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 October 1, 2025, through March 31, 2026

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

April 1, 2026

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, the second occurred ten months after the Effective Date, the third review occurred nineteen months after the Effective Date and the fourth review occurred twenty-three months after the Effective Date. The first report focused on understanding the service delivery system and the organization of ACBHD. The second report reflected an assessment of the County's progress from the previous report and identified any areas where work is in progress or still needs to be completed. The third report focused on interviewing the clients currently receiving services. The fourth report focused on interviewing clients currently receiving services and on a tour of an Institution for Mental Diseases (IMD) and interviewing the staff and clients.

A draft of this report was submitted to the parties on February 24, 2026. 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 due date for the final Fourth Report by an additional month. 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 had been meeting every other week with the DOJ and DRC. Since January 28, 2026, the Independent Reviewer has met every other week with DRC. In addition, the Independent Reviewer met once a month with ACBHD Deputy Directors and Alameda County's counsel. 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 November 10, 2025, the Independent Reviewer emailed ACBHD a request for documents, including client records, a list of staff and clients to be interviewed, and the long term care facility to be toured. The Independent Reviewer requested a random sample of ten client records for services currently being provided or were provided within the last year, from each of the following service categories:

a. ACCESS,
b. FSP (both adults and transitional aged youth),
c. ACBHD records for patients seen at John George Psychiatric Hospital, and
d. IMD.

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

During the months of September 2025 through February 2026, the County uploaded documents to the file sharing site for the Independent Reviewer. All these documents were reviewed by the Independent Reviewer and helped form the Independent Reviewer's interview questions for the on-site review.

Data is collected by the fiscal year and the latest data available from ACBHD is from Fiscal Year 2024 to 2025. The fourth report would utilize the same data from the same fiscal year. Since the data for that fiscal year was reported in the third report, it was not included in the fourth report. The Independent Reviewer will request Fiscal Year 2025 to 2026 data for the fifth report.

The Independent Reviewer utilized the previous reports and the updated protocol that was developed based on the Settlement Agreement with feedback from the parties. The parties previously agreed with the use of this 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 virtual interviews of the staff from December 3, 2025, through February 3, 2026. On-site reviews in Alameda County occurred on December 17, 2025, January 7, and January 16, 2026. During the on-site review the Independent Reviewer interviewed four community provider staff and interviewed 15 clients currently receiving services.

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 function*s.*

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 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. 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.” (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 Fourth Report

SERVICE COMMITMENT	SC	PC	NC	NA	TOTAL
1. Crisis Services	17	1	0	2	20
2. Full Service Partnership	11	4	0	1	16
3. Service Teams (Intensive Case Management)	4	0	0	0	4
4. Outreach, Engagement, Linkages, and Discharge Planning	22	4	0	0	26
5. Culturally Responsive Services	6	0	0	0	6
Totals	**60**	**9**	**0**	**3**	**72**

Percent of Each Rating for Reporting Period

Ratings	First Report	Second Report	Third Report	Fourth Report
Substantial Compliance	0*	42%	61%	83%
Partial Compliance	62.5%	22%	25%	13%
Non-Compliance	0	0	0	0
Not Applicable	37.5%	36%	14%	4%
Total	**100%**	**100%**	**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 crisis system and expanding crisis intervention services. In Alameda County, crisis 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.

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).

For this report, the Independent Reviewer interviewed the ACCESS Division Director and the Interim Director of the Crisis Systems of Care. ACBHD continues to offer a countywide crisis system. The crisis system of care was described in previous reports and ACBHD continues to offer prevention and early intervention, crisis intervention, crisis stabilization, and post-crisis follow-up services.

Crisis services continue to be provided by ACBHD staff and through contracts with providers which were outlined in previous reports. The previous report included the

number of calls and the location of the calls for the past several fiscal years. Since the data is the same for this report as the last report, the chart was not included in this report. Evidence reviewed continues to support compliance with this requirement.

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 continues to operate 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 with Crisis Support Services of Alameda County (CSS) for coverage of the telephone line after hours, weekends and holidays. CSS also provides crisis intervention and suicide prevention services on the local crisis line (1-800-309-2131) and the 988 Suicide and Lifeline (formerly known as the National Suicide Prevention Lifeline), and the Substance Use Helpline after hours (1-844-682-7215). (CSS Annual Report, 2024-2025).

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 DHCS. Previously, the Independent Reviewer reviewed ACBHD's policy and procedures.

