oakland and is housed in the fire department. The ACBHD reported that peers and EMT's are a part of the County's crisis services.

² [National Guidelines for Behavioral Health Crisis Care \(samhsa.gov\)](https://www.samhsa.gov) at page 50-51.

Service	Clients FY 22/23	Episodes FY 22/23	Clients FY 23/24	Episodes FY 23/24
5150 by clinician	13	13	*	*
5150 Danger to Others	238	271	167	180
5150 Danger to Self	255	267	161	169
Gravely Disabled	241	271	204	217

* Data was redacted due to ACBHD privacy protocols

This chart indicates that the highest number of 5150's during both fiscal years continues to be a danger to others and gravely disabled closely followed by danger to self. A client may have one or more episodes during the fiscal year which is why the number of clients does not exactly match the number of episodes.

The statements made in the initial report regarding mobile crisis services continue to be accurate for the second report. For example, it is not clear how ACBHD deploys their mobile crisis teams, and which team should respond to a particular crisis. It seems to be based on availability and location of the crisis in the county. ACBHD has now added reporting response times requirement into the contracts for the community based providers.

ACBHD is taking steps to begin to monitor MCT/MET response times and is aiming for implementation in Summer 2025. Because there has not been six months since the expansion of the mobile crisis teams, the Independent Reviewer will monitor and report on the sustainability in subsequent reports.

Requirement: *Mobile crisis services shall be provided with the purposes of reducing, to the greatest extent possible, interactions with law enforcement during a mental health crisis, reducing 5150 and John George psychiatric emergency services ("PES") placement rates, and increasing use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkage to services).*

Evidence was found regarding the purpose of mobile crisis services to reduce interactions with law enforcement, reduce 5150s and increase use of community based services. Evidence of this was found in the interviews with mobile crisis staff and the crisis system of care management staff and a review mobile crisis program information. ACBHD recently expanded the number of mobile crisis teams from 14 to 17 with the greatest increase in the number of CATT teams.

The Independent Reviewer did request a ride-along with the mobile crisis staff for the second on-site review. However, no crisis calls were received during the time allotted on the Independent Reviewer's schedule.

There was an overall decrease in all the 5150 categories from Fiscal Years 2022/23 to Fiscal Year 2023/24. ACBHD did identify the following as possible reasons for an overall decrease in the number of 5150's:

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- Collaboration with diversion sites such as Amber CSU, CRTs, Sobering and detox facilities and improved outreach and engagement activities
- Increased usage of the Stanley Brown Safety Planning tool during mobile crisis interventions
- Updates to Crisis Intervention Training for first responders
- Advertising of 988
- Additional mobile crisis team for East County
- Quarterly Crisis Services System of Care presentation for various stakeholders.

ACBHD continues to provide mobile crisis services with the purpose of achieving the above stated outcomes as demonstrated by the review of documents and interviews with ACBHD staff and community based provider staff.

Requirement: *The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams, and agrees to maintain this as a minimum capacity.*

ACBHD reported that it either operated or contracted for the following 17 mobile crisis teams:

- **MCT** - 3 teams serving north, south and east county
- **MET**- 2 teams serving Oakland and Hayward
- **CATT** – 12 teams service entire county with staging posts in Oakland, San Leandro, Hayward, Livermore, and Fremont

ACBHD has a contract with the Indigo Project to develop and conduct a Mobile Crisis Assessment of the needs and gaps in mobile crisis coverage. The Draft Mobile Crisis Assessment was provided on January 31, 2025. The findings were as follows:

“The assessment found that ACBH needs a minimum of 2.5 – 5 additional FTE Mobile Crisis Teams from the baseline identified in this assessment in order to meet the estimated mobile crisis need, based on the Crisis Now benchmark that 32% of known crisis events are responded to by mobile crisis intervention.” (Page 24)

The Mobile Crisis Assessment also noted that ACBHD has already added or plans to add four additional mobile crisis teams which is outlined below.

Requirement: *The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than **one year** after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”). The Mobile Crisis Assessment will be informed by and will appropriately take into account (i) community and stakeholder input; and (ii) all necessary data and information sufficient to assess the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.*

The final version of the Mobile Crisis Assessment was provided on January 31, 2025. The Mobile Crisis Assessment is also posted on ACBHD’s website.

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The Mobile Crisis Assessment stated the following: “This assessment was informed by necessary data and information sufficient to assess the need for crisis services, as well as community and stakeholder input. The assessment results in an estimate of the amount and number of mobile crisis teams needed to provide timely, in-person mobile crisis coverage county-wide”. (Page 3)

Requirement: *The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer (see section III.1.a of this Agreement) for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the Mobile Crisis Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final Mobile Crisis Assessment will promptly be made available to the public.*

ACBHD contracted with the Indigo Project to develop and conduct a Mobile Crisis Assessment of the needs and gaps in mobile crisis coverage. The Indigo Project submitted a draft of the methodology for this assessment in May 2024. This draft was submitted to DOJ and DRC for their feedback on May 14, 2024. Feedback from the Independent Reviewer and DOJ and DRC was submitted to ACBHD on May 28, 2024. The final version of the Mobile Crisis Assessment was provided on January 31, 2025. The Mobile Crisis Assessment is also posted on ACBHD’s website.

Requirement: *Based on the County’s Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.*

The findings of the Mobile Crisis Assessment are as follows:

The assessment also identified existing gaps in mobile crisis coverage. Based on mobile crisis team operating hours and time of mobile crisis calls in FY23-24, mobile crisis coverage is needed overnight and on weekends. Mobile crisis coverage is also needed in North County, particularly Oakland. Males and Black and African American individuals also appeared less likely to participate in mobile crisis services and were more likely to be admitted to crisis receiving centers. Based on ACBHD’s mobile crisis team expansion of 4 FTE mobile crisis teams, including 2 overnight CATT teams and an MCT East County team, the County has fulfilled the addition of 2.5 – 5 FTE mobile crisis teams necessary to address mobile crisis needs. (Pages 27-28)

During the Mobile Crisis Assessment, ACBHD further expanded the number of mobile crisis teams as follows:

- MCT: ACBH implemented a fourth team in March 2024
- CATT: ACBHD implemented two new teams in partnership with ACBH, Bonita House and Falck in May 2024, and November 2024
- CATT: ACBHD plans to implement another team in 2025.

When implementation is completed, ACBHD will have expanded the number of mobile crises teams and meets the recommendations outlined in the Mobile Crisis Assessment. Because the expansion has not been in effect for more than 6 months, the Independent Reviewer will review the sustainability of the expansion in subsequent reports.

Requirement: *FSPs will provide crisis intervention as set forth in section II2.m in this Agreement.*

During the initial review period, the Independent Reviewer undertook the following activities to determine compliance with FSPs providing crisis intervention services:

- Review of ACBHD's FSP policy and procedures,
- Review of community-based provider contracts scope of work, and
- Interviews with community-based provider staff and supervisors.

For the second review, the Independent Reviewer interviewed several community based provider staff, reviewed FSP client records and interviewed clients receiving FSP services. All agreed that FSP provides crisis intervention services.

Because this requirement is tied to section II2.m of the Settlement Agreement and that requirement has a deadline in the future, this requirement will be reviewed in subsequent reports.

Requirement: *Each mobile crisis team shall include at least one mental health clinician.*

As described above, the Mobile Crisis Teams continue to include two clinicians, Mobile Engagement Teams pairs a clinician with a police officer, and Community Assessment and Transport Team (CATT) pairs a clinician with an Emergency Medical Technician.

Requirement: *Trained peer support specialists shall be part of the County's crisis services team and shall be included in outreach and engagement functions.*

ACBH reported that peers and EMT's are a part of the County's crisis services. The Independent Reviewer interviewed three peer support specialists during the second on-site review. They reported that they are part of the crisis services teams and described their role as being partners with the clinicians. The peers stated that some of their work activities include responding to crisis calls with the mobile crisis team, collecting collateral information during a crisis event, and providing crisis intervention services.

Requirement: *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.*

The current number of CRT beds continues to be at the same number of beds as reported in the first report.

CRT Facility	Community-Based Provider	Number of Beds
Amber House	BACS	16
Woodroe House	BACS	16
Jay Mahler	Telecare	16
TOTAL		48

ACBHD has met this requirement and has sustained this requirement for more than six months per the Settlement Agreement.

Requirement: *Within two years of the Effective Date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based provider(s) to add a mixture of 25 additional CRT and/or peer-respite beds.*

ACBHD reported that two additional CRTs will be opened in the future. ACBHD plans to contract for an additional 32 beds with Telecare and La Familia, which will bring the total number of CRT beds to 80 beds.

Requirement: *A purpose of CRT facilities and peer-respite homes is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization. They are intended to be used by people experiencing or recovering from a crisis due to their mental health disability for short-term stays and provide support to avoid escalation of a crisis. CRT facilities and peer-respite homes are unlocked.*

During the second on-site review, the Independent Reviewer was able to tour Woodroe Place and Jay Mahler and interview their staff. These facilities are unlocked. The Independent Reviewer reviewed client records who had received CRT services, community-based contracts scope of work and the community-based providers Operation Manual. There was evidence found that the goal of CRT facilities is to de-escalate or avoid a crisis and reduce unnecessary hospitalization.

The tour of Sally’s Place occurred on 1/22/2025. The Independent Reviewer interviewed the staff, toured the facility and spoke to two clients. The facility had a warm, homelike, and welcoming atmosphere and it was unlocked. The staff reported that the maximum length of stay is 14 days.

Data collected in FY 2023-24 showed a slight increase in the number of clients who received CRT services compared to FY 2022-23: 698 clients compared to 663 clients, respectfully.

Outcome	Number of Clients FY 22/23	Percentage FY22/23	Number of Clients FY 23/24	Percentage FY 23/24
Admitted to hospital	48	7%	50	7%
Connected to CBS	140	21%	123	18%

Discharged to other facilities	130	20%	155	22%
Detention to Santa Rita Jail	20	3%	22	3%

This chart indicates a slight increase in the number of clients discharged to other facilities from last fiscal year. Overall, there was not a significant change from one fiscal year to another.

Requirement: *Peer staff will be on-site 24-7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.*

ACBHD reported that the County only has one peer respite home that opened in 2020 named Sally’s Place. As discussed above, the tour of Sally’s Place occurred on 1/22/2025. The Independent Reviewer interviewed the staff, toured the facility and spoke to two clients. The staff reported that peer staff are on-site 24/7. The tour of the facility confirmed that it is a six bed facility.

Requirement: *Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.*

The Independent Reviewer previously reviewed client records of clients who had received CRT services, community-based contract’s scope of work and the community-based providers Operation Manual. During the second on-site review the Independent Reviewer toured Woodroe Place and Jay Mahler and interviewed staff. Both ACBHD staff and community-based provider staff confirmed that housing continues not to be a condition for admission to CRT.

Requirement: *CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis teams.*

Admissions to CRT may be made directly by MCT. This was confirmed by ACBHD staff and community provider staff.

Requirement: *The County’s crisis system will be designed to prevent unnecessary hospitalizations, IMD admissions, law enforcement interactions, and incarceration.*

For the initial report, the Independent Reviewer interviewed ACBHD staff, community-based provider staff, reviewed policy and procedures and community-based Operations Manual, indicating that the crisis services are designed in the manner stated. For the second review, the Independent Reviewer interviewed ACBHD staff and mobile crisis staff. ACBHD did provide a policy and procedure and a daily checklist for the on-duty clinician for the mobile crisis team. The role of the on-duty clinician is to triage the crisis calls received and determine the most appropriate response from Crisis Services using the Dispatch Tool. ACBHD provided a copy of the Dispatch Screening Tool which includes the following:

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- a screen for medical issues,
- a safety assessment,
- screen for under the influence of substance and alcohol,
- reason for the call
- screen for location safety, and
- dispatch decision.

The dispatch decision consists of whether the mobile crisis team will be dispatched with or without law enforcement, which mobile crisis team is dispatched, or if the mobile crisis team was not dispatched and why.

ACBHD previously identified the need to expand CSU, CRT, peer respite, and mobile crisis teams. ACBHD has already expanded the number of mobile crisis teams as follows:

- **MCT:** ACBHD implemented a fourth team in March 2024.
- **CATT:** ACBHD implemented three new teams in partnership with ACBH, Bonita House and Falck in May 2024, and November 2024 with the third in 2025.

ACBHD also reported that two additional CRTs will be opened in the future. ACBHD plans to contract for an additional 32 beds with Telecare and La Familia, which will bring the total number of CRT beds to 80 beds.

Summary of Crisis Services Findings

Overall, there are twenty service commitments in the Crisis Services component of the Settlement Agreement. ACBHD received substantial compliance for 14 service commitments, a rating of partial compliance for one requirement, and a rating of not applicable rating for five service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirements:

1. *The County will continue to offer county wide crisis system and expand crisis intervention services.* There was evidence through data, community based provider contracts and interviews with ACBHD staff and community based provider staff that the requirement for offering a county wide crisis system has been met.
2. *The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.* Evidence was found from ACBHD regarding protocols and education efforts regarding crisis services, including a description of mobile crisis services and data relating to the individuals served by mobile crisis.
3. *Mobile crisis services shall be provided with the purposes of reducing, to the greatest extent possible, interactions with law enforcement during a mental health*

crisis, reducing 5150 and John George psychiatric emergency services (“PES”) placement rates, and increasing use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkage to services). Evidence was found through interviews on the purpose of mobile crisis services. The Independent Reviewer interviewed mobile crisis staff, the crisis system of care management staff, reviewed mobile crisis program information, and related data.

4. *The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams and agrees to maintain this as a minimum capacity.* ACBHD reported that it operates 14 mobile crisis teams and has expanded to 17 teams.
5. *The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than one year after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”).* ACBHD contracted with the Indigo Project to conduct the Mobile Crisis Assessment, and the final version was provided on January 31, 2025.
6. *The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer.* The Indigo Project submitted a draft of the methodology for this assessment in May 2024. The final version of the Mobile Crisis Assessment was provided on January 31, 2025. The Mobile Crisis Assessment is also posted on ACBHD’s website.
7. *Each mobile crisis team shall include at least one mental health clinician.* There was evidence that the Mobile Crisis Teams includes two clinicians, Mobile Engagement Teams pairs a clinician with a police officer, and Community Assessment and Transport Team (CATT) pairs a clinician with an Emergency Medical Technician.
8. *Trained peer support specialists shall be part of the County’s crisis services team and shall be included in outreach and engagement functions.* The Independent Reviewer interviewed the peer support specialists who are part of the County’s crisis services teams.
9. *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.* ACBHD has met this requirement and has sustained this requirement for more than six months with plans to expand the number of CRT beds.
10. *A purpose of CRT facilities and peer-respite homes is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization.* Evidence was found through tours of the facilities, reviews of contracts with community based providers, community-based providers Operation Manual and through interviews with ACBHD staff and community provider staff.
11. *Peer staff will be on-site 24-7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.* Evidence was found on the tour of the peer-respite home and through interviews with the staff and clients.

12. *Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.* Evidence was found through a review client records, community-based contract's scope of work, the community-based providers Operation Manual, tours of the facilities and interviews with staff.
13. *CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis teams.* Evidence was found through interviews with ACBHD staff and community provider staff.
14. *The County's crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.* Evidence was found through interviews of ACBHD staff, community-based provider staff, reviewed policy and procedures and community-based Operations Manual.

ACBHD achieved Partial Compliance for the following:

1. *The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available) to ensure there is "no wrong door" for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmline teams to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.* The Independent Reviewer needs to examine the protocol for conducting warm handoffs and will report findings in a subsequent report.

ACBHD achieved Not Applicable for the following:

1. *With the Maintain a 24/7 crisis hotline is the following requirement: No later than **18 months** after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis.*
2. *Mobile crisis teams will provide a timely in-person response to resolve crisis as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.*
3. *Based on the County's Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.*
4. *FSPs will provide crisis intervention as set forth in section II2.m in this Agreement.*
5. *Within **two years** of the effective date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based provider(s) to add a mixture of 25 additional CRT and/or peer-respite beds.*

FULL SERVICE PARTNERSHIPS

Full Service Partnerships (FSP) services are defined in California Code of Regulations Title 9, Section 3620, which defines the Full Spectrum of Community Services necessary to attain the clients treatment goals. FSP services are intended to be flexible and provided at a level of intensity and location that meets the client's needs. FSP services are intended to reduce hospitalization, utilization of emergency health care, and criminal justice involvement. FSP services in Alameda County are provided through contracts with community-based providers.

FSP services were assessed for the second report through interviews with ACBHD staff, community-based provider staff and the supervisor of FSP programs, reviewed client records and interviewed four clients currently receiving FSP service.

Requirement: *The County offers FSPs through community-based providers that provide services under the Community Services and Supports ("CSS") service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10.*

*Within **two years** from the effective date, the County will add 100 FSP slots for adults and transition aged youth for a total of 1,105 FSP slots for that population. The County will utilize the FSP slots that are added under this Agreement to serve individuals 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.*

ACBHD continues to contract with community-based providers for the provision of FSP services. ACBHD provided the contract's scope of work, and the Independent Reviewer conducted interviews with ACBHD staff and community-based provider staff.

The addition of 100 additional slots has a deadline of two years from the effective date of the Settlement Agreement and is not applicable at this time. ACBHD is complying with this requirement in advance of the Settlement Agreement's timeline: 50 slots were added in January 2024 and another 150 additional slots were added in December 2024. The Independent Reviewer will continue to monitor this and will report on implementation in subsequent reports.

Requirement: *Within **one year** from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the "FSP Assessment").*

The Draft FSP Assessment was provided to the Independent Reviewer on January 28, 2025, and thus met the one year deadline for completing an assessment. The Independent Reviewer sent the draft to the DOJ and DRC the next day. The Draft FSP Assessment included individuals ages 18 and older who met FSP eligibility criteria.

Individuals ages 16 and 17 are included in the Children’s FSP programs and ACBHD stated that it was not possible for them to provide the data.

Because the FSP Assessment has not been finalized, the Independent Reviewer will provide an update on this in subsequent reports.

Requirement: *The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to: i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services; ii. Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment, and length of time from identification to enrollment; iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups; and iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.*

The Draft FSP Assessment included the data described above along with community and stakeholder feedback. The Draft FSP Assessment stated the following:

“This assessment also considers an analysis of any demographic or other variables that may influence participation in FSP programming as well as the challenges and barriers in identifying, referring, engaging, and serving individuals who need an FSP-level of care. This assessment is informed by local service utilization data, community and stakeholder input, and available literature and evidence-based practices and results in an estimate of FSP slots needed to appropriately serve individuals who meet FSP eligibility criteria.” (Page 3)

The FSP Assessment has not been finalized, and the Independent Reviewer will continue to monitor and will report on the progress in subsequent reports.

Requirement: *The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately*

take into account such feedback and comment before finalizing the County's FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.

ACBHD has contracted with the Indigo Project to conduct an FSP assessment to identify needs and gaps for individuals ages 16 and older. Indigo Project submitted a draft of the design and methodology of the assessment to the Independent Reviewer on March 29, 2024. The Independent Reviewer sent the draft to the DOJ and DRC on April 1, 2024, and they returned the draft with their comments and edits on May 2, 2024. A meeting was held on June 14, 2024, with Indigo, ACBHD, and the Independent Reviewer to discuss the edits and to finalize the design and methodology.

The Independent Reviewer did meet with the Indigo Project on 12/6/2024. The Draft FSP Assessment was provided to the Independent Reviewer on January 28, 2025, and was sent to the DOJ and DRC the following day. The Independent Reviewer provided feedback to ACBHD on March 19, 2025, that was based on the Independent Reviewer's review and the DOJ and DRC's feedback.

The FSP Assessment has not been finalized, and the Independent Reviewer will continue to monitor and will report on the progress in subsequent reports.

Requirement: *Based on the County's FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.*

The FSP Assessment has not been finalized, and the Independent Reviewer will continue to monitor and will report on the progress in subsequent reports.

Requirement: *As used in this Agreement, one "slot" (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time. FSPs will provide services necessary to attain the goals identified in each FSP recipients' Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1).*

Evidence was found regarding the definition of one slot through interviews with ACBHD and community provider staff and review of contracts with the community providers. The Independent Reviewer reviewed client records of clients receiving FSP services, interviewed four clients currently receiving FSP services in a virtual setting. Based on that information, it is determined that FSPs are in fact providing the necessary services.

The Independent Reviewer will need to review additional client records and conduct additional interviews and will report on the sustainability and durability in subsequent reports.

Requirement: *Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person's individualized goals and the Full Spectrum of Community Services necessary to attain those goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual.*

The Independent Reviewer previously reviewed ACBHD's policies and procedures for FSP. For the second report, the Independent Reviewer reviewed client records. FSP client records listed the issues that the client identified, individualized goals, and the client's treatment plan or problem list were consistent with the assessment. The client records indicated that the issues identified were being addressed. In addition, the Independent Reviewer interviewed four clients receiving FSP services in a virtual setting to confirm that they receive services consistent with their wishes. Clients spoke of being reminded of and then transported to their psychiatric appointments, receiving food and clothing, and assistance with finding housing. Clients reported the importance of staying on their medications and how the services were helping them with that goal.