ACBHD provided the Crisis Services Manual (11/6/2024) which states the following:

> Crisis Services is a county-wide field based program designed to provide urgent mental health services including prevention, early intervention, outreach, engagement, crisis intervention, de-escalation, assessment, post-crisis follow-up, and linkage to ongoing mental health care and other psychosocial services. (Page 8).

The Independent Reviewer previously interviewed both the Interim Director, Crisis Services System of Care and the ACCESS Division Director regarding this requirement. The Interim Director reported that the 988 call center workflow has been updated for clients to self-identify by pressing "2" on their telephone keypads if there are an existing FSP client. When a caller presses 2, the counselor will get a visual indication on the computer screen, and the counselor will support the caller in accordance with existing crisis line protocols. The counselor will offer the caller a transfer to an FSP staff, and if the caller agrees, CSS will transfer the caller to the appropriate FSP program. Clients have the option of obtaining support from 988 and they can get connected to an FSP service provider. This was also reported in the CSS Annual Report, 2024-2025 and

CSS reported that they have started to collect data for FSP clients who contact the crisis line. The Interim Division Director for the Crisis Services reported that this process has been successful, and that ACBHD is continuing with this procedure.

Evidence from interviews from the on-site reviews continue to report that the crisis hotline has a clinician available to support crisis hotline services 24/7. CSS did previously provide a copy of their organizational structure which included the staff's name, title, and licensure. Evidence reviewed support compliance with this requirement.

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 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.*

Previous reports outlined the services provided by CSS, which also operates the 988 system for the County. Coordination with entities responsible for managing urgent and emergency care response line was outlined in a previous report. The interaction and coordination with 911 and the mobile crisis were also described in previous report. The Independent Reviewer previously reviewed ACBHD's policy and procedures and data collected from the ACCESS line. The Executive Director of Crisis Support Services reported that 988 is available in Alameda County and has telephone and text capability 24/7.

ACBHD and Crisis Support Services of Alameda/988 regularly host the quarterly 988 collaborative meetings with 911, 988, law enforcement, fire department, all mobile crisis teams, peer responders, family advocates, Emergency Medical Services (EMS), and other community based providers. In addition, ACBHD hosts a 988 conference annually each September.

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 previously 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 ACBHD Interim Crisis System of Care 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 Mobile Evaluation Team (MET) and the Mobile Crisis Team (MCT) may be accessed by the crisis telephone number or by 911. The Community Assessment and Transportation (CATT) Team may be accessed by 911 or 988. Referrals from 988 are directed to ACCESS. Additional entry points

include 911, 988, or the main crisis telephone number (800-309-2131). This is in addition to the Mental Health Treatment & Referral Helpline (800-491-9099) and the Substance Use Treatment & Referral Helpline (844-682-7215).

ACBHD did report the demographics on the calls they received which include the following: 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. The ACCESS Division Director reported that a report has been finalized and is reviewed on a regular basis. ACBHD shared a copy of this report with the Independent Reviewer.

As mentioned above, the 988 call center workflow has been updated for clients to self-identify as an existing FSP client by pressing “2” on their telephone keypads. The counselor responding to the call, transfers the caller to the appropriate FSP provider if the caller agrees and the FSP program will accept the warm handoff. Previously, ACBHD provided a copy of the warm hand-off procedure from a contracted community based provider. 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.”

ACBHD provided the ACCESS protocol for referrals during the day. ACBHD provided the “Full Service Partnership Protocol” from CSS for after hours and shared this protocol with the Independent Reviewer. This protocol describes the telephone process and describes full service partnerships. The counselor can transfer the call to an FSP staff if needed. This protocol states that a counselor receives a visual indication on the computer screen when a client has called via the Full Service Partnership Dialpad. The counselor offers support and if the client agrees, transfers the client to an FSP staff. A list of providers and contact information is included in this protocol.

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.*

Previously, the Independent Reviewer reviewed ACBHD’s educational materials and documents regarding crisis services, a description of mobile crisis services and data relating to the individuals served by mobile crisis. Previously, 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 Screening Tool to determine the response. ACBHD also provided the Dispatch Screening Tool that is used and includes the dispatch decision.

The Independent Reviewer previously interviewed the ACBHD Interim Division Director for Crisis Services, who reported that ACBHD is strategic in response to calls when the call is received at the main crisis line or from 988. This Interim Director reported that the Dispatch Screening Tool is the protocol for dispatching the appropriate mobile crisis unit. This tool is for triage, and it determines the level of severity of the crisis. The Dispatch Screening Tool requires the following information:

- Contact information and location,
- Screen for urgent medical issues,
- Conduct safety assessment, which include danger to self or others,
- Screen for under the influence of substances or alcohol,
- Obtain reason for call,
- Screen for location safety,
- Collect additional information such as accessibility needs and others on location
- Dispatch decision which includes the need for law enforcement for safety reason, and
- Language or accessibility needs.

Typically, 988 will deploy the CATT if needed, after hours and on weekends.

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 continues to report that the number of mobile crisis teams has expanded from 14 teams to 17 teams[1], with three different models for mobile crisis services described in previous reports.

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]

DHCS considers a mobile crisis team response to be timely if it is within 60 minutes of dispatch in urban areas or within 120 minutes of dispatch in rural areas. The ACBHD Interim Division Director for Crisis System of Care reported that ACBHD is now collecting timeliness data for the mobile crisis teams. CATT data, which the County collects from its contracted CATT provider, continues to reflect timely response and

[1] The County currently has contracted for 12 CATT teams and operates five teams itself (three MCT and two MET) for a total of 17 teams. Additionally, 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.

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

reported that the average response time is 28 minutes for the last six months. The ACBHD Interim Crisis System of Care Director reported that ACBHD has added a Floater Mobile Crisis Team, who can be deployed throughout the county.

ACBHD monitors MCT/MET response times and has developed a report which ACBHD was shared with the Independent Reviewer. This report was from October 2, 2025, to December 10, 2025, and 98 percent of the evaluations occurred under 60 minutes.

ACBHD staff continued to state during interviews that the purpose of MCT is to reduce interaction with law enforcement and to reduce inpatient admissions. The number of involuntary holds (5150) and the number of clients for the past three fiscal years was reported in a previous report. ACBHD also provided their telehealth policy and procedure. This policy states the following:

> Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. Providers determine if a benefit or service is clinically appropriate to be provided via a telehealth modality, subject to member consent (Page 2).

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).*

In previous reviews, evidence was found regarding the purpose of mobile crisis services to reduce interactions with law enforcement, reduce involuntary inpatient admissions, 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 of mobile crisis program information. ACBHD also provided the ACBHD Crisis Services System of Care Diversion List which lists the following services providers which an individual experiencing a crisis may be referred:

- Wellness Centers,
- Crisis Residential Treatment (CRTs),
- Crisis Stabilization Units (CSUs),
- Sobering Center and Detoxification Program,
- Sally's Place, and
- Urgent Medication Clinics.

The ACBHD Interim Division Director for the Crisis Services reported that the staff also screen for any potential danger with the current crisis incident. If there are no safety risks, the MCT and/or CATT will respond without law enforcement involvement.

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.*

The Independent Reviewer interviewed the ACBHD Interim Division Director for the Crisis System of Care for mobile crisis services who discussed the number of mobile crisis teams. Previous reports outlined the following mobile crisis teams and ACBHD staff continues to report that ACBHD either operated or contracted for the following 15 mobile crisis teams:

- **MCT** - 3 teams, one serving North County, one service South County, and one countywide team,
- **MET**- 2 teams serving Oakland and Hayward,
- **CATT** – 10 teams[3] servicing the entire County with staging posts in Oakland, San Leandro, Hayward, Livermore, and Fremont.

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 posted on ACBHD's website.

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).

The conclusion of the Mobile Crisis Assessment is as follows:

> Based on ACBH'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. However, going forward, ACBH should regularly monitor

[3] Although CATT is contracted to provide 12 teams in FY 2025/26, CATT currently operates 10 teams.

mobile crisis capacity and coverage to ensure mobile crisis services continue to meet community needs. (Page 28).

The Mobile Crisis Assessment also included this summary of stakeholder feedback:

> The preliminary results of the assessment were shared with a group of subject matter experts (SME), including mobile crisis and other crisis service providers, first responders, and people with lived experience of mental health crisis and mobile crisis services. The discussion with the SMEs served to refine estimates for mobile crisis services and provide additional context and feedback about assessment findings. (Page 9).

The Mobile Crisis Assessment also listed the following data sources:

- FY21-24 ACBH Mobile Crisis Data: call volume, placement of psychiatric holds, and demographic characteristics of individuals receiving mobile crisis services
- FY23-24 City Mobile Crisis Team Data: volume of mobile crisis calls and placement of psychiatric hold.
- FY21-24 Crisis Receiving Center Data: admissions to crisis receiving centers in Alameda County, number of admissions and demographic characteristics of individuals.
- FY23-24 Hospital Emergency Department (ED) Data: admissions to EDs for mental health-related crises, time of day of admissions, and demographic characteristics of individuals admitted to the ED.
- FY22-23 Crisis Support Services of Alameda County Crisis Call Data**:** de-identified crisis hotline call log data—including time of the call, type of call, suicide risk level, and referrals and emergency procedures. (Page 10).