The Independent Reviewer will need to interview more clients and review more records since the sample size was small, to determine sustainability and durability. The Independent Reviewer will continue to monitor and will report on this in subsequent reports.

Requirement: *Services provided through FSPs will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals' needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.*

The Independent Reviewer previously reviewed ACBHD's policy and procedures for FSP. For the second report, the Independent Reviewer reviewed client records for clients receiving FSP services. Client records indicated that a variety of services were being provided in several settings, and were based on client preference.

The Independent Reviewer also interviewed four clients receiving FSP services in a virtual setting. The clients reported that their FSP staff did work with them on setting their goals per the client's preference. Clients also verified that services are flexible and provided at the frequency and location of their choosing.

However, the Independent Reviewer also reviewed ACT Fidelity Assessments for the FSP providers and learned that several FSP providers were not meeting the High Fidelity rating with frequency or intensity of services. Several FSP providers received scores of 2 or 3 out of 5, and many of the assessments recommended that FSP providers increase their average number of face-to-face visits per week. In addition, many of the assessments also recommended that the FSP providers increase the number of minutes they are spending with clients per week.

Data provided by the County also demonstrates that, on average, FSP providers are only meeting with their clients once a week, but High Fidelity requires 3 or more face to face contacts per week.

The chart below indicates the top locations where FSP services were provided for the Fiscal Year 2022-23 and for FY 2023-24.

Treatment Location	# Clients FY22-23	# Clients FY23-24
Field	1,072	1,078
Office	1,128	1,067
Telephone	1,073	762
Client's Home	815	672
Telehealth	549	587
Other Community Location	225	333
Group/Boad and Care	*	302
Inpatient - Psychiatric	286	282
Satellite Office	**	214
Health/Primary Care	145	128
Psychiatric Residential	133	124
Inpatient (non-psychiatric)	*	77
School	53	67
Community Mental Health	*	66
Skilled Nursing Facility	*	63
Unknown Location	*	48
Prison/Correctional Facility	52	45
Homeless/ER Shelter	32	41
Temp Lodging (hotel, camp)	*	38
Emergency Room	*	36
SUD Residential	*	34
Public Health Clinic	*	24
FQHC	*	17

* Not reported | ** Data was redacted due to ACBHD privacy protocols

This chart indicates that the majority of services are being provided in the field and at the office. There was a slight increase in the number of field based services and office based services but there was a decrease in the number of home visits. While there was a decrease in the number of telephone calls, this is due to ACBHD splitting out the data from a telephone service provided to the client versus when a call was made but the client was not available. The actual total of calls made whether the client was available or not was 1,370.

The Independent Reviewer will need to interview more clients and review more records since the sample size was small, to determine sustainability and durability. The Independent Reviewer will continue to monitor and will report on this in subsequent reports.

Requirement: *FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.*

The Independent Reviewer previously reviewed ACBHD's policy and procedures for FSP services. ACBHD contract language includes the following for community based providers providing FSP services:

- A. Program Goals - Contractor shall provide services to accomplish the following goals:
- i. Improve the ability of clients to achieve and maintain an optimal level of functioning and recovery;
 - ii. Improve the ability of clients to secure and maintain stable permanent housing in the least restrictive and most integrated living situation appropriate to meet their needs and preferences;
 - iii. Reduce criminal justice involvement and recidivism;
 - iv. Reduce client hospitalizations and utilization of emergency health care services for mental health and physical health issues;
 - v. Ensure that clients obtain and maintain enrollment in health insurance and other public benefits programs for which they are eligible;
 - vi. Connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers;
 - vii. Increase educational and/or vocational attainment among clients;
 - viii. Help clients to increase their monthly income and financial assets;
 - ix. Increase client participation in meaningful activities;
 - x. Decrease social isolation among clients; and
 - xi. Assist and empower clients to transition into the least intensive level of service appropriate to meet their needs.

Performance Improvement Activities Contractor shall provide Performance Improvement Activities to accomplish the following goals:

- i. Improve client access to care;
- ii. Increase quality;
- iii. Improve outcomes;
- iv. Ensure program accountability; and
- v. Increase program efficiencies.

The Independent Reviewer reviewed client records, interviewed four clients in a group virtual setting currently receiving FSP services, and interviewed community-based

provider staff. All indicated that services are designed to reduce hospitalization and the utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing.

The chart below is ACBHD outcomes for FSP clients related to housing for discharges during Fiscal Year 2022 to 2023. For comparison, data from Fiscal Year 2022-23 is in parentheses.

Housing Status	At Admission	Percent Admission	At Discharge	Percent Discharge
Independent	75 (73)	31% (31%)	74 (72)	31% (30%)
Unknown or other	46 (45)	19% (19%)	58 (54)	24% (23%)
Homeless	58 (56)	24% (24%)	48 (48)	20% (20%)
Group Housing	46 (45)	19% (19%)	32 (32)	13% (14%)
Medical Facility	*	*	13 (13)	5% (5%)
Justice Related	*	*	*	*
Rehabilitation	*	*	*	*

* Data was redacted due to ACBHD privacy protocols.

There was little to no change from one fiscal year to the other. This chart indicates that the largest percentage of clients who received FSP services continue to be discharged to independent living. Over forty percent were discharged to an unknown place or were homeless. While this seems to be a high percentage, it also speaks to the housing issues in Alameda County.

ACBHD reported that there was a reduction in hospitalization days, incarceration days and sub-acute days for eight out of the nine programs. The ACBHD ACT Review Guide stated the following:

“The goal of the ACT Fidelity review is to continue to observe positive trends in the metrics of service provision and reductions in hospitalization and jail days. ACBH will continue to track the outcome data that is collected from the Fidelity Review process and offer technical support as needed to assist the teams with implementing the ACT model. The overall goal is to improve the lives of the individuals supported.” (Page 2)

The Independent Reviewer will need to interview more clients and review more records since the sample size was small, to determine sustainability and durability. The Independent Reviewer will continue to monitor and will report on this in subsequent reports.

Requirement: *FSP programs will be implemented using high fidelity to the Assertive Community Treatment (“ACT”) evidence-based practice, including that: (i) FSP programs are provided by a team of multidisciplinary mental health staff who, together,*

provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals; (ii) FSP teams operate at a 1:10 mental health staff to client ratio.

During this review period, the Independent Reviewer undertook the following activities to determine compliance with the above FSP-related services: toured two community-based providers of adult FSP services, interviewed five community-based provider staff from the two FSP community-based providers visited and reviewed client records.

For the initial review, the Independent Reviewer completed the following:

- Reviewed ACBHD's FSP policy and procedures,
- Reviewed ACBHD community-based provider contracts scope of work for the provision of FSP services, and
- Reviewed ACBHD's ACT training materials.

The MHSA Annual Plan Update (Draft) for FY24/25 describes the difference between FSP and the ACT model as follows:

“In California, Full Service Partnership (FSP) programs are intended to be the most intensive level of publicly-funded outpatient treatment programs (in addition to Laura’s Law, or Assisted Outpatient Treatment/AOT programs). Some counties, like Alameda, base their FSP service models on the ACT evidence-based model that operates nationally; this model is the highest intensity service level for outpatient services. FSP ACT model programs are team structured with a staff to partner ratio of 10:1 and provide coordinated comprehensive services that support and promote recovery” (Page 80).

ACBHD staff and community-based provider staff reported that the FSP program design in Alameda County is based on the ACT model. Previously, community based providers staff reported that ACBHD conducts a fidelity assessment of the ACT model annually. For the second report the Independent Reviewer was able to review the 2024 fidelity review assessment from nine programs providing FSP services. The programs were assigned an overall total fidelity score, and those scores translated to a description of fidelity. The results of the community based providers are as follows:

- Two providers scored high fidelity,
- Six providers scored moderately high fidelity, and
- One provider scored moderate fidelity.

The ACBHD Deputy Director of Clinical Operations reported that the staff to client ratio for FSP is 1 to 10. This was also confirmed by the provider’s contract’s scope of work and by interviews with community-based provider staff.

The Independent Reviewer was able to confirm through the fidelity assessment results, client records sampling, and individual client interviews that FSP programs are being implemented using high fidelity to the ACT evidence-based practice.

Requirement: *FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than **eighteen (18) months** after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBHD contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.*

FSP services are intended to provide crisis intervention services. During the initial review period, the Independent Reviewer undertook the following activities to determine compliance with the above FSP-related requirements:

- Review of ACBHD's FSP policy and procedures,
- Review of community-based provider contracts scope of work, and
- Interviews with community-based provider staff and supervisors.

ACBHD's policy titled "24/7 Coverage Requirements for Children, TAY, Adult and Older Adult Full Service Partnerships" states the following:

Each FSP will have a telephone number that is answered by a live person available to the clients/families of the program after hour crisis needs 24 hours a day, 7 days a week. A direct care staff member working in the FSP will be on-call to respond to urgent client/family needs 24 hours a day, 7 days a week to provide field or phone-based crisis interventions as appropriate.

For the second report, the Independent Reviewer reviewed client records and interviewed four clients receiving FSP services. The clients reported that crisis services are provided when necessary.

This requirement is not due at this time and will be reviewed and discussed in subsequent report.

Requirement: *FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.*

FSP services are to include the provision of or the arrangement for Individual Placement and Support (IPS) services. Previously, ACBHD provided two client records where IPS services were provided, that indicated that employment services were being provided. Community-based provider staff reported that ACBHD conducts an annual IPS fidelity assessment.

ACBHD provided three IPS Supported Employment Fidelity reports. These reports can result in a rating of Exemplary Fidelity, Good Fidelity, Fair Fidelity, and Not Supported

Employment depending upon the total points received for the requirements with a maximum of five points per requirement. The results were as follows:

- one provider received a Good Fidelity rating
- two providers received a Fair Fidelity rating

ACBHD also provided two IPS Quality Improvement Reports for two community based providers. These reports are not fidelity reports but can be used between fidelity reviews when annual reviews are not possible. The intent of these quality improvement reviews is as follows: to provide a roadmap that will help IPS programs provide effective services and to provide a snapshot of current practices”.

ACBHD contracts with community based providers to deliver IPS services based on the client’s individualized interests, skills, and needs. The Settlement Agreement does not require an IPS fidelity score only that ACBHD arranges for supported employment services for FSP clients based on their choice. ACBHD does conduct fidelity assessments on an annual basis and also conducts quality improvement reviews with their contracted community based providers. ACBHD is monitoring their providers on the delivery of supported employment services and making the appropriate recommendations for improvement.

Requirement: *Housing: The Parties recognize that permanent, integrated, stable housing with Housing First principles is critical to improving treatment engagement and supporting recovery. (i) FSP clients will receive a housing needs assessment, and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency’s Coordinated Entry System (“CES”), or through other County and community resources.*

FSP participants are to receive a housing assessment and be referred to the Health Agency Services Coordinated Entry System (CES). Evidence of housing needs and wishes of the client was found in the client records. Client interviews also revealed that their housing wishes were reported.

The Independent Reviewer interviewed two staff from CES during the on-site review. They reported that client voice is important and that they utilize the Housing First Model. The policy and procedures for CES were provided and it states the following:

“The Coordinated Entry process uses specific Assessments to obtain information about both the immediate and long-term needs of persons and households seeking services. Portions of these assessments are weighted and assigned points leading to a score which is used, along with eligibility information, for placing participants on queues for referral to crisis and housing resources. Because of the lack of sufficient resources, prioritization in the Alameda County system is based on a range of factors to determine who among the population experiencing homelessness has the greatest number or level of critical needs

and/or lesser likelihood of being able to become rehoused without assistance. Factors that are considered include age and size of household, current and past housing situations, length of time homeless, disabilities and health conditions, barriers to rehousing such as past housing loss and criminal legal interactions, and risk of or vulnerability to exploitation and violence. Factors used for crisis prioritization are a subset of those used for housing prioritization.” (Page 11)

During the second on-site review, the Independent Reviewer heard in numerous interviews with ACBHD staff, community-based provider staff and clients that permanent housing continues to be a challenging issue in Alameda County. In addition, the MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states a reoccurring theme in the community listening session was “address basic needs such as insecure housing” (Page 65). The report also states that housing and homelessness ranks as the number one concern for adults and older adults (Page 87).

Great Hope FSP (Adobe Services) reported the following in the MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026 regarding barriers to services:

“Difficulty in securing units under the changing Fair Market Rates (FMR). There was a decline in available and viable units within Alameda County. Landlords unwillingness to work with subsidized housing was also a challenge, discriminatory language or behaviors with landlords towards subsidized housing recipients was a contributing factor” (Page 132).

Strides Program (Telecare) reported the following challenges in the MHSA Annual Plan Update (Draft) for FY 24/25:

“FY22/23 was a time of great uncertainty due to the stressors of the global pandemic (increasing COVID outbreaks again), housing insecurity, increased risk of substance use, increase of hate crimes directed at vulnerable populations, increased cost of living, especially for housing and food. While all these factors impact our partners, the most challenging in the past year include the dangerous risk of overdose and death due to fentanyl and other street drugs, as well as increasingly complex psychiatric / medical presentations with our clients and the shortage of appropriate, supportive housing resources available.” (Page 137).

The MHSA Annual Plan Update (Draft) for FY24/25, identifies several recurring themes in numerous listening sessions. One theme identified was “housing continuum”. The plan lists the following strategies and solutions:

- “Increase prevention and early intervention programs to avoid homelessness.
- Provide safe/welcoming places with direct services and housing for those with mental health challenges, aiming to prevent additional trauma.
- Provide emergency housing lasting a minimum of 6 months, followed by long-term supportive housing.

- Support housing interventions with additional funding for operational support to meet the needs of the community that include comprehensive and wraparound services.
- Establish accountability and check-and-balance mechanisms in housing programs and services.
- Ensure transparency in decision-making processes related to housing” (Page 54).

The loss of Board and Care homes in the County and the subsequent loss of those beds, has also had an impact the housing situation.

ACBHD provided the following data regarding the client’s housing at the beginning of FSP services and when the client discharges from FSP services for Fiscal Year 2023/24.

Housing Status	At Admissions	At Discharges
Independent	75	74
Unknown or Other	46	58
Homeless	58	48
Group Housing	46	32
Medical Facility	*	13
Justice Related	*	12
Rehabilitation	*	*

* Data was redacted due to ACBHD privacy protocols

Given the challenges in providing housing, both temporary and permanent, the Independent Reviewer expects the implementation of housing-related settlement provisions to require continued effort. This includes the coordination with the relevant County entities that fund and support the development of affordable housing and/or have the authority to prioritize the delivery of existing housing to the population covered by the settlement. The Independent Reviewer notes that the ACBHD’s activities with respect to housing are confined to obligations with the FSP and Service Team clients.

It is noteworthy that ACBHD was awarded \$14,040,909 from DHCS for Round 3 of the Behavioral Health Bridge Housing Program. The Independent Reviewer will continue to examine the issue of both temporary housing and permanent housing in subsequent reports.

Requirement: *As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.*

The staff from CES reported that there are a number of priority factors based on the assessment that determine if the client is placed in the housing queue. While FSP clients are not identified as a priority factor, many clients are given priority based on

their diagnosis, current housing, income, and psychiatric history. The CES also reported that they do try to solve the problem of the client's immediate housing needs, but that locating permanent housing can take years to complete.

As described above, the policy and procedures for CES were provided and it states the following:

“The Coordinated Entry process uses specific Assessments to obtain information about both the immediate and long-term needs of persons and households seeking services. Portions of these assessments are weighted and assigned points leading to a score which is used, along with eligibility information, for placing participants on queues for referral to crisis and housing resources. Because of the lack of sufficient resources, prioritization in the Alameda County system is based on a range of factors to determine who among the population experiencing homelessness has the greatest number or level of critical needs and/or lesser likelihood of being able to become rehoused without assistance. Factors that are considered include age and size of household, current and past housing situations, length of time homeless, disabilities and health conditions, barriers to rehousing such as past housing loss and criminal legal interactions, and risk of or vulnerability to exploitation and violence. Factors used for crisis prioritization are a subset of those used for housing prioritization.” (Page 11)

The Independent Reviewer will continue to examine the issue of both temporary housing and permanent housing in subsequent reports.

Requirement: *If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.*

The ACBHD Senior Executive Team previously reported that the County Housing Department used to be under ACBHD, but it was moved to the Alameda County Health, Office of the Agency Director. The Senior Executive Team reported that this change has been a challenge in serving their clients. The County does have a number of coordinated housing resource centers located throughout the county. ACBHD provided documentation of housing training from the Alameda County Office of Homeless Care and Coordination, now known as the Alameda County Health Office of Housing and Homelessness.

The community based providers previously reported that they can locate temporary housing for their FSP clients by using hotel vouchers. Both the community based providers and the FSP clients interviewed reported that FSP staff do work to locate temporary housing for their clients. This was also found in the client records for the clients receiving FSP services.

The Independent Reviewer needs to examine this requirement further with regard to locating housing promptly and that the temporary housing is stable. It is also important to verify the transition from temporary housing to permanent housing since it is difficult to find permanent house in the county.

Requirement: *Permanent housing provided under this section II.2.o will be provided in the least restrictive and most integrated setting that is appropriate to meet individuals' needs and preferences. (v). Nothing in this section II.2.o is intended to override an FSP client's preferences.*

Given the challenges in locating permanent housing in Alameda County, The Independent Reviewer will continue to monitor the efforts of ACBHD to provide permanent housing. The Independent Reviewer needs to examine further the requirement for least restrictive and most integrated setting appropriate to meet the client's needs and preferences.

Summary of Full Service Partnership Findings

Overall, there are sixteen service commitments in the Full Service Partnership section. There were two service commitments that received a rating of substantial compliance, eight with a rating of partial compliance and six service commitments that were not applicable. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirements:

- 1. FSP programs will be implemented using high fidelity to the Assertive Community Treatment ("ACT") evidence-based practice, including that: (i) FSP programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals; (ii) FSP teams operate at a 1:10 mental health staff to client ratio. Evidence was found with review of ACBHD's FSP policy and procedures, review of contracts, review of ACBHD's ACT training materials. interviews of community-based provider staff, tour of the facilities, and a review of the 2024 fidelity review assessment reports.*
- 2. FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs. Evidence was found in client records, interviews with community-based provider staff, and a review of the IPS Supported Employment Fidelity reports.*

ACBHD achieved Partial Compliance for the following requirements:

1. *As used in this Agreement, one “slot” (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one individual at a given time. FSP will provide services necessary to attain the goals identified in each FSP recipients’ Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1). The Independent Reviewer will need to review additional client records and conduct additional interviews and will report on the sustainability and durability in subsequent reports.*
2. *Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person’s individualized goals and the Full Spectrum of Community Services necessary to attain those goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual. The Independent Reviewer will need to review additional client records and conduct additional interviews and will report on the sustainability and durability in subsequent reports.*
3. *Services provided through FSPs will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals’ needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate. The Independent Reviewer will need to review additional client records and conduct additional interviews and will report on the sustainability and durability in subsequent reports.*
4. *FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals’ ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.*
5. *Housing: FSP clients will receive a housing need assessment and will receive support and assistance to secure and maintain, as needed, affordable, (1) temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency’s Coordinated Entry System (“CES”), or through other County and community resources. Evidence was found in the client files, interviews with clients and interviews with community based provider and ACBHD staff. ACBHD staff provided the housing and homeless dashboard that is based on the episode date at admission and at discharge. However, with both on-site reviews, staff and clients report that permanent, safe housing is very difficult to find in Alameda County.*
6. *As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing. The Independent Reviewer interviewed CES staff who stated the FSP clients do not receive priority, many clients are given priority based on their diagnosis, current*

housing, income, and psychiatric history. The CES also reported that locating permanent housing can take years to complete. The Independent Reviewer will continue to monitor this requirement.

7. If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis. The Independent Reviewer needs to examine this requirement further with regard to finding housing promptly and that the temporary housing is stable. It is also important to verify the transition from temporary housing to permanent housing since it is difficult to find permanent house in the county.

8. Permanent housing provided under this section II.2.o will be provided in the least restrictive and most integrated setting that is appropriate to meet individuals' needs and preferences. (v). Nothing in this section II.2.o is intended to override an FSP client's preferences. Given the challenges in providing housing, both temporary and permanent, the Independent Reviewer needs to continue to examine the issue of both temporary housing and permanent housing the least restrictive and most integrated setting in subsequent reports.

ACBHD achieved Not Applicable for the following:

- 1. The County offers FSPs through community-based providers that provide services under the Community Services and Supports ("CSS") service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10. Within **two years** from the effective date, the County will add 100 FSP slots for adults and transition aged youth for a total.*
- 2. Within **one year** from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the "FSP Assessment").* While the Draft FSP Assessment was completed within the established deadline, it has not been finalized. *of 1,105 FSP slots for that population.*
- 3. The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to:*
 - i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services;*
 - ii. Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment,*

and length of time from identification to enrollment; iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups; and iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.