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 the DOJ and DRC for their feedback on May 14, 2024. Feedback from the Independent Reviewer and the 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).

The Independent Reviewer interviewed the ACBHD Interim Director of Crisis Services System of Care and the Mobile Crisis Supervisor. The Interim Division Director reported that staff have been hired and trained for the expanded teams. In addition, the county added in a Floater Mobile Crisis Team that can be deployed anywhere in the county when the need arises. Three of the expanded teams are in operation, bringing the total number of teams to 15 (i.e., three MCT, two MET, and ten CATT). In addition, the East County MCT has been changed to a Floater Mobile Crisis Team that can be deployed anywhere in the county when the need arises.

In the CSS Annual Report, 2024-2025, it was reported that CSS collaborates with the CATT team for individuals who could benefit from a mobile crisis service from midnight to 8am. CSS worked with a community based provider who provides mobile crisis services, to develop and train the crisis line counselors.

Consistent with footnote 2 in the Settlement Agreement, the Independent Reviewer will not render a compliance determination regarding the reasonableness of any expansion.

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

Previous reports outline the actions the Independent Reviewer took to examine compliance with this requirement. This includes the review of policy and procedures, interviews with community based provider staff, review of ACBHD contract scope of work, review of client records, and interviews with clients.

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 third report, the Independent Reviewer interviewed eight FSP clients face-to face, interviewed three community based provider staff, and reviewed additional client charts. The clients reported that staff were available if they were experiencing a crisis and that the staff would provide crisis intervention services at their location. The clients also spoke about how staff would work with them to prevent any crises from occurring.

For this report, the Independent Reviewer interviewed 11 clients currently receiving FSP services. These clients reported that staff are available, and they know who to contact if they are experiencing a crisis.

Because this requirement is tied to section II2.m of the Settlement Agreement, the Independent Reviewer will continue to monitor the County's compliance with this requirement for sustainability and durability.

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

Staffing for the mobile crisis teams are as follows:

- MCTs continue to include two clinicians,
- MET pairs a clinician with a police officer, and
- CATT pairs a clinician with an Emergency Medical Technician.

Evidence of this was found in the second on site review from interviews with mobile crisis staff and the crisis system of care management staff and a review mobile crisis program information. The Mobile Crisis Supervisor for a contracted provider that provides mobile crisis services, stated that this is the staffing model. The Mobile Crisis Assessment provided the following statement on staffing:

> Although the specific models differ across ACBH mobile crisis programs, all ACBH-operated and contracted teams have at least one mental health clinician at all times and respond to acute mental health crises including evaluation for placement of a 72-hour psychiatric hold (i.e., 5150 holds for adults ages 18 and older or 5585 holds for youth younger than 18). (Page 14).

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

Under ACBHD's Office of Health Equity is the Office of Peer Support Services which is,

> committed to transforming the behavioral health system by engaging, promoting, supporting and empowering peers receiving services, and peer-run organizations and programs.

The Office of Peer Support Services ensures that peer support services and trainings are available and accessible to individuals with mental health and substance use needs who are on the journey to wellness and recovery.

The Peers Organizing Community Change (POCC) is a program of the ACBHD's Office of Peer Support Services. ACBHD reported that the department has over 2,000 peers and the mission of the POCC is to,

> " .. improve the quality of life for Alameda County residents who have mental health or mental health, and substance use issues, in whatever settings they find themselves, and to provide the consumer perspective in transforming Alameda County Behavioral Health Care Services into a recovery vision that is consumer-driven, culturally responsive, and holistic in its services and supports. The POCC provides an empowered and informed voice: of, by, and for consumers in the behavioral health care system, related systems, and in the community."

Previously, the Independent Reviewer interviewed three peer support specialists, and they 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, providing support and referrals, and providing crisis intervention services. Peers can connect to a shared lived experience, provide emotional, informational and practical support, and advocacy for the individual. Peers can connect with the individual in a non-clinical way to assist the individual with what the individual wants or needs. The peers can be the calm, rational, and experienced voice to support the individual in making the best treatment choices for that individual.

Previously, the Independent Reviewer interviewed the Consumer Relations Manager who is the ACBHD Peer Support Manager. This Manager reported that peer services are offered throughout ACBHD's systems of care. Peers are engaged in crisis services and will follow up after a crisis with the individual with the goal of diverting the individual from an involuntary locked facility. The peers provide support and referrals to the individual with no time limits on continuing to provide these services.