- 4. The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before finalizing the County's FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.*
- 5. Based on the County's FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.*
- 6. FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than **eighteen (18) months** after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBHD contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.*

SERVICE TEAMS (INTENSIVE CASE MANAGEMENT)

Service Teams are intended to provide services to adults with serious mental illness to decrease or diminish mental health symptoms in order for them to integrate into the community and avoid patterns of psychiatric hospitalization. Service Teams provide support to individuals considered to need a lower level of case management and support interventions than those receiving FSP services. Service teams are intended to serve adults ages 18 and above who have high utilization of emergencies and/or urgent behavioral health systems.

Service Teams were assessed for this second report through review of contracts with community based providers, interviews with ACBHD staff, community-based provider staff and supervisors, reviewing client records, interviewing clients receiving this service, and reviewing data provided by ACBHD.

Requirement: *The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.*

ACBHD continues to contract with thirteen community-based providers for Service Teams for a total of 2,228 slots and plans to maintain this level of service. The Independent Reviewer verified the sustainability and durability of this requirement through review of ACBHD contracts, interviews with community based provider staff, review of client records, and interview of clients.

Requirement: *The County will explore community needs and opportunities for expanding Service Teams as appropriate.*

The Draft of the FSP Assessment was an opportunity to explore community needs regarding FSP and Service Teams services. The Draft includes data from Service Teams and included the Service Team staff as subject matter experts. ACBHD provided a tracking log of the number of clients being served by the community based providers. There is capacity with the community based providers to incorporate FSP clients who are ready to step down to a lower level of care.

Because the FSP Assessment has not been finalized, the Independent Reviewer will examine this further in subsequent reports.

Requirement: *Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; (any county data on this) and will be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.*

The Independent Reviewer was able to interview four service team clients in a virtual group setting. The clients reported that they are receiving services that are flexible and that assist with their autonomy. They reported that they did not have to wait for services to begin. They reported that they receive help with their housing, food and clothing. They also received help with their medication and with staying on their medication. The staff will call to remind the client of a scheduled appointment and will provide transportation to the appointment. The staff also help clients with finding a job and will help the clients with writing their resume. If the client has a crisis after regular business hours, the staff are available to provide crisis intervention services. They reported that the staff will also come to their house to check on them. One client stated that the

Service Teams are “my lifeline”. Overall, all of the clients had very positive things to say about the services they were receiving.

Data of services provided by ACBHD indicated that for FY 2023/24, the frequency of contacts was 2.7 per month. In comparison FY 2022-23, the frequency of contacts was just slightly higher with 2.9 contacts per month. Previous evidence included a review of the contracts with community-based providers, policy and procedures, and interviews with community-based provider staff and supervisors. ACBHD provided contracts with community based providers which required the services as follows: “Assist clients in attaining a level of autonomy within the community of their choosing”.

The chart below are the top treatment locations for Fiscal Year 2023-244

Treatment Locations	Number of Clients
Office	1,567
Telephone	1,220
Field	1,039
Patient’s Home	623
Telehealth	587
Location Unknown/Other	114
Other Community Location	171
Group/Board and Care Home	152
Health/Primary Care	132
Satellite Office	138
Skilled Nursing Facility	50
Community Mental Health Center	61
Psychiatric Inpatient	56
Inpatient (Non Psychiatric)	36
Homeless/ER Shelter	21
Psychiatric Residential Treatment	27
Court	17
Public Health Clinic	14
Emergency Room Hospital	*

* Data was redacted due to ACBHD privacy protocols

ACBHD provided outcomes data for these clients who completed six consecutive months during the 12-month fiscal year. The results were a 79 percent reduction in psychiatric hospital or crisis stabilization unit when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year.

Requirement: *Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.*

Client interviews and a review of client records confirmed that they receive assistance in finding housing and with maintaining housing. Clients reported that they will receive rental assistance if it is needed in order to maintain their housing. Previous evidence was found in the contracts with community-based providers, policy and procedures, review of client records, and interviews with community-based provider staff and supervisors that assistance with housing needs are provided. In addition, ACBHD recently added up to \$60,000 per fiscal year (depending on size of the Service Teams) to assist individuals who needed housing assistance via client support expenditure funding.

However, because housing is such a complex issue, the Independent Reviewer would like to examine the support and assistance for temporary and permanent housing further.

Summary of Service Team Findings

Overall, there are four service commitments in the Service Teams (Intensive Case Management) component of the Settlement Agreement. ACBHD received substantial compliance for two service commitments, a rating of partial compliance for one of the service commitments, and a rating of not applicable for one of the service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirements:

1. *The County will maintain 2,168 slots to provide intensive case management through Service Teams.* ACBHD continues to contract with thirteen community-based providers for Service Teams for a total of 2,228 slots. These slots have been maintained for over 6 months.
2. *Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and will be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.* The Independent Reviewer reviewed client records and interviewed clients who have received these services who confirmed that these services were provided.

ACBHD achieved Partial Compliance for the following:

1. *Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.* The Independent Reviewer interviewed CES staff, interviewed clients and reviewed client records which provided evidence of the services being provided.

ACBHD achieved Not Applicable for the following:

- 1. The County will explore community needs and opportunities for expanding Service Teams as appropriate.*

OUTREACH, ENGAGEMENT, LINKAGES, AND DISCHARGE PLANNING

The Settlement Agreement outlines service components related to outreach, engagement, linkages, and discharge planning. Among other services, the services under this section relate to connecting individuals with the services they need to avoid unnecessary institutionalization and incarceration, and discharge planning from facilities such as John George Psychiatric Hospital, Santa Rita jail, and Villa Fairmont Rehabilitation Center.

Requirement: *The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.*

ACBHD does maintain a 24/7 telephonic ACCESS Line. ACBHD's 24/7 telephone number is posted on their website. ACBHD staff answer the telephone calls during the day and then the telephones are rolled over to Crisis Support Services of Alameda County. The ACCESS telephone number is available on the county's website.

The Independent Reviewer previously interviewed ACCESS staff and the ACCESS Supervisor. The Independent Reviewer interviewed the ACCESS Supervisor during the second on-site review and reviewed ACCESS client records.

Requirement: *The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS or its successor, in order to facilitate prompt and appropriate connection to services following an eligible individual's contact with ACCESS.*

ACCESS staff continue to collect demographic information, current symptoms, and historical information from the caller and then utilize a screening tool to determine eligibility for services. ACCESS teams do not complete the formal clinical assessment. Currently, ACCESS writes up a referral and sends that referral to the community-based provider who then contacts the client to schedule an intake appointment. The community-based providers reported that they complete the clinical assessment.

ACBHD is making meaningful efforts to provide real-time appointments, which at present involve technological and other back-end improvements that would be the foundation for system changes and data collection. In addition to information previously provided, ACBHD has recently received County Board of Supervisors approval to explore a sole source agreement with Epic Systems Corporation (EPIC) for electronic

health record and billing operations software. The Epic project will be conducted in four (4) main phases:

Phase I: Develop ACBHD and Santa Rita Jail requirements and finalize the Epic contract for Board of Supervisor review and approval in the Fall of 2025.

- Phase II: On or around January 2026, project preparation will begin followed by Epic implementation.
- Phase III: With a target date of July 2027 for an official Epic Go-Live, followed by a six (6) month stabilization period.
- Phase IV: ACBHD will evaluate opportunities and timing to implement Epic in remaining ACBH Departments.

ACBHD currently has a pilot underway with Pathways to Wellness where ACCESS coordinates a call with Pathways to Wellness staff and provides the client with a warm handoff to Pathways to Wellness in real time. There are two ACCESS Clinical Review Specialists (CRSs) dedicated to this pilot and have a collaborative relationship with the intake staff at Pathways to Wellness. The CRSs conduct a warm hand off from the ACCESS line to Pathways to Wellness. The pilot is ongoing, and data is being collected on the efficacy of this pilot. ACBHD plans to review the data over an extended period of time to determine if clients who are transferred to Pathways to Wellness have better outcomes and/or follow through with connecting to services than through their regular process.

The Independent Reviewer needs to obtain an update on the technological and other back-end improvements for providing real-time appointments. The Independent Reviewer also will review any outcomes from the Pathways to Wellness pilot for subsequent reports.

Requirement: *When an individual with serious mental illness (1) is identified by the County through section 11.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBHD contracted entity for behavioral health services, the County or an ACBHD contracted community provider will determine the person's eligibility for community-based behavioral health services and, unless the person can no longer be contacted or declines further contact, will provide a complete clinical assessment of the individual's need for community-based behavioral health services (an "assessment").*

For the second report, the Independent Reviewer reviewed client records from ACCESS and interviewed the ACCESS supervisor. The Independent Reviewer had previously reviewed the following for the initial report:

- Policy and procedures,
- Contracts with community-based providers and
- Interviewed ACCESS staff.

ACCESS staff determines eligibility for specialty mental health services at the time of the initial telephone call and the determination is based on medical necessity as defined by the State Department of Health Care Services. ACBHD's policy titled "Adult/Older Adult Outpatient Level of Care Determination states the following:

Individuals new to ACBH services are initially assessed to determine if they meet medical necessity. After medical necessity has been met, a Clinical Review Specialist within the ACCESS unit works with the person and his/her/their supports if appropriate to identify biopsychosocial needs, strengths, and cultural factors relevant to their recovery process. The ACBH Adult/Older Adult Level of Care Determination Tool is completed during this process. This information is used to determine the most appropriate level of care and service provider. (Page 4).

The ACCESS Supervisor stated that ACCESS does not conduct the assessment but sends a referral to the appropriate community based provider. ACBHD provided samples of the referrals from ACCESS which the Independent Reviewer was able to review. The interviews with the community based provider staff confirmed that they conduct the assessment.

The Independent Reviewer only examined the process for individuals referred by ACCESS to community based providers. The Independent Reviewer will need to review the other part of this requirement which is as follows: *identified by the County through section II.4.e* or who *contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBHD contracted entity for behavioral health services.* The Independent Reviewer will review additional ACCESS client records to verify the sustainability and durability of this requirement for subsequent reports.

Requirement: *Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services. As discussed above, the County uses ACCESS to determine eligibility for community-based behavioral health services, and ACCESS refers individuals out to community-based providers for the clinical assessment.*

ACCESS continues to determine eligibility of the individual and then refers the case to the appropriate community-based provider. ACBHD staff interviews and the review of ACCESS client files confirmed that ACCESS does make appropriate referrals to community-based providers. ACBHD also provided samples of the referrals from ACCESS. ACBHD provided a copy of the monthly ACCESS Capacity and Referral Report which lists each program name and current vacancies in each program.

The contract with ACBHD and the community based provider states the following: "Upon receiving a referral from ACCESS, Contractor shall provide assertive outreach to secure treatment engagement."

The chart below reflects data from Fiscal Year 2022-23 regarding access to providers.

Number of Referrals	Number of Referrals Connected to Care	Percent of Referrals Connected to Care	Number of Clients	Number of Clients Connected to Care	Percent of Clients Connected to Care
629	448	71.22%	597	428	71.69%

This chart is only for level one care (i.e. Outpatient) based on the Level of Care Determination Tool. The other levels of care are not indicated which are higher levels of care. The chart indicates that out of 597 clients referred to outpatient, 71.69 percent were connected to treatment services.

The Independent Reviewer will need to examine the number of referrals for FSP or Service Teams and then how many were connected to those services. The Independent Reviewer also needs to examine the assignment process further with the community based providers.

Requirement: *This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.*

Interviews with ACCESS staff plus the on-site review confirmed that ACCESS does make appropriate referrals to community-based providers. ACBHD did provide a report on when assessments are completed by the community-based provider and the number of hours of service provided. The Independent Reviewer interviewed eight clients who reported that they did not have to wait to complete the intake and assessment and for services to begin.

ACBHD provided a copy of the warm hand-off procedure from a contracted community-based provider. The procedure requires the community-based provider staff to contact the client within 24 hours of receiving the referral and offer an intake/assessment appointment within one week of receiving the referral. The Independent Reviewer examined another contract with a community based provider that stated: “Upon receiving a referral from ACCESS, Contractor shall provide assertive outreach to secure treatment engagement.”

Requirement: *Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations. Following a quality review, the County will take appropriate action, if any is indicated, based on the results of the quality review, and the results will inform the County’s FSP Assessment under Section II.2.c.*

The initial report indicated that there have not been any situations where an FSP Team or Service Team were not available to take a case. This was reported by the community-based providers, ACBHD staff, and ACBHD Senior Executive Team. However, ACBHD staff reported that this has occurred in the past several months. They reported that ACCESS now has a way to identify when there are no FSP Team or Services Team available in their electronic health records. Their data system can generate a weekly report that is distributed to the managers for review. The staff also reported that they meet on a weekly basis with the Adult and Older Adult System of Care to review the report. The goal of this meeting is to identify other resources for the client while they are waiting for an FSP Team or Service Team. The ACCESS Supervisor has requested that the number of days on the waiting list be added to the report. The Supervisor also stated that the client remains on the report until they have been officially connected to either an FSP Team or Service Teams. The Supervisor also stated that the report is too new to identify any trends at this point.

Because this situation has just started to occur, the Independent Reviewer will need to monitor this and will report on the status in subsequent reports.

Requirement: *Within two (2) years of the effective date of the Agreement, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.*

This requirement is not due yet and will be discussed in subsequent reports.

Requirement: *The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. In order to do so, this system will focus on factors that include, among others, whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), frequent hospitalizations for mental health reasons, and/or frequent incarcerations (and, in the case of incarcerations, received behavioral health services during an incarceration). The County will connect such individuals, as needed, to FSPs, Service Teams, or other community-based services. The County will use a culturally responsive, peer driven approach that builds on the person's strengths and goals and seeks to address the individual's concerns regarding treatment (including service refusals). Outreach and engagement will include frequent, in person contact in the field in locations convenient to the person. Outreach and engagement will include using the Familiar Faces program to identify and connect with individuals who do not follow up regarding services after experiencing a crisis. Beginning no later than **six (6) months** after the Effective Date, the County will track progress in connecting individuals to needed services.*

Previously, the Adult and Older Adult System of Care Director reported that the County has an Outreach and Engagement (O&E) team. Mobile crisis staff reported that there are three community-based providers who provide outreach and engagement services.
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The O&E Team engages with individuals that are not currently receiving any services. The Interim Director of Crisis Services System of Care reported that there is a Geriatric Assessment Response Team (GART) that can receive referrals from the public, the calls will be screened for both clinical needs and the consumer's health insurance coverage according to professional best practices.

The ACBHD continues to contract for those community-based providers and continues to require that the staff conduct the outreach in the client's natural environment. Previously, evidence was found in policy and procedures along with interviews with community-based providers that individuals are connected to FSP, Service Teams or appropriate community-based services as needed. ACBHD also provided the policy and procedures for the Crisis Connect/Post-Crisis Follow-Up Team. This policy provides guidance on the responsibilities and procedures for O&E teams in conducting in-reaching, referrals, and follow-up for consumers not connected to existing ACBHD services.

ACBHD provided a power point presentation on their outreach and engagement plan which was implemented 9/9/2024. ACBHD implemented the following three teams:

- Crisis Connect/Post Crisis Follow-up Team (CC/PCFT): Six-person team who provide in-reach at JGP and anywhere else in the county to individuals in need of assessment for and linkage to ongoing Behavioral Health/SUD care and other social services.
- Adult Recovery, Outreach and Connection Program (ADROC): Short-Term (90-day) Intensive Case Management for adults, age 25 and older, who are not already connected to the system of care, appear to be experiencing a mental health crisis, and/or have received care in a sobering/detox center, crisis stabilization unit, crisis residential treatment, or inpatient psychiatric hospital.
- Transitional Age Youth Recovery, Outreach and Connection Program (TAYROC): Short-Term (90-day) Intensive Case Management Program for individuals, ages 16 through 24, who are not connected to the system of care, appear to be experiencing a mental health crisis, and/or have received care in a sobering and detox center, crisis stabilization unit, crisis residential treatment, or inpatient psychiatric hospital.

CC/PCFT provides face-to-face in-reach at PES and inpatient units at John George Psychiatric Hospital from 8:30 am to noon Monday through Friday and also receive direct referrals from John George Psychiatric Hospital social workers. CC/PCFT conducts brief screening with clients and will refer clients back to existing provider if they are already linked to services.

For clients that need more support and are not already connected, CC/PCFT will do a warm hand off to the ADROC and TAYROC team who provide face-to face, in-reach to PES and inpatient units at John George Psychiatric Hospital at least once daily, Monday through Friday from 11:30am to 3:00pm. ADROC and TAYROC can work with the individuals post discharge for up to 90 days. The in-reach process aims to engage

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clients, understand their needs, facilitate a smooth transition to other ongoing community-based services, and provides linkage and support during the post-crisis period.

Individuals who are reluctant to consent to services and are at risk of re-hospitalization will be referred to IHOT by CC/PCFT via ACCESS. Goals of these teams are as follows and determined by data, documentation and disposition:

- Number of clients assigned to Service Team,
- Reduce Crisis SOC Recidivism, and
- Continuous participation in services for 6 to 12 months.

ACBHD did provide their tracking log of high inpatient and subacute utilizers. ACBHD reported that the Familiar Faces was a grant funded program, and the grant has expired. However, the Familiar Faces program has been incorporated into existing programs described above.

The Independent Reviewer needs to examine how ACBHD is focusing on the factors identified and how those factors will assist the identification of the population that should receive outreach and engagement services. The Independent Reviewer will also examine how ACBHD is tracking the progress of connecting individuals to appropriate services. The Independent Reviewer will continue to monitor the outreach and engagement plan that was implemented less than six months.

Requirement: *The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact, and will coordinate with these entities to rapidly connect individuals to those services as appropriate.*

Previously, evidence was found of information and education provided to, or coordination with, criminal justice entities for rapid connection to community-based services. ACBHD provided examples of training and educational material that are used to educate providers about alternatives to incarceration, arrest and law enforcement contact. The Independent Reviewer interviewed the Forensic, Diversion, and Re-entry Services Director during both the initial and the second on-site review. The Forensic, Diversion and Re-entry Services Director reported that there are regular multiple meetings with the Sheriff's Office. The Forensic Director also reported that there are re-entry teams that work with the individual within 72 hours of booking to assist the individual with treatment services.

The Independent Reviewer will need to examine how ACBHD coordinates with the above entities to rapidly connect individuals to those services as appropriate.

Requirement: *The County will provide information and education to ACBHD-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.*

Previously, evidence was found of information and education to ACBHD-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact. ACBHD provided many examples of training material that are used to educate providers about available services. Some of these training topics were as follows: overview of working with participants in the criminal justice field, ACT, crisis services, youth justice, and re-entry mental health programs. Interviews with community-based provider staff confirmed that there is coordination with ACBHD regarding rapid connection to community-based services as an alternative to hospitalization or incarceration.

The Forensic, Diversion and Re-entry Services Director reported that they work closely with the Sheriff's Office to coordinate referrals to the community based providers. The Forensic, Diversion and Re-entry Services Director also reported that they have a standing meeting with the offices of the District Attorney and Public Defender regarding referrals to the Behavioral Health Court. The Forensic, Diversion and Re-entry Services Director stated that in collaboration with the Superior Court of Alameda County, they have a pilot at the jail for pre-trial diversion which began on 4/1/2024. ACBHD provided a report on the number of people served.

Requirement: *The County will work with law enforcement to direct referrals to the In-Home Outreach Team ("IHOT").*

ACBHD has the following four In Home Outreach Teams (IHOT):

- One Transitional Age Youth (TAY) County-wide team,
- Three adult teams based on region, and
- A pilot team was added to conduct intensive in reach at Washington Hospital (Fremont) for persons who are familiar faces of the Emergency department.

The TAY IHOT team is comprised of a clinician, two peer providers, and one family member provider. The Adult IHOT teams are comprised of one licensed team lead, a case manager, a peer provider and a family member provider. All teams provide family members for support and education. The purpose of IHOT is to outreach and engage individuals who have historically been difficult to engage into services. IHOT also provides linkages with services that address serious mental health issues and substance use. Law enforcement may refer to IHOT as described in the IHOT Operations Manual and in the ACBHD contract scope of work.

The Independent Reviewer interviewed three IHOT staff during the second on-site review. The IHOT staff confirmed that they work with law enforcement and also receive referrals from ACCESS and crisis residential treatment programs.

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Requirement: *The County will ensure that people with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within **two years** of the Effective Date.*

This requirement will be discussed in subsequent reports.

Requirement: *In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases (“IMDs”). “IMD” as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review (“UR”) pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual’s needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess appropriateness for discharge in light of community-based services appropriate to the individual.*

The Independent Reviewer interviewed the Adult and Older Adult System of Care Director during the second on-site review. This Director reported that the pilot has been implemented, and it has been successful. The Director reported that they meet monthly with community based providers to review each client nearing discharge. This Director also provided the Independent Reviewer with an example of the utilization review from Morton Bakar. Some of the categories listed in this report include the following: planned next steps towards discharge, barriers to discharge, and stability. This Director reported that the county is seeing shorter lengths of stays in the IMDs since the implementation of the utilization review. For example, the length of stay at Villa Fairmont Mental Health Rehabilitation Center was an average of 120 to 130 days. This length of stay has been reduced to approximately 90 days.

The Independent Reviewer will continue to monitor the utilization review pilot and will provide an update in subsequent reports.

Requirement: *Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual’s discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual’s needs, consistent with the individual’s preferences. As part of assisting individuals to transition to the most integrated setting appropriate, appropriate community-based services will be identified. Where applicable and with the individual’s (and, when relevant, his or her legal representative’s) consent, FSP and Service Team providers will participate in the discharge planning process.*

Discharge begins at intake per community-based provider staff interviewed, and per the ACBHD contract. ACBHD provided examples of contracts that require the placement be of a less-intensive level of care and include appropriate referrals to community-based providers. Community-based provider staff interviewed continue to report that they

participate in the discharge planning process. Interview with Adult and Older Adult System of Care Director indicated that there is an acute care coordination meeting every week. The purpose of this meeting is to review cases and to monitor the client's progress and transition to a different level of care, as appropriate.

The Independent Reviewer will review additional client records and will tour an IMD facility and will report on this in subsequent reports.

Requirement: *If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or designee) will be notified, and the County will work to arrange such services as promptly as possible.*

It was previously reported that this situation had not occurred. However, within the last several months, ACBHD staff are starting to see this occur. ACBHD implemented a process to track this occurrence within their IT system. The ACCESS Supervisor reported that there are meetings with the FSP teams and the ACCESS staff every week. This Director also reported that this same group meet quarterly to review any trends. This Director reported that they do refer the client to another service while waiting for a slot to open in a FSP team. One barrier that has resulted in FSP being unavailable is workforce shortages and there is high turnover with this position.

Since this situation has only recently occurred, the Independent Reviewer will continue to monitor and will follow up in a subsequent report.

Requirement: *The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.*

Interview with Adult and Older Adult System of Care Director indicated that there continues to be an acute care coordination meeting every week. The purpose of this meeting is to review cases and to monitor the client's progress and transition to a different level of care, as appropriate. The implementation of the utilization management pilot has also assisted with this process. This Director also reported that the Adult/Older Adult System of Care has created three new positions to assist with transitions of care into and out of acute inpatient and IMD settings and they are currently in the hiring process.

Requirement: *Linkages for Services Following Discharge from John George PES and Inpatient. The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5. The County will collaborate with John George to support John George's safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate,*

including through ACBHD's critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services.

*Beginning no later than **eighteen (18) months** after the Effective Date, the County's role in this collaboration will include, to the fullest extent reasonably practicable: (1) using available data to promptly identify individuals registered by John George who are both (a) likely to be, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration, and (b) likely to be eligible for and in need of FSP or Service Team services; (2) upon identification, to the extent that the individual has not yet been discharged, promptly coordinate with John George to determine whether the individual is eligible for and in need of any such services; and (3) if the individual is eligible for and in need of any such services and to the extent that the individual has not yet been discharged, promptly connecting the individual to an FSP or Service Team to commence engagement, which may include participation in discharge planning and commencement of services upon the individual's discharge.*

John George has three units for a total of 69 beds and an additional 11 beds for Psychiatric Emergency Services (PES) for a grand total of 80 beds. ACBHD staff and community provider staff continue to report that the relationship with John George continues to improve. They primarily point to the John George Psychiatric Hospital Social Worker at John George who communicates with ACBHD and community provider staff on a daily basis to coordinate care. ACBHD Senior Executive Team reported that ACBHD staff are invited to participate in the discharge process.

The Independent Reviewer was given a tour of the Inpatient facility and the Psychiatric Emergency Services facility. The Independent Reviewer also interviewed John George Psychiatric Hospital staff along with the Forensic Psychologist, Social Worker, and the Chair, Department of Psychiatry. The Independent Reviewer reviewed 20 client records.

The Adult and Older Adult System of Care Director reported that they now have access to John George's electronic health record which indicates progress, and they use this real-time access for care coordination purposes.

There are portions of this requirement that are not due to begin until eighteen months from the effective date of the Settlement Agreement and will be discussed in a subsequent report.

Requirement: *The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual's FSP or Service Team (if any) in the discharge planning process and, with respect to patients determined eligible for and in need of such services under section II.4.k.ii above, invite and actively include representatives of the County or a County-contracted community based service provider*

in the discharge planning process. To the fullest extent reasonably practicable and within the direct control of the County and its community-based service providers, and with the individual’s consent, the County will ensure that: (1) representatives of the FSP or Service Team are included in the discharge planning process for those individuals who are assigned to or are clients of a County FSP or Service Team; and (2) representatives of the County or a County contracted community-based service provider are included in the discharge planning process for those individuals who are not assigned to an FSP or Service Team but who have been identified as eligible for an FSP or Service Team under section II.4.k.ii above. To the extent that John George routinely does not include such representatives in the discharge planning process, the County will seek to identify and reasonably address barriers to John George’s inclusion of such representatives in discharge planning.

ACBHD Senior Executive Team previously reported that ACBHD staff are invited to participate in the discharge planning process. The Senior Executive Team also reported that the goal is for prompt connection to community-based services. There are two Critical Care Managers that assist with acute inpatient care coordination between the following: acute and subacute, acute and crisis residential, inpatient and outpatient, and discharge planning. John George Psychiatric Hospital attends the weekly care coordination meeting and care conferences, as needed. The John George Psychiatric Hospital Social Worker reported that she regularly communicates with the community based providers regarding discharge. The staff of the community based providers also confirmed this.

The Adult and Older Adult System of Care Director reported that they are creating a transition team to assist with their transition back into the community.

The chart below shows the number of clients served at John George Psychiatric Hospital based on data for the last two fiscal years.

Service Modality	FY 2022-23 Number of Episodes	FY 2022-23 Number of Clients	FY 2023-24 Number of Episodes	FY 2023-24 Number of Episodes
Crisis Stabilization	8,584	4,270	8,404	4,274
Hospital	2,304	1,564	2,535	1,714

The number of clients admitted to the crisis stabilization unit remained roughly the same from one fiscal year to the other. The number of clients served at the inpatient hospital and the number of episodes slightly increased from FY 2022-23 to FY 2023-24.

Since this requirement incorporates II.4.k.ii which is not yet due, the Independent Reviewer will review this requirement and will report on the implementation in a subsequent report.

Requirement: *Beginning no later than **eighteen (18) months** after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital to promptly identify individuals with serious mental illness who are discharged to the community and who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration in accordance with section II.4.e. and will comply with its obligations under section II.4.c.*

This requirement will be discussed in subsequent reports.

Requirement: *The County will use programs designed to reach individuals who do not follow up regarding services.*

Previously, the Adult and Older Adult System of Care Director reported that the County has an Outreach and Engagement(O&E) team. The outreach and engagement teams were described in a previous requirement. There are also three community-based providers who provide outreach and engagement services. One example is from BACS, a community-based provider, who has an Assertive Outreach Protocol for clients who do not engage or follow-up for services. This protocol requires the community-based provider staff to continue outreach and engagement efforts for minimum of 90 days from the last date of service.

The Independent Reviewer interviewed three staff from the IHOT team. The staff confirmed that they are trying to engage a client within 90 days. The staff reported that there are peer counselors, and a family advocate who also provide outreach and engagement to the clients who do not follow up for services. The peer counselors reported that they try to meet the client where they are at and treat them with respect. They also reported that the lack of permanent stable, safe housing is the biggest challenge.

Requirement: *The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP's or Service Team's prompt resumption of services upon discharge.*

The Adult and Older Adult System of Care Director previously reported that they have access to John George Psychiatric Hospital's electronic health record, and they use this real-time access for care coordination purposes. ACBHD staff and the Social Worker at John George Psychiatric Hospital confirmed that they do collaborate when clients are admitted facilitating prompt resumption of services upon discharge. Further, the new Transition of Care team will assist with notification of FSPs and Service Teams when their clients are at John George Psychiatric Hospital.

Requirement: *Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v.*

County of Alameda Consent Decree (including section III.I, “Discharge Planning,” page 49:13-51:18). The County will ensure that ACBHD collaborates with the County Sheriff’s office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.

The Forensic, Diversion and Re-entry Services Director previously reported that there are multiple meetings with the Sherriff’s Office. For example, leadership meets twice a month, re-entry staff meet weekly, and suicide prevention meets monthly. The Director reported that there are two dedicated FSP teams that are through contracts with community-based providers. There is also one re-entry team, and this team refers to community-based services. The Director also described the Community Assessment, Referral and Engagement Services (C.A.R.E.S) ACT Court. This program diverts individuals away from jail and the criminal justice system into supportive services and, per legislation, referrals can be made by various entities, including law enforcement.

The Independent Reviewer interviewed the Forensic, Diversion and Re-entry Services Director during the second on-site review. This Director confirmed that their re-entry teams start working with the individual within 72 hours of booking. The purpose is to coordinate re-engagement with services upon release or to initiate new referrals for ongoing behavioral health services in the community. The re-entry team provides support to individuals to provide a warm handoff to services. This Director also stated that if the individual refuses services, the team tries 3 times to engage the individual into services.

The chart below, indicates that for Fiscal Year 2023 to 2024, only 18.84% of the individuals discharged were served in a new or existing community based provider within 30 days of jail discharge.

Number of MHS Clients Released and Served in MHS in the Previous Year	Number of MHS Clients Served in New Community Based Episode Within 30 Days of Jail Discharge	Percent of MHS Clients Served in New Community Based Episode Within 30 Days of Jail Discharge	Number of MHS Clients Served in New or Existing Community Based Episode Within 30 Days of Jail Discharge	Number of MHS Clients Served in New or Existing Community Based Episode Within 30 Days of Jail Discharge
3,126	333	10.65%	697	22.3%

The Independent Reviewer needs to examine ACBHD’s best efforts to identify and implement appropriate strategies to improve warm handoffs to individuals for appropriate services.

Requirement: *Beginning no later than **eighteen (18) months** after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.*

This requirement will be discussed in subsequent reports.

Requirement: *Beginning no later than **six (6) months** after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.*

It was previously reported that this situation did not occur. However, within the last several months, ACBHD staff are starting to see this occur. ACBHD also implemented a process to track this occurrence within their IT system. As stated previously, the Adult and Older Adult System, Forensic Reentry system, and ACCESS meet weekly and review individuals who need FSP or Service Team level of care to make assignments to open slots and assign interim services until slots become available. The Adult and Older Adult Systems of Care Director reported that there are monthly meetings with the FSP Teams and the ACCESS staff every week. This Director also reported that this same group meet quarterly to review any trends. This Director reported that they do refer the client to another service while waiting for a slot to open in a FSP team. The Forensic, Diversion and Re-entry Services Director reported that referrals for FSP are sent to ACCESS. The Forensic, Diversion and Re-entry Director reported that they are piloting the use of tablets to assist with the coordination and warm handoff for the individuals being released.

Since the situation of unavailability of FSP or Service Teams has only recently occurred, the Independent Reviewer will continue to monitor and will follow up in a subsequent report.

Requirement: *With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any, based on the results of the evaluation in section II.4.i.ii. and the quality reviews in section II.4.i.iii. Where appropriate, the results of the quality reviews under section II.4.i.iii will inform the County's FSP Assessment under section II.2.c.*

The Forensic, Diversion and Re-entry Services Director reported that supervisors and managers are now conducting chart reviews on a regular basis. This Director reported

that they also review the re-entry plans and provide training to the community based provider staff. One example of a change as a result of the quality reviews was to list medications on the re-entry plan. ACBHD did provide the assessment form and the re-entry form to the Independent Reviewer.

There is also the Multi-Disciplinary Forensic Team (MDFT) comprised of Alameda County law enforcement agencies, Alameda County District Attorney's Office, Alameda County Behavioral Health Care and allied service providers. The goal of MDFT is to provide assistance to individuals diagnosed with mental illness, substance abuse, and co-occurring disorders. MDFT is committed to reducing recidivism by assisting these individuals in obtaining psychiatric evaluation, treatment, and ongoing services leading to recovery and the wellness of the individual and the greater community.

This requirement incorporates service commitments II.4.1.ii and II.4.1.iii which are not due yet, the Independent Reviewer will examine the action taken by ACBHD and report on the results in subsequent reports.

Requirement: *The County will use programs designed to reach individuals who do not follow up regarding services, consistent with section II.4.e.*

The Forensic, Diversion and Re-entry Services Director previously reported that there is ACBHD re-entry team based at the county jail who follows-up with these individuals. Two behavioral health clinicians are available to assist individuals in navigating services after they are released from jail. This Director confirmed that their re-entry teams start working with the individual within 72 hours of booking. The purpose is to coordinate re-engagement with services upon release. The re-entry team provides support to this individual to provide a warm handoff to services. This Director also stated that if the individual refuses services, the team tries 3 times to engage the individual into services.

Summary of Outreach, Engagement, Linkages, and Discharge Planning Findings

This is the largest service commitment in the Settlement Agreement. Overall, there are twenty-six service commitments in the Outreach, Engagement, Linkages and Discharge Planning component of the Settlement Agreement. ACBHD received substantial compliance for eight service commitments, a rating of partial compliance for six service commitments and a rating of not applicable for 12 service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirements:

1. *The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below. ACBHD does maintain a 24/7 telephonic ACCESS Line and the number is posted on their website.*

Evidence was found during the on-site reviews, interviews of ACBH staff and supervisor, and in reviewing client records.

2. *This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.* Evidence was found in contracts, community based provider procedures, client records, interviews with ACCESS staff, interviews with clients, and the on-site review.
3. *The County will provide information and education to ACBHD-contracted behavioral health providers and will coordinate with these entities to rapidly connect individuals to those services as appropriate.* Evidence was found in the information and education materials, training documents, and interviews with ACHBD staff. There are regular meetings with the police department, and there is a pilot at the jail for pre-trial diversion.
4. *The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).* Evidence was found in the interviews with the IHOT staff, review of training materials, review of policy and procedures and review of data collected.
5. *The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.* Evidence of care coordination was found in interviews with ACBHD staff, review of client records, and a weekly meeting to review cases that monitor the client’s progress and transition to a different level of care, as appropriate.
6. *The County will use programs designed to reach individuals who do not follow up regarding services.* Evidence was found in interviews with ACBHD staff including the IHOT team, training materials, policies and procedures, and community based outreach and engagement teams.
7. *The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP’s or Service Team’s prompt resumption of services upon discharge.* Evidence was found in interviews with ACBHD staff, John George Psychiatric Hospital staff and with ACBHD having access to John George Psychiatric Hospital’s electronic health record, and they use this real-time access for care coordination purposes.
8. *The County will use programs designed to reach individuals who do not follow up regarding services, consistent with Section II.4.e.* Evidence was found in interviews with ACBHD staff and through documents regarding the re-entry teams.

ACBHD achieved Partial Compliance for the following requirements:

1. *The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS, in order to facilitate prompt and appropriate connection to services following an eligible individual's contact with ACCESS.* The Independent Reviewer needs to obtain an update on the technological and other back-end improvements for providing real-time appointments along with any outcomes from the Pathways to Wellness pilot for subsequent reports.
2. *When an individual with serious mental illness (1) is identified by the County through section II.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBHD contracted entity for behavioral health services, the County or an ACBHD contracted community provider will determine the person's eligibility for community-based behavioral health services and, will provide a complete clinical assessment.* The Independent Reviewer needs to review the other part of this requirement and will review additional ACCESS client records to verify the sustainability and durability of this requirement in the next report.
3. *Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services.* The Independent Reviewer will need to examine the number of referrals for FSP or Service Teams and then how many were connected to those services. The Independent Reviewer needs to examine the assignment process further with the community based providers.
4. *The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.* The Independent Reviewer needs to examine how ACBHD coordinates with the above entities to rapidly connect individuals to those services as appropriate.
5. *Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual's discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual's needs, consistent with the individual's preferences.* Evidence of discharge planning was found in interviews with community-based provider staff, and in contracts with community based providers. The Independent Review needs to review client records and tour an IMD facility.
6. *Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v.*

County of Alameda Consent Decree (including section III.I, "Discharge Planning," page 49:13-51:18). The County will ensure that ACBHD collaborates with the County Sheriff's office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services. The Independent Reviewer needs to examine ACBHD's best efforts to identify and implement appropriate strategies to improve warm handoffs to individuals for appropriate services

ACBHD achieved Not Applicable for the following:

- 1. Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations.*
- 2. Within **two (2) years** of the effective date of the Agreement requires ACBHD to, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.*
- 3. The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. Beginning no later than six (6) months after the Effective Date, the County will track progress in connecting individuals to needed services.*
- 4. The County will ensure that individual's with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within **two years** of the Effective Date.*
- 5. In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases ("IMDs"). "IMD" as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review ("UR") pilot program.*
- 6. If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or designee) will be notified, and the County will work to arrange such services as promptly, as possible.*
- 7. Linkages for Services Following Discharge from John George PES and Inpatient. The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and*

John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5. The County will collaborate with John George to support John George's safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate, including through ACBHD's critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services.

8. *The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual's FSP or Service Team (if any) in the discharge planning process and, invite and actively include representatives of the County or a County-contracted community based service provider in the discharge planning process.*
9. *Beginning no later than **eighteen (18) months** after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital.*
10. *Beginning no later than **eighteen (18) months** after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.*
11. *Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations,*
12. *With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the County will take appropriate action, if any, based on the results of the evaluation in section II.4.1.ii and the quality reviews in section II.4.1.iii. Evidence was found in interviews with ACBHD staff, review of documents, supervisors and managers conducting chart reviews, the federal monitor quarterly chart reviews and with the Multi-Disciplinary Forensic Team.*

CULTURALLY RESPONSIVE SERVICES

The Settlement Agreement outlines the service components under Culturally Responsive Services which include the County continuing to ensure that all services are culturally responsive and person-centered. In Alameda County, Culturally Responsive Services are organized under the Office of Health Equity with a Director who reports directly to the Behavioral Health Director. During the second on-site review, the Independent Reviewer was able to interview the Director, Office of Health Equity.

Requirement: *The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. The County will continue to provide and expand culturally responsive behavioral health services, including through community-based and peer-run organizations, and will continue to identify and implement culturally and linguistically appropriate and affirming strategies and practices to help reduce behavioral health disparities across racial, ethnic, cultural, and linguistic groups.*

Alameda has six threshold languages as defined by DHCS Information Notice #20-070. The most prevalent threshold language is Spanish. The other five threshold languages are as follows: Cantonese, Farsi, Mandarin, and Vietnamese.

ACBHD developed a strategic plan dated May 13, 2024, with seven themes and strategic directions. There are two goals in this plan that are related to Culturally Responsive Services. The first goal is to uplift community assets for policy/program development and the second goal is to increase equitable care for communities facing the greatest inequities through outreach, recruitment, and programs and opportunities for improvement especially for diverse Asian, Black, and LGBTQIA2S+ communities.

ACBHD has a Cultural Competence Plan (CCP), December 2024 Plan Update. The plan describes the following:

- **Vision:** We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.
- **Values:** ACBHD's values reinforce our commitment to not only recognize the cultural, linguistic, and ethnic diversity of our community but also actively integrate cultural competency and humility into our services. By living the following values, we aim to create a system that supports and empowers all beneficiaries to achieve equitable health and wellness outcomes.
- **Access:** We value collaborative partnerships with peers and consumers, families, service providers, agencies, and communities, where every door is the right door for welcoming people with complex needs and assisting them along their journey toward wellness, resilience, and recovery.

- **Consumer and Family Empowerment:** We value, support, and encourage individuals and their families to exercise their authority to make decisions, choose from a range of available options, and develop their full capacity to think, speak, and act effectively in their own interest and on behalf of others they represent.
- **Best Practices:** We value clinical excellence through best practices, promising community driven ideas, and effective outcomes, including prevention and early intervention strategies, to promote well-being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.
- **Health & Wellness:** We value the integration of psychological, emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.
- **Culturally Responsive:** We value the integration of psychological, emotional, spiritual, and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.
- **Socially Inclusive:** We value advocacy and education to eliminate stigma, discrimination, isolation, and misunderstanding of persons experiencing mental illness, trauma, and substance abuse disorders. We support social inclusion and the full participation of our clients, consumers, patients, and family members to achieve fuller lives in communities of their choice – where they can live, learn, love, work, play, and pray in safety, security, and acceptance.

The CCP, December 2024 Plan Update reported the following regarding workforce capacity and needs:

The ACBHD aims to be intentional in its recruitment and retention efforts, given Alameda County’s diversity and ongoing labor challenges in the behavioral health sector. Through the needs assessment, the ACBHD wanted to understand the diversity of the workforce and the existing strategies to recruit and retain a diverse workforce.

Finding 1: Hiring and recruiting staff reflective of the client population is both a priority and a challenge for community-based providers.

Finding 2: There is a shortage in bilingual and racially diverse staff, especially clinicians. Providers spoke to the critical need for enhanced linguistic diversity and cultural competence within the workforce.

Finding 3: Providers who participated in the needs assessment reported experiencing challenges in meeting the complex health and social needs of their clients, which can contribute to burnout.

Finding 4: Providers expressed support for the critical role that the family and peer workforce can play in meeting their clients' needs and reported engagement efforts. (Pages 135-140)

The CCP, December 2024 Plan Update did identify the following issues from survey respondents and focus group participants the following:

In noting gaps in the behavioral health system, respondents mentioned concerns around language capacity and the system's limited ability to support people who do not speak English. For programs serving those with severe mental illness, community members mentioned a need for more family input for treatment and a better understanding of the Health Insurance Portability and Accountability Act. Community input highlighted the need for more centralized resources for people experiencing homelessness and increased the quality and cultural responsiveness of services for the African American/Black community. (Page 59).

The MHSA Annual Plan Update (Draft) for Fiscal Year 2024 through 2025 includes the goal of being culturally responsive which is defined as follows:

"We honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service setting, treatment options, and in the processes, we use to engage our communities" (Page 10).

The MHSA Annual Plan Update (Draft) for FY24/25, identifies several recurring themes as identified by numerous listening sessions conducted between October 2023 through January 2024. One theme identified was "Access, Coordination and Navigation to Services". The plan lists two strategies and solutions related to cultural competency which are as follows:

- Prioritize bilingual services to support multiple languages in the growing client base and improve accessibility for diverse communities.
- Implement culturally sensitive and appropriate outreach strategies to effectively engage diverse communities (Page 53).

The MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states that three of the reoccurring themes in the community listening session were as follows: "More services for the African American community across the lifespan; supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers and; and the need for increased language capacity" (Page 65).

ACBHD provided contracts with their community based providers which stated the following: "Contractor shall maintain staffing with professional experience and expertise in providing evidence-based, culturally, and linguistically appropriate services, particularly for any designated priority populations that Contractor has agreed to serve."

Interviews with both ACBHD staff and community-based provider staff previously indicated that the services provided are culturally responsive and person centered. The Independent Reviewer was able to review over fifty client records where the client's goals are identified and were developed in a manner consistent with a person-centered approach. The Independent Reviewer also interviewed eight clients in a virtual group setting, and they confirmed that services are provided in a culturally responsive and person-centered manner. Clients spoke about receiving culturally appropriate services surrounding the holidays such as their traditional meals.

ACBHD also conducts a Cultural Responsiveness Committee (CRC) and the community-based providers also reported that the County staff, community-based providers staff, and stakeholders attend these meetings. The Independent Reviewer reviewed the minutes for four committee meetings in 2024. These meetings are facilitated by the Health Equity Policy and Systems Manager. During the meeting, the CCP is discussed along with updates from the various culturally responsive advisory committees, announcements of trainings and upcoming events of interest.

The CCP, December 2024 Plan Update has a section on strategies and efforts for reducing racial, ethnic, cultural, and linguistic mental health disparities. The plan stated that: "We are intentional in our efforts to reduce mental health disparities and create a more equitable and inclusive behavioral health system." (Page 61). This section in the Plan includes the following:

- Identified unserved/underserved target populations with disparities,
- Identified disparities within target populations,
- Strategies/objectives/actions/timelines,
- Additional strategies/objectives/actions/timeline and lessons learned, and
- Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities.

Requirement: *The County will continue to operate the Office of Health Equity within ACBHD, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBHD, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client centered care that considers the whole person and all their needs.*

ACBHD previously provided an organizational chart that indicates that the Director, Office of Health Equity, reports directly to the ACBHD Director. This division also includes the Office of Ethnic Services, the Office of Peer Support Services, the Office of Family Empowerment Services, Health Equity Policy, Community Relations, and Workforce Education and Training (WET). The division also oversees operations related to Patients' Right Advocacy. The Independent Reviewer interviewed the Director, Office of Health Equity during the second review.

In December 2023, ACBHD conducted a listening session with the Executive Team at the LGBTQ Center in Oakland and learned more about the needs of its clients and the LGBTQ Community. This was reported in the MHSA Annual Plan Update (Draft) for FY 24/25 which included the following:

“They are seeing a need for more programs to address social isolation in the elderly population. The housing being developed is not created with LGBTQ concerns in mind and accommodations for the LGBTQ community are leading to displacement from new developments. Also, needs for LGBTQ people in homeless encampments need to be addressed due to rising threats and violence. HIV is an ongoing problem that is receiving less resources but still needs to be addressed. Overall, the LGBTQ Center is looking to bring on a care navigator and would like to continue to participate in county programs” (Page 441).

The CCP, December 2024 Plan Update lists out the number of coalitions/committees with stakeholder participation to provide feedback to the department. Some of these coalitions/committees are as follows:

- ACBH Pride Coalition,
- Asian American, Native Hawaiian, and Pacific Islander Advisory (AANHPI) Committee for Health and Wellness,
- African American Steering Committee for Health and Wellness,
- First 5 Help Me Grow,
- Latinx/Latino Advisory Committee for Health and Wellness, and
- Mental Health Association for Chinese Communities.

Requirement: *No later than **fifteen (15) months** after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity’s public internet website setting forth aggregated data metrics on the populations served by ACBHD (including individual racial and ethnic groups broken down by geographic area within the County) and various communities’ service needs (including racial and ethnic groups’ needs for FSP, Service Team, and IHOT services in geographic areas within the County.*

ACBHD completed the dashboard, and it is uploaded to their website. ACBHD hosted a stakeholder and community meeting on March 6, 2025, to obtain their feedback. Subsequent reports will address this further as the deadline is 15 months after the effective date of the Settlement Agreement.

Requirement: *The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services*

in the County. The Health Equity Officer will periodically make recommendations to the Director of ACBHD on how to improve culturally responsive services in the County and coordinate with the County's other diversity, equity, and inclusion programs and activities.

This will be discussed in subsequent reports since this requirement is not due at this time.

Requirement: *The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County's service delivery system. The African American Wellness Hub facility will serve as a hub and coordinating center for a variety of behavioral health services, community-based supports, and linkages for the Black/African American community in the County. The County will provide opportunities for community and stakeholder engagement over the course of this project to further the project's focus on providing culturally inclusive, respectful, and relevant supports to the County's Black/African American clients and community.*

Previously, the Health Equity Division Director reported that the County found a building, and Escrow has closed on the building. The African American Wellness Hub will serve as a focal point designed to preserve and actualize the core understanding and best practices of African American clients and community members with a focus on wellness.

The County has dedicated \$19 Million dollars to this effort. ACBHD provided evidence of multiple listening sessions with stakeholders. At the Board of Supervisors meeting on 9/17/2024, the Board approved the following:

- The initial project budget for the African American Wellness Hub Project in the amount of \$5,000,000;
- The use of Alameda County Health, Behavioral Health Department funds for the initial project budget for the African American Wellness Hub Project, in the amount of \$5,000,000;
- Authorized the Director of the General Services Agency or her designee to issue Task Order No. 20115, in the amount of \$3,866,861, with Vanir Construction Management, Inc., for the program and project management services for the African American Wellness Hub.

The Health Equity Division Director stated that the plan from the County's General Services is to tear down the existing building on the land and to build a new building. This Director reported that they meet with the stakeholders on an as needed basis. Some examples of the stakeholder meetings include topics such as CARE Court and Prop 1 implementation. This Director also reported that the county continues a commitment to this project.

Requirement: *The County has implemented and will continue to provide periodic and ongoing trainings to all ACBHD staff and ACBHD-contracted community-based providers regarding: culturally responsive services; trauma-informed care; inequities across race, ethnicity, sex, sexual orientation, gender identity, and disability; anti-racism and implicit bias. A primary intent of such trainings is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.*

Training is provided upon hire and throughout the year. The ACBHD Health Equity Division Director reported that training is under the purview of the Office of Ethnic Services within ACBHD Department in collaboration with the Workforce and Education Team. The Health Equity Division Director also reported that the County has a contract with ONTRACK to provide the Culturally and Linguistically Appropriate Services (CLAS) training and offers training each month. For the community-based providers, the following language was found in their contract with ACBHD: “Contractor shall ensure annual training of all applicable employees, volunteers, board members, owners, and/or agents who are providing and/or supporting services under this Agreement on Administrative and Compliance Requirements, in areas including but not limited to: documentation standards, billing requirements, Culturally and Linguistically Appropriate Standards (CLAS), Annual Compliance/Code of Conduct, and Health Insurance Portability and Accountability Act (HIPAA)/Privacy and Security.”

The CCP, December 2024 Plan Update stated the following:

Steps to Provide Required Cultural Competence Training to 100% of Staff Over Three-Year Period: To ensure that all staff complete the required Cultural Competence Training, ACBHD requires compliance for all internal staff. Each contracted provider is required to abide by contractual obligations. Completion of required cultural competency training is reviewed annually by ACBHD staff.

Per the executed contract: Provider, Program and Staff Information Contractor shall submit any needed updates to provider, program and staff information, as well as attestation of accuracy of information on file by the 15th of each month as requested by ACBH to complete required publications, submissions and monitoring including but not limited to Provider Directory and Network Adequacy Reporting. Contractor’s submission shall include but not be limited to Contractor’s cultural and linguistic capabilities in service delivery and documentation of staff completion of cultural competence training and shall be in accordance with the format specified by ACBH and the California Department of Health Care Services (DHCS).

The Health Equity Division Director reported the following activities to ensure that the training requirements are met:

1. Sign-in sheets are collected at the training and reviewed as part of compliance.

2. Each contract with a community based provider is required to provide CLAS training to all direct service staff and managers who are providing or supporting services through this Agreement. The staff are to complete at least four CLAS training courses annually. The community based provider submits the following information by July 10th of the following fiscal year to the ACBHD Office of Ethnic Services:
 - a. An electronic survey that demonstrates Contractor's implementation of CLAS Standards,
 - b. A list of CLAS trainings attended by staff and managers who are providing or supporting services through this Agreement; and
 - c. A summary or copy of a plan to further implement CLAS Standards throughout the organization.
3. The Office of Ethnic Services conducts a survey at the end of each year to assess and confirm attendance, plans and adherence to CLAS standards each year. A copy of the survey results was provided for review.
4. QA/QI team performs audits and the CLAS standard portion of the contract is assessed.

Trainings also include an evaluation form to be completed if CEUs are to be issued. Some trainings do include a post test. In addition, the Health Equity Division Director reported that they currently collect attendance at the class, but that ACBHD is moving toward a more efficient process where each CLAS training has an electronic sign-in sheet. This process will allow for the normalization of collected information. Office of Ethnic Services is also moving toward collecting data on ACBHD hosted CLAS trainings via the internal announcement portal in FY 2025-26.

ACBHD provided an EXCEL sheet summarizing the topic of the training, date of the training, who attended, and the attendees' organization for review. Some of the trainings were as follows: Trauma informed and culturally responsive practices working with Asian American, Native American, and Pacific Islander clients, CLAS standard and stigma discrimination reduction in behavioral health, and Mental health services with Latinx populations.

Summary of Culturally Responsive Services Findings

Overall, there are six service commitments in the Culturally Responsive Services component of the Settlement Agreement. ACBHD received substantial compliance for four service commitments, and a rating of not applicable for two service commitments. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirement:

1. The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. ACBHD provided evidence of their strategic plan, the CCP plan, and minutes of the CC committee

meetings. Review of contracts with community based providers and interviews with community based provider staff and with clients also confirmed that services provided are culturally responsive and person-centered.

2. The County will continue to operate the Office of Health Equity within ACBHD, will report to the Director of ACBHD, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders and to ensure clients receive high quality and client centered care that considers the whole person and all their needs. There is evidence to support compliance with this requirement through interviews with ACBHD staff, community provider staff, and the CCP December 2024 Plan Update minutes of the Cultural Responsiveness committee.

3. The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County's service delivery system. The County continues to support the African American Wellness Hub with finding a building and General Services work to build a new building. ACBHD provided the approval of project by the Board of Supervisors, listening sessions from the stakeholders, a YouTube video regarding the African American Wellness Hub and interviews with ACBHD staff.

4. The County has implemented and will continue to provide periodic and ongoing training to all ACBHD staff and ACBHD-contracted community-based providers. The primary intent of such training is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations. ACBHD provided the following evidence: trainings occur on a regular and sustained basis, procedure to ensure all staff are attending these training courses and a list of training topics.

ACBHD achieved Not Applicable for the following:

*1. No later than **fifteen (15) months** after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than **one month** before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website.*

2. The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services in the County.

SUMMARY AND NEXT STEPS

This is the second report from the Independent Reviewer regarding the Settlement Agreement between the County of Alameda and ACBHD with Disability Rights California (DRC), and the United States Department of Justice (DOJ) which became effective on January 31, 2024. ACBHD has been very cooperative in providing the information requested by the Independent Reviewer.

A rating of substantial compliance was given in 42 percent of the service commitments, a rating of partial compliance was given in 22 percent and a rating of not applicable was given for 36 percent of the service commitments.

The draft of the second report was issued on February 28, 2025. Per the Settlement Agreement, the parties have fifteen (15) days to provide comments and responses to the Independent Reviewer for consideration. The finalized report is submitted to the parties and made public, with any redactions necessary under California or Federal Law.

The Independent Reviewer will continue to evaluate implementation of all provisions. The Independent Reviewer will also verify if the requirements were sustained after six months and are durable for any of the partial compliance ratings given. The Independent Reviewer will also monitor the implementation of any of the requirements given a not applicable rating if the deadline is during the next report. The next report is to be submitted 20 months after the effective date of the Settlement Agreement.

Attachment I: Ratings of Service Commitments

SERVICE COMMITMENT	RATING ³	
1. Crisis Services	First Report	Second Report
1.a. The County will continue to offer a countywide crisis system and expand crisis intervention services.	PC	SC
1.a.i. Maintain a 24/7 crisis hotline. The crisis hotline will provide screening and de-escalation services on a 24/7 basis. No later than 18 months after the Effective Date, the County will expand the 24/7 crisis hotline to provide triage and the identification of full service partnership clients on a 24/7 basis. Beginning no later than 18 months after the Effective Date, the crisis hotline will have a clinician available to support crisis hotline services 24/7.	NA	NA
1.a.i. (2) The County will coordinate with entities responsible for managing urgent and emergency care response lines, including but not limited to the crisis hotline, 911, FSP warmlines, and 988 (when and if such coordination is available), to ensure there is “no wrong door” for accessing appropriate crisis services. The County will have and will implement protocols for when to conduct warm handoffs from its crisis hotline to FSP warmlines to provide appropriate services. The County will respond to 911-dispatch inquiries in order to facilitate an appropriate behavioral health response to crises.	PC	PC
1.a.i.(3) The County will implement protocols and education efforts to ensure appropriate deployment of County mobile crisis teams in response to calls received through emergency response lines.	NA	SC
1.a.ii.(1) Mobile crisis teams will provide a timely in-person response to resolve crisis as appropriate. When clinically appropriate, mobile crisis services may be provided through the use of telehealth.	PC	NA
1.a.ii.(2) Mobile crisis services shall be provided with the purpose of reducing, to the greatest extent possible, interactions with law enforcement during mental health crisis, reducing 5150 and John Geoge psychiatric emergency services (PES) placement rates, and increasing the use of voluntary community-based services (including diversion, care coordination, transportation, and post-crisis linkages to services).	PC	SC
1.a.ii.(3) The County has recently expanded its mobile crisis capacity to nine (9) mobile crisis teams and agrees to maintain this as a minimum capacity.	PC	SC
1.a.ii. (4) The County shall complete an assessment of needs and gaps in mobile crisis coverage, no later than one year after the execution of this Agreement, that is designed to determine the amount and number of mobile crisis teams needed to provide mobile crisis services consistent with this Agreement (the “Mobile Crisis Assessment”). The Mobile Crisis Assessment will be informed by and will appropriately take into account (i) community and stakeholder input; and (ii) all necessary data and information sufficient to assess	NA	SC

³ Due to the temporal limitations of this report, a rating of substantial compliance was not yet possible. Second Report April 14, 2025

the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.		
1.a.ii.(5)The County will provide a draft of the design of the Mobile Crisis Assessment to the Independent Reviewer (see section III.1.a of this Agreement) for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the Mobile Crisis Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final Mobile Crisis Assessment will promptly be made available to the public.	NA	SC
1.a.ii.(6) Based on the County’s Mobile Crisis Assessment, the County will reasonably expand its mobile crisis services as needed in order to operate a sufficient number of mobile crisis teams to provide timely and effective mobile crisis response.	NA	NA
1.a.ii.(7) FSPs will provide crisis intervention as set forth in section II2.m. in this Agreement.	PC	NA
1.a.ii.(8) Each mobile crisis team shall include at least one mental health clinician.	PC	SC
1.a.iii. Trained peer support specialist shall be part of the County’s crisis service team and shall be included in outreach and engagement functions.	PC	SC
1.b.i. Maintain 45 crisis residential treatment (CRT) beds.	PC	SC
1.b.ii. Within two years of the effective date of the Agreement, the County will make all reasonable efforts to contract with one or more community-based providers to add a mixture of 25 additional CRT and/or peer-respite beds.	NA	NA
1.b.iii. A purpose of CRT facilities and peer-respite is to promptly deescalate or avoid a crisis and reduce unnecessary hospitalization. CRT facilities and peer-respite homes are intended to be used by people experiencing or recovering from a crisis due to their mental health disability for short-term stays and to provide support to avoid escalation of a crisis. CRT facilities and peer-respite homes are unlocked.	PC	SC
1.b.iv. Peer staff will be on-site 24/7 at peer-respite homes. Peer-respite homes shall serve no more than 6 individuals at a time.	NA	SC
1.b.v. Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.	PC	SC
1.b.vi. CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis.	PC	SC
1.c. The County’s crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.	PC	SC
2. Full-Service Partnerships (FSP)		
2. a. and b. The County offers FSPs through community-based providers that provide services under the Community Services and Supports (“CSS”) service category, in accordance with 9 C.C.R. §§ 3620, 3620.05, and 3620.10. Within two years from the effective date, the County will add 100 FSP slots for adults and transition aged	NA	NA

<p>youth for a total of 1,105 FSP slots for that population. The County will utilize the FSP slots that are added under this Agreement to serve individuals 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05.</p>		
<p>2.c. Within one year from the Effective Date, the County will complete an assessment of needs and gaps in FSP services for individuals ages 16 years and older that is designed to determine the number of additional FSP slots needed to appropriately serve individuals ages 16 and older who meet FSP eligibility criteria under 9 C.C.R. § 3620.05 (the “FSP Assessment”).</p>	NA	PC
<p>2.d. The FSP Assessment will be informed by and will appropriately take into account all necessary and appropriate data and information, which the County will collect and analyze as part of the FSP Assessment process, including but not limited to: i. Community and stakeholder input, including from FSP and other contracted providers, from organizations who make referrals for FSP services or regularly come into contact with individuals who are likely eligible for FSP services, and from individuals who receive or may benefit from FSP services; ii. Data regarding utilization of crisis services, psychiatric inpatient services, and FSP and other CSS services; indicators of eligibility for FSP; and numbers of individuals who have completed FSP eligibility assessments, outcomes following assessment, and length of time from identification to enrollment; iii. Analysis of numbers and demographics of sub-populations who (a) were not connected to FSP services despite multiple visits/admissions to PES, John George inpatient, and/or IMDs, (b) declined to consent to FSP services, or (c) stopped engaging with FSP services, and analysis of relevant barriers or challenges with respect to these groups; and iv. Research, literature, and evidence-based practices in the field that may inform the need for FSP services in Alameda County.</p>	NA	NA
<p>2.e. The County will provide a draft of the design and methodology of the FSP Assessment to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before proceeding with the FSP Assessment. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. Following the FSP Assessment process, the County will provide a draft of the FSP Assessment report to the Independent Reviewer for review, feedback, and comment, and will appropriately take into account such feedback and comment before finalizing the County’s FSP Assessment report. As part of this review, the Independent Reviewer will provide the draft to, and consider input from, DRC and the United States. The assessment and conclusions in the final FSP Assessment will promptly be made available to the public.</p>	NA	NA
<p>2.f. Based on the County’s FSP Assessment, the County will further reasonably expand its FSP program as necessary in order to appropriately serve individual ages 16 and older who meet eligibility criteria under 9 C.C.R. § 3620.05 consistent with their preferences.</p>	NA	NA
<p>2.g. and h. As used in this Agreement, one “slot” (such as an FSP slot or a Service Team slot) means the ongoing capacity to serve one</p>	PC	PC

individual at a given time. FSP will provide services necessary to attain the goal identifies in each FSP recipients' Individual Services and Supports Plan (ISSP) which may include the Full Spectrum of Community Services, as defined in 9 C.C.R. § 3620(a)(1).		
2.i. Consistent with 9 C.C.R. § 3620(a), (g), and (h), each FSP recipient will have an ISSP that is developed with the person and includes the person's individualized goals and the Full Spectrum of Community Services necessary to attain those goals. Each FSP recipient will receive the services identified in their ISSP, when appropriate for the individual.	PC	PC
2.j. Services provided through FSP will be flexible and the level of intensity will be based on the needs of the individual at any given time, including the frequency of service contacts and duration of each service contact. To promote service engagement, services will be provided in locations appropriate to individuals' needs, including in the field where clients are located, in office locations, or through the use of telephonic or other electronic communication when clinically appropriate.	PC	PC
2.k. FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their clients services designed to reduce hospitalization and utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing in the most integrated setting appropriate to meet their needs and preferences.	PC	PC
2.l. FSP program will be implemented using high fidelity to the Assertive Community Treatment (ACT) evidence-based practice, including that: (i.) FSP programs are provided by a team of multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals. (ii.) FSP teams operate at a 1:10 mental health staff to client ratio.	PC	SC
2.m. FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than eighteen (18) months after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBH contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.	NA	NA
2.n. FSPs will provide or arrange for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice. IPS supported employment focuses on engaging a person in competitive employment based on their individualized interests, skills, and needs.	PC	SC
2.o. Housing: The Parties recognize that permanent, integrated, stable housing with Housing First principles is critical to improving treatment engagement and supporting recovery. (i.) FSP clients will receive a housing needs assessment, and will receive support and assistance to secure and maintain, as needed, affordable, (1)	PC	PC

temporary housing, and (2) permanent housing, either directly from the FSP or by referral by the FSP to the County Health Care Services Agency's Coordinated Entry System ("CES"), or through other County and community resources.		
2.o.ii. As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.	PC	PC
2.o.iii. If an FSP client is waiting for permanent housing, the FSP will, as needed, promptly provide or secure temporary housing for the FSP client until permanent housing is secured. Temporary housing provided under this Agreement shall be stable and shall not be at a congregate shelter, except on an emergency basis.	PC	PC
2.o.iv. and v. Permanent housing will be provided in the least restrictive and most integrated setting that is appropriate to meet the needs and preferences. Nothing in this section II.2.o is intended to override an FSP client's preferences.	PC	PC
3. Service Teams (Intensive Case Management)		
3.a. The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.	PC	SC
3.b. The County will explore community needs and opportunities for expanding Service Teams as appropriate.	NA	NA
3.c. Service Teams will assist individuals in attaining a level of autonomy within the community of their choosing. Service Teams will provide mental health services, plan development, case management, crisis intervention, and medication support; and be available to provide services in the field where clients are located, in office locations, and through the use of telephonic or other electronic communication when clinically appropriate.	PC	SC
3.d. Service Team clients will receive support and assistance to access, as needed, temporary housing and permanent housing, through the CES and other available programs.	PC	PC
4. Outreach, Engagement, Linkages, and Discharge Planning		
4.a. The County will maintain a 24/7 telephonic hotline (the ACCESS line or its successor) to aid in implementing the provisions below.	PC	SC
4.b. The County will make meaningful efforts to create a system to provide real-time appointment scheduling, timely in-the-field assessments, and authorization of services by ACCESS or its successor, in order to facilitate prompt and appropriate connection to services following an eligible individual's contact with ACCESS.	PC	PC
4.c. When an individual with serious mental illness (1) is identified by the County through section II.4.e, or (2) contacts (or another individual does so on his or her behalf) the County (e.g., the ACCESS program or its successor) or an ACBH contracted entity for behavioral health services, the County or an ACBH contracted community provider will determine the person's eligibility for community-based	PC	PC

behavioral health services and, unless the person can no longer be contacted or declines further contact, will provide a complete clinical assessment of the individual's need for community-based behavioral health services (an "assessment").		
4.c.i. Following such assessment, individuals determined to be eligible for and in need of FSP or Service Team services will be assigned to an FSP or Service Team's caseload to commence the provision of services.	PC	PC
4.c.ii. This assessment and assignment process will be promptly completed, and those services initiated in a prompt manner sufficient to reduce the risk of prolonged and future unnecessary institutionalization, hospitalization, or incarceration.	PC	SC
4.c.iii. Beginning no later than 6 months after the Effective Date, the County will document all situations in which an eligible individual is assessed as in need of FSP or Service Team services, but such FSP or Service Team services were not immediately available and will conduct regular quality reviews to identify such situations. Following a quality review, the County will take appropriate action, if any is indicated, based on the results of the quality review, and the results will inform the County's FSP Assessment undersection II.2.c.	NA	NA
4.d. Within two years of the effective date of the Agreement, the County will develop, implement, and staff a System Coordination Team to improve linkages to community-based services across the County's behavioral health system. The System Coordination Team will coordinate system care and improve transitions of care.	NA	NA
4.e The County will implement a system to identify and provide proactive outreach and engagement to individuals with serious mental illness who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration. In order to do so, this system will focus on factors that include, among others, whether individuals with serious mental illness have had frequent contacts with crisis services (including PES), frequent hospitalizations for mental health reasons, and/or frequent incarcerations (and, in the case of incarcerations, received behavioral health services during an incarceration). The County will connect such individuals, as needed, to FSPs, Service Teams, or other community-based services. The County will use a culturally responsive, peer driven approach that builds on the person's strengths and goals and seeks to address the individual's concerns regarding treatment (including service refusals). Outreach and engagement will include frequent, in person contact in the field in locations convenient to the person. Outreach and engagement will include using the Familiar Faces program to identify and connect with individuals who do not follow up regarding services after experiencing a crisis. Beginning no later than six (6) months after the Effective Date, the County will track progress in connecting individuals to needed services.	NA	NA
4.f The County will explore, collaborate with, and support as appropriate programs that provide connection to community-based services as alternatives to incarceration. The County will provide	PC	PC

information and education to prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.		
4.g. The County will provide information and education to ACBHD-contracted behavioral health providers about available community-based services that can provide alternatives to unnecessary institutionalization and hospitalization and reduce risk of unnecessary law enforcement contact and will coordinate with these entities to rapidly connect individuals to those services as appropriate.	PC	SC
4.h. The County will work with law enforcement to direct referrals to the In-Home Outreach Team (“IHOT”).	PC	SC
4.i. The County will ensure that people with co-occurring SUD can access and receive services, including through the development of two (2) substance use mobile outreach teams, within two years of the Effective Date	NA	NA
4.j.i and ii. In-Reach to, and Discharges to Community-Based Services from, Medicaid Institutions for Mental Diseases (“IMDs”). “IMD” as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review (“UR”) pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual’s needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess appropriateness for discharge in light of community-based services appropriate to the individual.	NA	NA
4.j.iii. Promptly after an individual eligible for ACBHD services is admitted to an IMD in the County, the individual will begin receiving discharge planning services. The individual’s discharge plan will include transitioning the individual to the most integrated setting appropriate to the individual’s needs, consistent with the individual’s preferences. As part of assisting individuals to transition to the most integrated setting appropriate, appropriate community-based services will be identified. Where applicable and with the individual’s (and, when relevant, his or her legal representative’s) consent, FSP and Service Team providers will participate in the discharge planning process.	PC	PC
4.j.iv. If the unavailability of FSP or Service Team services is preventing discharge from an IMD to a community setting, then the director of ACBHD (or designee) will be notified, and the County will work to arrange such services as promptly, as possible.	PC	NA
4.j.v. The County will promptly notify ACBHD-contracted FSP and Service Team providers when their clients are receiving care at an IMD, to ensure that the provider promptly resumes services upon discharge, as appropriate.	PC	SC

<p>4.k.i. and ii. Linkages for Services Following Discharge from John George PES and Inpatient. (i.) The Parties understand that John George is required to provide discharge planning to and effectuate safe discharges of patients at John George PES and John George inpatient in compliance with applicable laws, regulations, and contractual obligations, including, but not limited to, 42 C.F.R. § 482.43 and California Health & Safety Code §§ 1262 and 1262.5. (ii.) The County will collaborate with John George to support John George’s safe and effective discharges of eligible individuals from John George PES and John George inpatient to community-based services as appropriate, including through ACBH’s critical care managers and contracted community-based providers, with the goal of increasing the prompt connection to community-based services for patients that are eligible and appropriate for community-based services. The County will request that John George promptly notify the County when it identifies someone who may be eligible for any such services. Beginning no later than eighteen (18) months after the Effective Date, the County’s role in this collaboration will include, to the fullest extent reasonably practicable: (1) using available data to promptly identify individuals registered by John George who are both (a) likely to be, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration, and (b) likely to be eligible for and in need of FSP or Service Team services; (2) upon identification, to the extent that the individual has not yet been discharged, promptly coordinate with John George to determine whether the individual is eligible for and in need of any such services; and (3) if the individual is eligible for and in need of any such services and to the extent that the individual has not yet been discharged, promptly connecting the individual to an FSP or Service Team to commence engagement, which may include participation in discharge planning and commencement of services upon the individual’s discharge.</p>	NA	NA
<p>4.k.iii. The County will request that John George Psychiatric Hospital invite and actively include representatives of an individual’s FSP or Service Team (if any) in the discharge planning process and, with respect to patients determined eligible for and in need of such services under section II.4.k.ii above, invite and actively include representatives of the County or a County-contracted community based service provider in the discharge planning process. To the fullest extent reasonably practicable and within the direct control of the County and its community-based service providers, and with the individual’s consent, the County will ensure that: (1) representatives of the FSP or Service Team are included in the discharge planning process for those individuals who are assigned to or are clients of a County FSP or Service Team; and (2) representatives of the County or a County contracted community-based service provider are included in the discharge planning process for those individuals who are not assigned to an FSP or Service Team but who have been identified as eligible for an FSP or Service Team under section II.4.k.ii above. To the extent that John George routinely does not include</p>	PC	NA

such representatives in the discharge planning process, the County will seek to identify and reasonably address barriers to John George's inclusion of such representatives in discharge planning.		
4.k.iv. Beginning no later than eighteen (18) months after the Effective Date, the County will use electronic health record and registration information provided to the County by John George Psychiatric Hospital to promptly identify individuals with serious mental illness who are discharged to the community and who are, for reasons related to their serious mental illness, at risk of unnecessary institutionalization, hospitalization, or incarceration in accordance with section II.4.e. and will comply with its obligations under section II.4.c.	NA	NA
4.k.v. The County will use programs designed to reach individuals who do not follow up regarding services.	PC	SC
4.k.vi. The County will collaborate with John George to ensure that John George promptly notifies FSP and Service Team providers when their clients are registered or admitted to receive John George PES or John George inpatient care, to facilitate the FSP's or Service Team's prompt resumption of services upon discharge.	PC	SC
4.l.i. Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v. County of Alameda Consent Decree (including section III.I, "Discharge Planning," page 49:13-51:18). The County will ensure that ACBHD collaborates with the community's office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.	PC	PC
4.l.ii Beginning no later than 18 months after the Effective Date, the County will periodically (at least every six months) evaluate FSPs' and Service Teams' (a) participation in discharge and reentry planning for their clients following notification of incarceration, (b) participation in discharge and reentry planning for incarcerated individuals referred to such provider, and (c) their success in re-engaging or newly engaging their client upon release. This evaluation will include analysis of timeliness, trends, and causes of identified problem areas. The Parties understand that FSP and Service Team participation in discharge and reentry planning may be provided through the use of telephonic or other electronic communication when clinically appropriate or as necessary to respond to public health considerations.	NA	NA
4.l.iii. Beginning no later than six (6) months after the Effective Date, the County will document all situations in which an individual identified by ACBHD as eligible and in need of FSP or Service Team Services and such FSP or Service Team services were not immediately available upon release and will conduct regular quality reviews to identify such situations.	NA	NA
4.l.iv. With the goal of reducing risk of unnecessary institutionalization, incarceration, and law enforcement contacts, the	NA	NA

County will take appropriate action, if any, based on the results of the evaluation in section II.4.I.ii. and the quality reviews in section II.4.I.iii.. Where appropriate, the results of the quality reviews under section II.4.I.iii will inform the County's FSP Assessment under section II.2.c.		
4.I.v. The County will use programs designed to reach individuals who do not follow up regarding services, consistent with Section II.4.e.	PC	SC
5. Culturally Responsive Services		
5.a. The County will continue its ongoing efforts to ensure that all services provided under this Agreement are culturally responsive and are person-centered. The County will continue to provide and expand culturally responsive behavioral health services, including through community-based and peer-run organizations, and will continue to identify and implement culturally and linguistically appropriate and affirming strategies and practices to help reduce behavioral health disparities across racial, ethnic, cultural, and linguistic groups.	PC	SC
5.b. The County will continue to operate the Office of Health Equity within ACBH, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBH, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client-centered care that considers the whole person and all their needs.	PC	SC
5.b.i. No later than fifteen months after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website setting forth aggregated data metrics on the populations served by ACBHD (including individual racial and ethnic groups broken down by geographic area within the County) and various communities' service needs (including racial and ethnic groups' needs for FSP, Service Team, and IHOT services in geographic areas within the County).	NA	NA
5.b.ii. The Health Equity Officer will thoroughly review the feedback from the stakeholder/community input meetings on how to improve culturally responsive services in the County. The Health Equity Officer will periodically make recommendations to the Director of ACBH on how to improve culturally responsive services in the County and coordinate with the County's other diversity, equity, and inclusion programs and activities.	NA	NA
5.c. The County will continue to support the African American Wellness Hub capital facilities project, with the goal of aligning culturally relevant and community focused services for Black/African American residents within the County's service delivery system. The African American Wellness Hub facility will serve as a hub and coordinating center for a variety of behavioral health services,	NA	SC

<p>community-based supports, and linkages for the Black/African American community in the County. The County will provide opportunities for community and stakeholder engagement over the course of this project to further the project's focus on providing culturally inclusive, respectful, and relevant supports to the County's Black/African American clients and community.</p>		
<p>5.d. The County has implemented and will continue to provide periodic and ongoing trainings to all ACBHD staff and ACBHD-contracted community-based providers regarding: culturally responsive services; trauma-informed care; inequities across race, ethnicity, sex, sexual orientation, gender identity, and disability; anti-racism and implicit bias. A primary intent of such trainings is to ensure the delivery of culturally responsive services and to increase engagement across historically underserved populations.</p>	<p>PC</p>	<p>SC</p>

RESOLUTION NO. 70,287-N.S.

MENTAL HEALTH SERVICES ACT (MHSA) INNOVATIONS (INN) ENCAMPMENT-BASED MOBILE WELLNESS CENTER PROJECT

WHEREAS, the City's Department of Health, Housing, and Community Services, Mental Health Division, currently receives Mental Health Services Act (MHSA) Innovations (INN) funds on an annual basis for short term projects that will increase learning in the mental health field through strategies that will either improve the access, quality, or outcomes of services, and/or promote community collaborations; and

WHEREAS, in order to utilize MHSA INN funds, the Mental Health Division must have a stakeholder informed, local and State approved plan in place; and

WHEREAS, the state required steps to obtaining an approved plan include: Community program planning; the development of a draft plan; the initiation of a 30-day public Review and Comment period; a Public Hearing at a Mental Health Commission meeting; and submissions to City Council and the State Mental Health Oversight and Accountability Commission for plan approvals; and

WHEREAS, community program planning and the development of the plan was conducted by a local consultant, Resource Development Associates (RDA), who was hired by the Mental Health Division following a competitive bid process; and

WHEREAS, over a five-month period, robust input was collected from individuals with lived or adjacent experiences of homelessness, community stakeholders, and staff through in-person and online surveys, one-on-one interviews, and virtual community meetings; and

WHEREAS, following the series of community engagement activities, multiple working sessions were facilitated with local homeless outreach providers and advocates, and additional internal review by BMH staff and city leadership further refined the project proposal; and

WHEREAS, a draft plan was developed to allocate \$2,802,400 of INN funds to be utilized over a five-year period, to implement a Mobile Wellness Center for services, activities, and supports for the unhoused population in Berkeley; and

WHEREAS, the Draft Plan was initially reviewed by the Berkeley Mental Health Commission, the MHSA Advisory Committee, and the California Mental Health Services Oversight and Accountability Commission (MHSOAC), and was modified based on input received; and

WHEREAS, A Public Review and Comment period was initiated from November 18 through January 26, followed by a Public Hearing on January 27 at the Mental Health Commission Meeting; and

WHEREAS, funding for this contract will be available each fiscal year from FY2023 – FY2027 through ERMA GL Code: 315-51-503-526-2020-000-451-636110.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the City Manager or her designee is hereby authorized to approve the MHSA INN Encampment-based Mobile Wellness Center Project Plan and any extensions, for services, activities and supports for homeless individuals in Berkeley, in a total amount not to exceed \$2,802,400 over a five-year period beginning in FY2023.

The foregoing Resolution was adopted by the Berkeley City Council on April 12, 2022 by the following vote:

Ayes: Bartlett, Droste, Hahn, Harrison, Kesarwani, Robinson, Taplin, Wengraf, and Arreguin.

Noes: None.

Absent: None.



Jesse Arreguin, Mayor

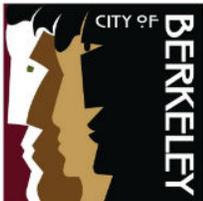
Attest: 

Mark Numainville, City Clerk

City of Berkeley MHSa Innovation Project Plan

Encampment-based Mobile Wellness Center

City of Berkeley Mental Health Division



RDA
CONSULTING



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Appendix A.....1A



City Name: City of Berkeley

Project Title: Encampment-based mobile wellness center for Berkeley's unhoused community members

Total Amount Requested: \$2,802,400

Project Duration: 5 years

Summary Statement: Pilot an encampment-based mobile wellness center that offers a customizable menu of activities and services (i.e. food/hygiene, service navigation, trauma-informed wellness, and community/enrichment) and is staffed by a team of peers that can offer culturally-specific services, including individuals from encampment communities in Berkeley.

Section 1: Innovation Requirement Categories

General Requirement:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing



Section 2: Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Approximately 1,100 unhoused individuals live in Berkeley, including both sheltered and unsheltered environments.¹ This represents 1% of Berkeley's total population. Not only is homelessness prevalent in Berkeley, most of the time it is also long-term: of the 1,100, 64% reported that their current episode of homelessness has lasted one year or more. Across the three most recent citywide point-in-time counts (2015-2019), unhoused Berkeley residents consistently identify supportive services, such as benefits/income assistance, rental assistance, or mental health services, as interventions that may have prevented homelessness. These findings indicate gaps in service accessibility, availability, and/or awareness when homelessness prevention is still possible. Moreover, as much as supportive services are needed upstream before homelessness occurs, they grow even more vital when an individual or family becomes unhoused. In recent years, including throughout the six-month long community input process that resulted in this project proposal, Berkeley residents consistently name homeless services as a top citywide priority.

Though both direct and supportive services for the homeless population are urgently needed and increasingly funded, take-up among unhoused community members in Berkeley remains low for certain services, particularly mental health services. Berkeley Mental Health (BMH) and the City of Berkeley have funded a wide variety of outreach teams to try and connect unhoused individuals to mental health services, and though these efforts have had some success, there remain a large set of individuals who indicate that they are uninterested in services despite appearing to have mental health conditions. Successfully supporting mental health and wellness for individuals who are not connecting to mental health services remains a gap and a challenge in the service landscape. To address this challenge, this project proposes an innovation at the nexus of **service provision** (by focusing on services that unhoused community members define as supportive of mental health, rather than explicitly and/or exclusively clinical services), **service location** (by bringing services onsite to encampments in Berkeley), and **service providers** (by employing individuals with lived or adjacent experience to homelessness, including individuals from encampment communities in Berkeley).

Proposed Project: Encampment-based Mobile Wellness Center

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

For its Innovation project, BMH is proposing an encampment-based mobile wellness center that would provide a menu of customizable services to Berkeley's unhoused population. The proposed project was developed using input obtained from community members with lived or adjacent experiences of homelessness during the community program planning (CPP) process. Through in-person and online surveys, 1:1 interviews and virtual community meetings, BMH collected robust input during the CPP process.

¹ https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf



The proposed innovation is embedding a mobile wellness center at encampment locations, with peer-led, customizable services that are supported by members of encampment communities in Berkeley. This combination is an innovative delivery model for services that promote health and wellness, while also being designed for those experiencing homelessness in our communities.

The proposed project adapts existing homeless outreach practices by operationalizing community input in the following ways.

- **Service Provision:** Rather than operating on a blanket assumption that clinical and/or psychiatric services should be prioritized, the wellness center project focuses on services identified by unhoused community members as most supportive of mental wellness. These are not traditional clinical mental health services.
- **Service Location:** The wellness center will be a mobile service center stationed at locations where homeless individuals are staying in Berkeley. By hosting services onsite at encampments and other locations where homeless individuals are staying, outreach transforms from outside-in to inside-out, from sporadic to ongoing, and from disconnected to integrated.
- **Service Providers:** Wellness center staff, including the program manager and peer providers, will include individuals with lived or adjacent experience of homelessness and/or recovery. In addition, the wellness center program will use funds to compensate individuals from encampments to connect consumers to services, incentivize participation among existing and potential consumers, and engage in day-to-day program planning and operations.

While many homeless outreach and/or mobile engagement programs employ peers, and others co-locate services with other agency (i.e. educational) or institutional (i.e. correctional) providers, no program adapts homeless outreach services in the above ways.

As the wellness center will **not** explicitly focus on clinical and/or psychiatric services, the project does not aim to directly increase access to traditional mental health services, nor improve the quality of traditional mental health service provision. Rather, it aims to leverage collaboration with unhoused community members to promote mental health outcomes for the target population through non-clinical means, which may include increases in service referrals, service linkages, and improvement of mental health wellness for participants. Figure 1 below summarizes key components of the project proposal.

Figure 1. Innovative Components of Wellness Center Project





Wellness Center Service Provision

“It’s not a psychiatrist they need, it’s not a behavioral modification they need; what they need is the basics of life – the ability to eat, wash themselves, read a book, meditate, drink water, take a walk, be around the people who you want to be around, go to the library. If those things were guaranteed, it would support mental health and head off the cases where people develop more deeply entrenched conditions, where they start evidencing behaviors that people assume are intrinsic – not realizing [these behaviors] are from all the times when they don’t know where they will be eating, will they have to eat out of a trash can, if when they sleep will someone kick them in the head.”

- Berkeley community member experiencing homelessness

The wellness center will deliver onsite services to Berkeley community members who are unhoused. Proposed services are informed directly from community input, with an emphasis on input from community members with lived experiences of homelessness during the CPP process. While some input did call for outreach that included therapeutic services, much of the input called for supportive services more generally. Table 1 lists the wellness center’s proposed service areas:

Table 1. Proposed Service Areas & Service Participants

	Food & Hygiene Services	Benefits Enrollment & Service Navigation	Trauma-Informed Wellness Services	Enrichment & Community Services
Proposed Service Areas	<ul style="list-style-type: none"> - Mobile showers - Hand-washing - Laundry tokens and/or laundry services - Snacks, water - Toiletries & personal hygiene products 	<ul style="list-style-type: none"> - Benefits enrollment (i.e. Medi-Cal, Medicaid, veterans’ services, HUD) - ID/document recovery - Appointment reminders - Transit assistance 	<ul style="list-style-type: none"> - Medication counseling - Meditation & mindfulness - Massage therapy - Music therapy - Stress management counseling - Peer-led wellness services 	<ul style="list-style-type: none"> - Day storage - Community enrichment events - Movement & exercise classes - Guided walks and nature-based enrichment - Community library
Service Estimates	<p><i>BMH estimates that up to 250 individuals will receive food/hygiene services each year, with 5-10% connecting to outside mental health services via this service area.</i></p>	<p><i>BMH estimates that up to 150 individuals will receive benefits/navigation services each year, with 5-10% connecting to outside mental health services via this service area.</i></p>	<p><i>BMH estimates that up to 150 individuals will receive wellness services each year, with 5-10% connecting to outside mental health services via this service area.</i></p>	<p><i>BMH estimates that up to 150 individuals will receive enrichment services each year, with 5-10% connecting to outside mental health services via this service area.</i></p>

Many of the above food, hygiene, and navigation services are comparable to those commonly provided by homeless outreach treatment teams and/or mobile engagement teams. However, in the mobile wellness center environment, service provision will be directed by the changing needs of the community,



with week-to-week service provision being planned via ongoing conversations with members of encampment communities. For example, while psychiatric and/or therapeutic services are not listed above due both to low take-up of these services among members of the unhoused population in Berkeley historically and a minority of community input requesting these services, community needs may shift, and wellness center staff will adapt service provision as needed. The customizable nature of service provision will be made possible through the provider itself, which will be a local organization with deep expertise across proposed service areas.

Coordination with local partners involved in current homeless outreach efforts will be central to service provision, in order to both build on existing efforts and to mitigate duplicative service delivery. For example, the wellness center program might partner with a local food pantry to coordinate meal delivery efforts to the encampment population. Input from members of the encampment community, those with lived experience of homelessness, and the service provider will also inform service provision in a fluid and iterative way, based on identified needs. This was a central theme of the input received from community members and individuals with lived experience during the CPP process – that services should support wellness in creative ways, without assuming that psychiatric or clinical intervention is appropriate for everyone. Community members shared that service delivery should be adaptive and offer a diverse menu of services.

Target Population. BMH estimates that the wellness center will serve up to 250 unique individuals each year, or roughly 25% of Berkeley’s current unhoused population. This estimate is based on annual service data from organizations providing outreach services to the unhoused population in Berkeley. The service estimates vary among service areas, as food/supplies represent a majority of services currently provided, compared to case management or other services. For this reason, the above estimates use the best available data, but still may be an over count of food/hygiene services and an undercount of other service areas.

BMH expects that individuals served by the wellness center will in large part reflect the demographics of the unhoused population in Berkeley. As described by the most recent point-in-time count conducted in 2019, the target population is predominantly male (66%), non-Hispanic/Latinx (88%), Black/African American (57%), single (vs. families), and does not identify as LGBTQ+ (86%). Around half (48%) of the target population is local and has lived in the community for 10 years or more.

The target population also has significant medical needs: 41% reported a disabling health condition, with 28% reporting chronic health problems. Just under one-half (42%) reported a psychiatric or emotional condition, 32% reported a substance use disorder, and 31% reported PTSD. The proposed design of the wellness center is responsive to these needs in regards to both the *types* of services provided as well as *how* those services are delivered.

Wellness Center Service Location

When the plan was initially developed, the City was planning to have a sanctioned encampment, and has since determined it could not find a place for one, so the mobile wellness center will go to multiple encampment sites, or other locations where unhoused individuals are staying. This means that it can provide onsite services where needed, can move where and if the community it is serving changes locations, but will have a consistent, visible presence wherever homeless individuals are staying. The plan is for the locations of service to remain flexible, as the location of encampments and other locations where homeless individuals are staying is fluid and changes on a regular basis.

The location of the proposed wellness center is one way in which it is intended to feel a part of the community it is serving. The other way this project aims to deliver services from the inside-out rather than



the outside-in is by bringing peers and individuals with lived experience, including individuals residing in the encampment, onboard the wellness center team.

Wellness Center Service Team

A key innovation of this project is that it will recruit and hire peers, or individuals with lived or adjacent experiences of homelessness, to staff the wellness center. In addition, the wellness center will compensate individuals who reside in encampment communities in Berkeley to support wellness center services in a separate capacity.

Since a community-based organization (CBO) will be implementing this project (not BMH), the CBO will hire the positions that will staff the mobile wellness center and will recruit and provide stipends to the individuals from encampment communities in Berkeley who are brought on to support wellness center activities.



While position titles will be adapted and finalized by the CBO during program launch planning, broadly, the wellness center team will consist of a **program director, program manager, peer providers, and members of the encampment community**. For the purposes of this project plan, individuals from Berkeley encampment communities who are brought on to work with the wellness center team are referred to as **partners from encampment communities**. This role, modeled on the Community Health Worker role as defined by the California Healthcare Foundation, will have the following core competencies and key duties:²

- **Cultural Competency.** Acting as a liaison between the encampment community and the wellness center, partners from encampment communities should represent and be able to communicate the needs of the encampment community. Their input and feedback should inform ongoing processes and programming as part of the wellness center project.
- **Information & Resource-Sharing.** Care for and support consumers by doing things such as sharing information regarding resources, documenting wellness center and service-specific utilization, and supporting the care and education provided by wellness center staff.
- **Social Supports.** Provide social support by being available to listen and talk through problems that consumers are experiencing, and referring them to the appropriate wellness center staff member(s). Onsite referrals from encampment community partners are meant to facilitate introductions and trust-building with wellness center staff.
- **Self-Care Coaching.** Educate consumers about self-care and help them learn self-care skills.

Partners from encampment communities will help encourage participation at the wellness center, help define service needs, and support service provision at the site. It will be up to the CBO implementing this project to define the criteria for this role. This proposal is therefore purposefully not prescriptive in defining eligibility. BMH would like to give CBO bidders an opportunity to leverage their insight and expertise in their proposals to define criteria for recruitment, as well as the training plan for this role.

BMH will defer to bidders to define the number and duration of cohorts of encampment community partners. However, proposals must include a plan for providing stipends and guaranteeing compensation for their work at the center.

² California Healthcare Foundation. “Building peer support programs to manage chronic disease: seven models for success.” Published Dec 2006. <https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf>



Full-time, onsite **peer providers** will coordinate and deliver wellness center services. This is a separate role from the partners from encampment communities. The latter are members of an encampment community who will be stipended, while peer providers will be FTE staff hired by the CBO. Peer providers will be trained in trauma-informed best practices for service delivery. Peer providers will have the following key duties, modeled on best practices set by the National Health Care for the Homeless Council, or NHCHC (these key duties are drawn from community input and cross-walked to NHCHC practices):³

- **Outreach/Enrollment.** Assist with enrollment into housing, nutrition, and health insurance programs and entitlements; provide culturally competent enrollment, health education, and outreach services; conduct motivational interviewing and rapport building with potential clients using empowering language and taking the lead from the client; offer friendly and helpful advice based on problems and concerns identified by the client; offer day-to-day survival tips and kits such as first aid, clothing, water, hand sanitizer, etc.
- **Navigation.** Help clients fill out and file paperwork for Medicaid, Medicare, Veterans Services, HUD, local housing authority, prescription coverage, and any other services; follow-up and track individuals experiencing homelessness and/or recently housed; schedule and remind clients of appointments and provide transportation if necessary; facilitate client empowerment to fully engage with all members of their health care team; accompany consumers on medical visits as a source of support; help consumers access needed supports for transitions such as attaining housing.
- **Advocacy/Education.** Develop and utilize connections with community service representatives to help clients get what they need; work with partners from the encampment community to update provider teams about what issues consumers are facing; collaborate with partners from the encampment community in program planning for the wellness center.

BMH expects proposals to include a robust training plan for wellness center staff, including a component for supervision and continuous performance evaluation. Depending on the proposal and the capacity of the service provider, this may involve subcontracting with organizations to provide training services. Stakeholder input emphasized the need for training and oversight, particularly to provide clear pathways for peer-to-peer team-building and conflict resolution. BMH would like to give bidders an opportunity to leverage their expertise to propose training components and performance evaluation modalities, rather than be prescriptive in this proposal as to what that will or should look like.

Finally, a **community of practice** comprised of program staff, consumers, community advocates, and city leaders will meet quarterly to create a learning space to exchange insights and tackle challenges related to the wellness center project. This community of practice may take the form of a formal advisory group or an informal relationship-building space. Following project approval and during the initial project development phase, the provider will work with stakeholders and community members, including unhoused Berkeley residents and homeless outreach staff, to collect input on how they would feel best supported by the community of practice.

Research on Proposed Innovation Project

Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

³ Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council, June 2011. <https://nhchc.org/>



Wellness Centers. Many homeless-serving agencies and community-based organizations in local jurisdictions have implemented wellness centers to deliver a multitude of services. Some localities, such as Victorville in San Bernardino County, are developing large wellness center campuses that will offer medical, recreational, and supportive services to individuals experiencing homelessness.⁴ Wellness center campuses are innovative, complex projects with high start-up and operational costs, with service delivery occurring in a brick-and-mortar location. Other cities, such as Los Angeles, provide multiple smaller wellness centers as service access points for the unhoused population.⁵

These examples of brick-and-mortar wellness centers largely operate during weekday business hours, and none of them are located within an encampment itself (although Los Angeles does have centers adjacent to Skid Row). BMH seeks to further innovate on the existing brick-and-mortar wellness center model by proposing a smaller-scale, mobile model that is able to go to multiple encampments.

Mobile Approaches in Healthcare for the Homeless. Generally, mobile models used in healthcare for the homeless (HCH) programs are limited to mobile health clinics, and BMH did not identify current or ongoing examples of mobile wellness centers that are co-located with existing encampments. Mobile health clinics embedded within a local or regional HCH service landscape, on the other hand, are increasingly common and well-researched, with thousands of active mobile health clinics nationwide.⁶ One such example is WeHOPE in East Palo Alto, which has a fleet of vehicles delivering mobile homeless services, including onsite hygiene services.⁷ The learning goals described in the following section are adapted in part from outcomes often seen in mobile health clinics. In this way, BMH looks to build on emergent learnings from the mobile HCH service landscape.

Peer-led Service Delivery. Integrating peer-led service delivery into mental health, substance use disorder, or homeless outreach programs is an emergent best practice across the HCH service landscape. Peer providers may already be credentialed, or the hiring organization may provide training as part of onboarding or ongoing professional development. In other cases, peers may not receive extensive formal training, or they may be volunteers. Regardless of the specifics of the position or training, a growing body of evidence suggests that the non-hierarchical, reciprocal relationship created between a peer provider and a consumer leads to better health outcomes.⁸

Wellness centers may be staffed by peers, such as the RAMS Inc. Peer Wellness Center in San Francisco.⁹ These wellness centers provide many of the same services that BMH is proposing to include in its wellness center. However, though many peer-staffed wellness centers do provide targeted services for people experiencing homelessness, BMH could not find examples of peer teams that formally include individuals from encampment communities on the team.

⁴<https://www.victorvilleca.gov/services/homeless-outreach/homeless-land-page/city-iniatives/wellness-recuperative-care-center>

⁵ <https://www.thepeopleconcern.org/homeless-services/>

⁶ Yu, Stephanie W Y et al. "The scope and impact of mobile health clinics in the United States: a literature review." International journal for equity in health vol. 16,1 178. Published Oct 2017.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629787/>

⁷ <https://www.wehope.org/mobile>

⁸ California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. <https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf>

⁹ <https://ramsinc.org/peer-based/>



Learning Goals

What is it that you want to learn or better understand over the course of the INN Project? How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project proposes innovations related to the method (peer- and community member-led) and location (encampment-based) of HCH service delivery. The following learning goals reflect what the project seeks to better understand in terms of the potential impacts of these innovations on consumer outcomes: Does providing wellness services onsite, in an encampment environment, make a difference in terms of consumers’ self-reported overall health and mental health, and their take-up of other health and mental health services? Does it matter that individuals from the encampment community are brought on-board and compensated to help deliver these services?

These questions are captured in the learning goals in Table 2 below. Target outcomes are listed for each learning goal, as well as the data that will be collected to measure progress toward these outcomes. While the specific data collection modalities may change, particularly as service providers transition from virtual back to in-person services, the survey and other tools listed are exemplars intended to reflect the key outcomes supporting each learning goal.

For each of these learning goals, the data collected by the evaluation team at pre-launch or at program launch will comprise the baseline levels for future evaluation reporting. From a program evaluation perspective, because there is not currently reliable data collection and reporting infrastructure to pull historical data from and provide to the evaluation team, the data collected by the evaluation team during its first data collection cycle will comprise the baseline for the learning goals. This will also provide an opportunity for the evaluation team to develop and calibrate mixed methods data collection tools.

Table 2. Proposed Project Learning Goals

	LG 1. Do onsite wellness center services have an impact on consumers’ overall and/or mental health?	LG 2. Do onsite wellness center services increase take-up of mental health services more broadly among consumers?	LG 3. How does having individuals from the community help provide services shape delivery, including satisfaction with services?
What do we want to learn?	#/% self-reported changes in overall health (+/-) #/% self-reported changes in mental health (+/-)	<i>New referrals:</i> # of new service referrals #/% linkages to services #/% service engagement <i>Existing referrals:</i> Δ in service engagement for wellness center consumers with prior service referrals	% satisfaction with wellness center services #/% new vs. returning consumers #/% of consumers recruited to wellness center services via partners from the encampment community Δ in service take-up between wellness center consumers & baseline service take-up



How will we learn it?	<ul style="list-style-type: none"> ✓ Pre/post surveys measuring consumers' self-reported overall health and mental health ✓ Focus groups with wellness center consumers ✓ Onsite observations at wellness center location(s) 	<ul style="list-style-type: none"> ✓ Interviews with wellness center consumers ✓ Interviews with wellness center staff ✓ Interviews with community-based service providers ✓ Program-level service referral/linkage data 	<ul style="list-style-type: none"> ✓ Focus groups with wellness center consumers ✓ Focus groups with wellness center staff ✓ Pre/post satisfaction surveys for wellness center consumers ✓ Onsite observations at wellness center location(s)
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These learning goals, along with the proposed key outcomes and data collection modalities, reflect the intention of the project evaluation to include robust and meaningful stakeholder participation.

Section 3: Regulatory Requirements

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BMH will follow all City of Berkeley contracting procedures to implement a Request for Proposal (RFP) process and execute a contract with the chosen vendor. BMH staff will monitor the contractor's performance to ensure quality and regulatory compliance.

Additionally, in terms of ensuring quality in service delivery, as part of the RFP process BMH will require bidders to demonstrate a clear understanding of current homeless outreach efforts that are underway in the community, and furnish an implementation plan that describes how this project will interface with existing efforts and coordinate with other service providers in the community.

Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

BMH conducted a series of virtual community outreach events during October – February 2020-21 to meet Community Program Planning (CPP) requirements as part of its MHS Innovation project development process.

With a core objective of identifying a project to support the mental health needs of unhoused community members, BMH implemented a two-tiered CPP process: first, BMH solicited feedback from individuals with lived experience as well as from community members more broadly; then, BMH engaged providers and advocates working in mental health and homelessness to review and further iterate community input.

As part of the initial CPP process, BMH conducted the following community outreach activities:

- **1:1 phone interviews with individuals with lived experiences of homelessness**
- **Paper surveys**, administered by outreach staff, **for individuals with lived experience of homelessness** who were unable to complete an interview
- **Virtual town hall**, open to all Berkeley community members



- **Online community survey**, open to all Berkeley community members

Following this series of community engagement activities, BMH facilitated multiple working sessions with local homeless outreach providers and advocates. The qualitative data from the initial CPP activities, together with the perspectives of local stakeholders with expertise in housing and homelessness, yielded a rich set of prospective project proposals. Additional internal review by BMH staff and city leadership further refined the Innovation project proposal.

Once the initial draft plan was created, it was reviewed by the Berkeley Mental Health Commission, the MHA Advisory Committee, and the California Mental Health Services Oversight and Accountability Commission (MHSOAC). The plan was then modified based on input received.

Figure 2 below shows the CPP process timeline for the Innovation project plan.

Figure 2. Community Program Planning Timeline



Due to the virtual nature of the Innovation CPP meetings, BMH was unable to obtain consistent demographic data for CPP process participants other than for paper survey respondents (paper surveys were administered to individuals experiencing homelessness).

Among paper survey respondents, 33% of respondents identify as Black or African American and 33% identify as White. Other race/ethnicity response categories are suppressed due to n<10. In terms of gender identity, 71% of respondents identify as men. Other gender identity categories are suppressed due to n<10. While all age categories are suppressed due to n<10, ages of survey respondents were equally distributed across age groups with the exception of lower response rates among respondents aged 18-29.

The draft plan was posted on the City of Berkeley’s MHA webpage and a 30 Day Public Review on the plan was held from November 18 to December 17. Notifications of the 30 Day Public Review were emailed and mailed to community members, MHA Stakeholders, City Commissioners and City of Berkeley staff. As the 30 Day Public Review period was held near the holidays, BMH decided to extend the timeframe to provide input until January 26, 2022. During this period a Press Release on the Draft Plan was initiated to provide broad awareness of the Draft Plan. A Public Hearing on the Draft Plan was held at the Mental Health Commission Meeting on January 27, 2022. Input received during either the public review period or the public hearing fell into the the following four categories:



- General feedback – Included comments that were both for and against the project, and general project questions.
- Utilizing Peer Providers in the project – Input received was supportive of the utilization of peers as providers, and included various questions around how peers would be trained and supported.
- Areas the project should incorporate – Included suggestions on additional areas the project should incorporate such as community First Aid classes and Harm Reduction, among others.
- Housing – Feedback was specific to housing availability, the need for additional housing, and the Section 8 Waiting List for housing.

Representatives from several community-based organizations also expressed support for the project and interest in the potential of collaborative efforts. Public comments are outlined in the Appendix A of this INN Plan and will be utilized to inform project implementation and/or future MHSa Plans and Updates.

Following the Public Hearing, the Mental Health Commission passed the following motion:

M/S/C (Fine, Jones) Recommend that the Berkeley City Council to approve the Mental Health Service Act Homeless Wellness Encampment project and send it to the Department of Health Care Services and the Oversight and Accountability Commission for the State of California for MHSa funding. Ayes: cheema, Escarcega, Fine, Jones, Prichett; Noes: None; Abstentions: Opton; Absent: Taplin.

MHSa General Standards

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSa General Standards listed below. If one or more general standards could not be applied to your INN Project, please explain why.

- **Community Collaboration.** This project was informed by an extensive community collaboration process. The final project idea was generated directly as a result of the two-tiered CPP process described above.
- **Cultural Competency.** The CPP process centered the perspectives of individuals with lived experiences of homelessness. A result of this is the main framing of this project; namely, that it does not purport to offer explicitly clinical interventions at an encampment site. Community members with lived experience shared nuanced perspectives, many of which called for more accessible opportunities for wellness opportunities and social interaction more holistically. This is what the wellness center proposes – to make services immediately accessible, and to make the center a “generalist” health/wellness endeavor, with a customizable menu of service offerings. Moreover, ongoing program planning will be informed via collaboration between the provider team and unhoused community members, ensuring the services remain relevant and culturally competent.
- **Client & Family-Driven.** Both phases of the CPP process included perspectives from individuals with lived or adjacent experiences of homelessness. These perspectives drove the project planning process and defined the wellness center as a viable project option. Moving from project planning to implementation, the wellness center will remain client-driven because consumer input will inform program planning and service delivery.
- **Wellness, Recovery, and Resilience-Focused.** The proposed project is responsive to the tenets of wellness, recovery, and resiliency. In particular, the learning goals reflect a commitment to long-term monitoring and evaluation of consumer outcomes related to mental health and wellness, as well as service engagement rates (including for recovery services and behavioral health services).



Moreover, one of the key ways in which the project aims to support consumer outcomes is by operating as a consumer-led initiative.

- **Integrated Service Experience for Clients and Families.** The encampment-based wellness center will effectively function as a possible entry-point to more specialized services, whether through onsite specialty service providers or via service referrals. This framework means that clients will have the opportunity to access a variety of services coordinated by or in tandem with the wellness center.

Project Sustainability

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Through the local evaluation process, community of practice meetings, and conversations with stakeholders and city leadership, BMH will regularly evaluate the wellness center project to ensure that the components that are successful, or the entire project, can continue. Funding for continuation could come from a variety of sources: the City of Berkeley General Fund, MHSA funds, and/or existing special taxes in Berkeley that fund homeless services.

Communication & Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

To support community-wide dissemination of project information and lessons learned, BMH will engage stakeholders via online public forums as well as virtual and in-person community meetings. These venues have successfully been used with previous MHSA Innovation projects, and feedback from stakeholders during the CPP process supporting this project largely reflected that community members appreciate diverse opportunities for input and discussion.

If a member of the community is interested in learning more about the project, they can use the following keywords in an Internet search:

- **Keywords:** City of Berkeley MHSA, Berkeley mental health projects, Berkeley wellness center, Berkeley encampment wellness center, Berkeley homelessness outreach



Timeline

Specify the expected start date and end date of your INN Project, the total timeframe (duration) of the project, and include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Program Year (FY2022-23 thru FY2026-27) Quarter	FY 22-23				FY 23-24				FY 24-25				FY 25-26				FY 26-27			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Phase 1. Project Launch																				
1.1 RFP & Contract Execution, Service Provider																				
1.2 RFP & Contract Execution, Local Evaluator																				
1.3 Wellness Center Procurement																				
1.4 Launch of Community of Practice																				
1.5 Community Outreach & Project Marketing																				
1.6 Recruitment of Partners from Encampment Community																				
Phase 2. Wellness Center Implementation																				
2.1 Community Practice Quarterly Meeting																				
2.2 Onboarding for Peer Providers																				
2.3 Onboarding for Peers from Encampment Community																				
2.4 Wellness Center Staff Training																				
Phase 3. Local INN Project Evaluation																				
3.1 Evaluation Plan Finalization																				
3.2 Data Collection and Tool Development																				
3.3 Baseline (Pre) Data Collection																				
3.4 Interim Data Collection																				
3.5 Interim Evaluation Reporting																				
3.6 Final (Post) Data Collection																				
3.7 Evaluation Report Development																				
3.8 Evaluation Report and Finalization & Dissemination																				
Phase 4. Sustainability Planning																				
4.1 Sustainability Planning Meetings																				
4.2 Continuation Funding Planning																				
4.3 Dissemination of Project Continuation Decisions																				
Phase 5. Project Close																				
5.1 INN Funding Close-out																				

Section 4: INN Project Budget & Source of Expenditures

Budget Narrative

Provide a budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 5 years is \$2,802,400, which will be allocated as follows:

Service Contract – Personnel plus non-eval direct costs (81%):	Procurement – Non-recurring costs (9%)	Evaluation – Direct costs (6%):	Administration – Indirect costs (4%):
<ul style="list-style-type: none"> \$259,600 in FY 22/23 \$504,200 in FY 23/24 \$504,200 in FY 24/25 \$504,200 in FY 25/26 \$504,200 in FY 26/27 	<ul style="list-style-type: none"> \$239,000 in FY 21/22 	<ul style="list-style-type: none"> \$15,000 in FY 22/23 \$35,000 in FY 23/24 \$35,000 in FY 24/25 \$35,000 in FY 25/26 \$45,000 in FY 26/27 	<ul style="list-style-type: none"> \$13,750 in FY 22/23 \$26,950 in FY 23/24 \$26,950 in FY 24/25 \$26,950 in FY 25/26 \$27,400 in FY 26/27
Total: \$2,276,400	Total: \$239,000	Total: \$165,000	Total: \$122,000



Personnel costs will total \$1,777,500 and will include all salaries and benefits of FTE staff. Personnel cost estimates are based on current-year ranges for similar positions in the Bay Area, based on job market data. The following are the FTE positions that are included in this cost proposal (the cost proposal also includes a .10 FTE director role for administrative and supervisory support):

- 1 FTE Program Manager: \$120,000 (salary + benefits)
- 3 FTE Peer Providers: \$88,500 per year (salary + benefits)
- .10 FTE Program Director: \$9,500 per year (salary + benefits)

Direct costs (less evaluation services) will total \$498,900 and will include programming expenses such as materials and supplies, technology, utilities, mileage, stipends, client transportation, subcontractors, etc. Personnel and direct costs combined (81% of the total proposed budget, as shown in the table above) will comprise the RFP funded value for the contracted service provider. The estimated total of the evaluation services contract is listed separately above, and in the budget table below, because BMH will use a separate RFP process to contract for evaluation services. This total needs to be clearly designated apart from the service contract with the selected CBO/service provider.

Evaluation services (direct costs) will total \$165,000 over the project lifecycle. The evaluation contract will include evaluation plan development, data collection tool development, data analysis, interim evaluation reporting, annual MHSOAC reporting, and a final evaluation report. While evaluation services comprise 6% of the total project budget, less procurement-related non-recurring costs (which are not relevant to the evaluation scope), evaluation services comprise over 7% of the total INN project budget.

Non-recurring costs will total \$239,000:

- \$220,000 for procurement (i.e. physical wellness center)
 - BMH will coordinate with the contracted service provider/CBO to identify the best way forward for procurement. For example, the mobile unit may be a single RV, it may be a different type of trailer with a hygiene station and/or shower unit, it may be multiple smaller vans/mobile units, or something else.
 - Programming costs, including any materials required for wellness center activities or to “stock” the center, will be funded through “direct services – programming” (line 5). This is separate from non-recurring costs.
- \$14,000 for wellness center technology (e.g. staff workstations and/or laptops and laptop docking stations, phone and tablet chargers, mobile cooling fans, etc.)
- \$5,000 for a local, community-based marketing campaign

Indirect costs will total \$122,000:

- \$8,200 for BMH monitoring and management of the evaluation services contract (line 14).
- \$113,800 for the contracted CBO/service provider’s administration, monitoring, and management of the Innovation project (lines 2 & 5).

In the “Budget Context – Expenditures by Funding Source and Fiscal Year” table below, indirect costs are reflected in the “administration” category, as indirect costs included in this project plan are administrative overhead costs. Row A1 shows total indirect costs.

Federal Financial Participation (FFP): There is no anticipated FFP.

Other Funding: N/A



Budget by Fiscal Year

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1.	Salaries (.1 x PD, 1 x PM, 3 x peer providers)	197,500	395,000	395,000	395,000	395,000	1,777,500
2.	Indirect Costs (admin/overhead)	10,400	20,000	20,000	20,000	20,000	90,400
3.	Total Personnel Costs	207,900	415,000	415,000	415,000	415,000	1,867,900
OPERATING COSTS							
4.	Direct Costs (programming)	62,100	109,200	109,200	109,200	109,200	498,900
5.	Indirect Costs (admin/overhead)	2,600	5,200	5,200	5,200	5,200	23,400
6.	Total Operating Costs	64,700	114,400	114,400	114,400	114,400	522,300
NON-RECURRING COSTS (equipment, technology)							
7.	Wellness center procurement	220,000	-	-	-	-	220,000
8.	Wellness center technology	14,000	-	-	-	-	14,000
9.	Marketing	5,000	-	-	-	-	5,000
10.	Total Non-recurring costs	239,000	-	-	-	-	239,000
CONSULTANT COSTS / CONTRACTS (Evaluation contract)							
11.	Direct Costs	15,000	35,000	35,000	35,000	45,000	165,000
12.	Indirect Costs (admin/overhead)	750	1,750	1,750	1,750	2,200	8,200
13.	Total Evaluation Costs	15,750	36,750	36,750	36,750	47,200	173,200
OTHER EXPENDITURES (please explain in budget narrative)							
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)		197,500	395,000	395,000	395,000	395,000	1,777,500
Direct Costs (lines 4 and 11)		77,100	144,200	144,200	144,200	154,200	663,900
Indirect Costs (lines 2, 5 and 12)		13,750	26,950	26,950	26,950	27,400	122,000
Non-recurring costs (line 10)		239,000	-	-	-	-	239,000
Other Expenditures (line 16)		-	-	-	-	-	-
TOTAL INNOVATION BUDGET		527,350	566,150	566,150	566,150	576,600	2,802,400



BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1.	Innovative MHA Funds	13,750	26,950	26,950	26,950	27,400	122,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	13,750	26,950	26,950	26,950	27,400	122,000

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1.	Innovative MHA Funds	15,750	36,750	36,750	36,750	47,200	173,200
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	15,750	36,750	36,750	36,750	47,200	173,200

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	TOTAL
1.	Innovative MHA Funds	527,350	566,150	566,150	566,150	576,600	2,802,400
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	527,350	566,150	566,150	566,150	576,600	2,802,400

*If "Other funding" is included, please explain.

APPENDIX A

PUBLIC COMMENTS

Input received on the proposed plan during the Public Review period and/or the Public Hearing:

General Input

- Plan is long over due.
- This sounds like a better way to provide needed services, hope it works.
- Well thought out and specific in its objective.
- Request that someone from the Commission be appointed to the RFP and Proposal review process.
- What we have here is a very bold and promising plan because un-bold, that is conventional plans have been very unsuccessful in doing much for the people we are trying to reach.
- Thank you for this, I am really excited about it.
- What do you anticipate with the increase in Omicron variants sweeping our community on how that may affect the program?
- How are you going to build trust so that unhoused neighbors will use this service?
- Substance Use Disorder is the main obstacle in getting people off the street. We should do everything we can to make meth and alcohol unavailable in our city and our streets.
- How will the Mobile Van safely serve encampments that are very close to Freeways?
- How will the Project coordinate with all the many homeless outreach services/agencies that already exist?
- What convinces you that folks who have until now rejected available services will do so if they are contacted by adjacent support staff or other residents of the homeless encampment? Is it the fact that services will be brought to the camps? If so, what are the experiences of local groups that are already doing this?
- I know many groups are delivering clothing, food and even cooked meals. How is that working? And will these be the same groups you plan to contract with? I am asking because I have some doubts about the success of the proposal. What are you planning on providing to motivate people who so far haven't been motivated to obtain mental health services? And if people aren't mentally healthy (48%), how do you expect them to continue receiving services when the grant is over?
- There is never any mention of Treatment in these proposals. Treatment is not aggressively being put in front of Mentally Ill individuals, so they can participate in their own treatment. I only hear the word "services", I never hear the word Treatment. Many people are dying on the streets who could be saved if through aggressive outreach and tough love approaches they entered into Treatment. Treatment and Substance Use Disorder services aren't even advertised where someone who is homeless could see them. Why aren't there billboards advertising where to get Treatment for Mental Health and Substance abuse on them? I see homeless mentally ill, substance addicted individuals everyday all around where I live and nothing is being done to help them. I am not seeing any success stories, and I should be seeing 100's of them. Because of the liberalism in Berkeley, people flock here and they can get anything they want on the streets. Many come here to die.

- Use the State millions we tax payers provide you intelligently. 1) Rehabilitative services for the gravely mentally ill/ drug addicted, should be a mandatory fact, with a) Residential treatment b) transitional housing with competent monitoring c) training and then d) housing. Hand holding and soft words by inexperienced MH workers, in a mobile hub, will be useless in helping the mentally challenged/drug addicted unhoused. Such an approach is an insult created by privileged professionals towards the unhoused mentally ill's severe needs, an insult as usual disguised as "compassion". DO NO HARM (Health care principle 101)! Poor or inadequate care is a health hazard and "it does harm"! Such "soft" ways are killing the unhoused in Berkeley. Such ways are also dangerous to safety, depressing and disconcerting for the rest of us, forced through our taxes to support incompetent measures over and over again. The citizens of Berkeley are exposed to dangerously disabled people roaming our streets, often harming self and others while money are spent on grossly inadequate "bandaid" measures. I am asking that you incorporate in your final project's layout the many voices of dissent such as mine, often muted in this self-proclaiming "open minded" town.

Input on utilizing Peer Providers:

- Strongly agree with having input and ongoing staff from the homeless community.
- Happy to hear that the "Peer Providers" will come from the communities they will be serving.
- Bringing on homeless people as peer counselors/advisors/information providers is a great concept. Will they have the listening skills and knowledge necessary to be effective? Or will they more likely advise others to do just as they did? And if they are basically providing information about food, shower, clothing and health resources, how does that differ from what we already do? How would it differ from just handing out leaflets? Half the homeless may reject all services, no matter who offers them.

Input on Areas the Project should Incorporate:

- Ensure services are tailored for individuals with disabilities, and there are opportunities for individuals with disabilities to provide input into the services provided.
- Yes, I think focus on joyful things! Just some ideas: Have a center where there is an opportunity to play music, dance and sing, do art, learn new things (music, dance, art) story-telling, eating good food, cooking.
- The project should offer First Aid classes to the community to assist individuals in need, like the Barefoot Doctors model.
- Safety training should be a big factor in populating the employees of the program.
- Incorporate yoga and Pranayama, Self-realization fellowship practices into the project to restore the spiritual, physical and mental balance of individuals.
- Since INN is focusing on providing mental health services to our unhoused neighbors, please put much thought into how you will keep track of people, avoid re-traumatizing folks and providing a continuum of care in what can be an extremely volatile living situation.

- Plan should also include the collection of data to identify mental illness, substance abuse and residence history.
- Please include TAYs Ages 18-30 as a separate study category. The youth that age-out of the foster care system should be an area of focus because if we can get them into a job training program at an early age perhaps we can prevent a lifetime of homelessness.
- The plan should include Harm Reduction. Don't hear much talk about the serious meth epidemic in Berkeley and how we are going to integrate any meaningful help in terms of harm reduction.
- It is particularly important for those who are running the project to engage very capable evaluators to evaluate how the project is doing. That means, most important, getting people from the outside of the project to do the evaluation. When you have mental health workers evaluating their own work, you cannot draw any conclusions from it.
- Suggest that the Wellness Center should add HMIS and the ability to conduct CMS assessments as it's very important that anyone with boots on the ground have the ability to be notified when someone is matched to a housing resource to be able to find them and get them to it.

Input on Housing:

- Money should be spent on housing and on getting individuals off the street.
- Understand the need for the unhoused to have mental health services, and yet continue to wonder whether money would be better spent on permanently housing people. Once they have shelter, then provide mental health services.
- Treat homelessness with homes. Homelessness causes and worsens mental illness. How to solve homelessness: End Section 8 waiting list. Make it immediate upon qualification. The existence of a waiting list causes homelessness. The existence of a waiting list in a place with homelessness so high is class war. Well wage your war. I think people with section 8 can use it and leave to find better housing elsewhere. And good. City density promotes Covid outbreaks. City density causes homelessness. The homicide rates are skyrocketing. We need to incentivize getting out of cities.

Representatives from several community-based organizations also expressed support for the project and interest in the potential of collaborative efforts. All input will be utilized to inform project implementation and/or future MHSA Plans and Updates.

Connect with Us

Mental Health

Mental Health Treatment & Referral Helpline

1 (800) 491-9099

TTY

1 (800) 533-5018

X

Substance Use

Substance Use Treatment & Referral Helpline

1 (844) 682-7215

X

Crisis Services

Dial 988 or (800) 309-2131

Text “Safe” or “Seguro” to 20121

National Suicide Prevention Lifeline

1 (800) 273-8255

X

Provider Directory

[Click for Full Provider Directory](#)

Alameda County ^{ac} _{bh} Behavioral Health Care Services

MENTAL HEALTH & SUBSTANCE USE SERVICES

 [Home](#)

 [1-800-491-9099](#)

 [Provider Directory](#)

 [Crisis Services](#)

 [Mental Health Advisory Board](#)

 [For Providers](#)

Forensic Services

CARE COURT

The Community Assistance, Recovery, and Empowerment (CARE) Act is a new civil court process that provides services to people who have certain mental health disorders and meet other criteria. The CARE Act allows specific people (known as “petitioners”) to request that an individual enter the CARE process. The CARE process involves assessments and hearings to determine whether the individual (known as a “respondent”) is eligible. If the respondent is eligible, a voluntary CARE agreement or court-ordered CARE plan may

be created for up to 12 months, with the possibility to extend for an additional 12 months. This agreement or plan includes services the individual can receive, such as behavioral health services, substance use disorder treatment, housing, and community supports.

WHO IS ELIGIBLE FOR CARE COURT?

To participate in CARE Court, the following criteria must be met:

- The individual must be 18 years or older
- The individual has a diagnosis in disorder class: Schizophrenia Spectrum or Other Psychotic Disorders
- The individual is currently experiencing behaviors and symptoms associated with severe mental illness (SMI)
- The individual is not clinically stabilized in ongoing voluntary treatment
- At least one of the following:
 - The individual is unlikely to survive safely without supervision and condition is substantially deteriorating
 - The individual needs services and supports to prevent relapse or deterioration, leading to grave disability or harm to others
- Participation in a CARE Plan or Agreement is the least restrictive alternative
- The individual must be likely to benefit from participating in a CARE Plan or Agreement

WHO CAN SUBMIT A PETITION TO BEGIN CARE COURT PROCEEDINGS?

- First Responders (i.e. Peace Offices, Firefighters, Paramedics, Mobile Crisis Response, Homeless Outreach Workers)
- Family Members (i.e. Parents, Siblings, Grandparents, Children)
- Public Guardian, or designee
- Hospital Director, or designee
- Licensed Behavioral Health Provider, or designee, if services have been provided within 30 days prior to submitting the petition
- Person living with the respondent

- Respondent (i.e. self-petition)
- Director of Adult Protective Services, or designee
- Director of California Indian Health Services Program, or designee
- Judge of a tribal court

CARE Act

The CARE Act authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court ordered CARE plan that may include

treatment, housing resources, and other services for persons with untreated schizophrenia and other psychotic disorders.

CARE ACT AT A GLANCE



CARE ACT ELIGIBILITY CRITERIA FACT SHEET



HOW TO FILE A CARE ACT COURT PETITION



CARE-100 (PETITION TO COMMENCE CARE ACT PROCEEDINGS)



CARE-101 (MENTAL HEALTH DECLARATION)



TERMINOLOGY



FAMILY SUPPORTER ROLE



FAQS



ELIGIBILITY CRITERIA VIDEO



LINK TO THE CARE COURT PAGE



LINK TO THE HMA PAGE



PRESENTATIONS AND RECORDINGS



Alameda County Health



**Behavioral Health
Department**

Alameda County Health

Office of the Director

- Mission, Vision, & Values
- BHD Policies and Legislations
- Office of Health Equity
- Announcements & Strategic Initiatives
- Organization Charts
- Executive Leadership Team
- ACBH / HCSA Program Offices

Mental Health

- Child & Youth Services (0 – 24 Years)
- Adult & Older Adult Services (18 Years +)

Substance Use

- Opioid Settlement

Forensic Services

- CARE Court
- Care First, Jails Last Taskforce

ACBHD Brochures

Clinical Support & Referrals

Seeking Services or Making a Referral?

Employment Services

Housing Services

Acute & Integrated Health Care

Acute & Crisis Services

Psychiatry and Nursing Services

Integrated Primary Care Services

Pharmacy Services

Integrated Member Handbook

Plan Administration

Health Records Requests

Digital Access to Health Information

Mental Health Services Act (MHSA)

Provider Info

File A Grievance (Client/Patient Only)

Financial Services

Innovative Programs

Community Services and Supports

Workforce Education and Training

Capital Facilities and Technology Needs

Prevention and Early Intervention

Whistleblower

Training