This Manager also described the ways in which peers participate in outreach and engagement activities by conducting in-reach at provider facilities such as John George, Villa Fairmont, Gladman, Board and Cares, etc. The peers work with the community based providers who contract with ACBHD and also work with faith-based leaders in the community.

ACBHD provided the policy and procedures for Peer Support Services. This policy and procedure outline the following:

- services,
- components of services,
- workforce,

- supervision and oversight requirements,
- documentation,
- billing Medi-Cal, and
- enrollment and the Start of Peer Support Services.

Evidence reviewed support compliance with this requirement.

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 previous reports.

CRT Facility	Community Based Provider	Number of Beds
Amber House	BACS	14
Woodroe House	BACS	15
Jay Mahler	Telecare	16
TOTAL		**45**

ACBHD has met this requirement and has sustained this requirement for more than six months per the Settlement Agreement. ACBHD also reported that two additional CRTs will be opened in the future.

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 has already contracted with La Familia for six additional peer-respite beds through Forensic Safe Harbor, a new forensic peer respite site located in San Leandro. The Independent Reviewer did review the amended contract with La Familia and ACBHD for these respite beds.

With respect to the remaining 19 beds under the settlement agreement, ACBHD has also been working with community-based providers on efforts to contract for an additional 32 beds with Telecare and La Familia, which will bring the total number of CRT beds to 80 beds. The ACBHD Interim Division Director for Crisis Services reported that construction is scheduled to begin in January 2026 for a new Hayward facility that will house eight CSU beds and 16 CRT beds. This facility will be operated by La Familia, which obtained a $3.85 million DHCS BHCIP grant for the project, aided by ACBHD's submission of a letter of support indicating its intent to enter into a contract with La Familia for the provision of CSU and CRT Medi-Cal specialty mental health services. The other planned CRT expansion is a 16-bed CRT program for adults with significant mental health needs and involvement with the criminal justice system, which will be operated by Telecare. Telecare obtained a $4.3 million DHCS BHCIP grant for the project, aided by ACBHD's submission of a letter of support indicating its intent to

enter into a contract with Telecare for the provision of Medi-Cal specialty mental health services to be provided at the Forensic CRT. ACBHD will be unable to finalize the contract with La Familia and Telecare for these 32 additional CRT beds until construction is complete and services can begin. In light of the funding and construction required for these new CRT facilities, ACBHD's support of these projects constitutes all reasonable efforts to contract to add additional CRT beds consistent with section II.2.b.ii.

ACBHD's contract with La Familia for six additional peer respite beds has sustainably and durably fulfilled part of ACBHD's requirements under section II.2.b.ii. With respect to the further CRT expansion, the Independent Reviewer will continue to monitor this expansion for ACBHD's continued reasonable efforts in support of contracting with La Familia and Telecare for additional CRT beds and will report on the sustainability and durability of those reasonable efforts in the next report.

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.*

Previous reviews included tours of the following:

- Woodroe Place
- Jay Mahler
- Amber House
- Sally's Place (Peer respite).

These tours confirmed that the facilities are not locked.

The Independent Reviewer previously reviewed client records, ACBHD contracts scope of work, and 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 Bay Area Community Services (BACS) Operation Manual contains a section titled "Crisis Intervention Protocol" for staff to follow when dealing with a client in crisis.

Previously, the Independent Reviewer interviewed clients at Jay Mahler and at Amber House. The clients reported that they were getting stable and they expressed how much they appreciate the staff at the facility. They talked about being in a stable environment and taking their medication each day which helps to reduce or avoid any crisis situation. They reported that staff are available to talk to whenever you need. They also reported that the therapy and groups were really helpful. They talked about how helpful the staff was and how the staff are not judgmental.

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. 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 which had no indication of housing as a condition for admission.

During previous on-site reviews, the Independent Reviewer toured the facilities listed above and interviewed staff. Both ACBHD staff and community based provider staff reported that housing is not 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 MCTs. This was reported 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.*

The Independent Reviewer previously interviewed ACBHD staff, mobile crisis 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. 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 Screening Tool. ACBHD provided a copy of the Dispatch Screening Tool which includes the following:

- 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 ACBHD Crisis Services Manual (11/6/2024) states that one of the goals of crisis services is to prevent unnecessary psychiatric hospitalizations. Interviews with ACBHD staff included a discussion on the need to prevent law enforcement interactions. The majority of the mobile crisis teams do not include law enforcement personnel. However, if there is a concern for safety due to a violent altercation, staff will request law enforcement. This is also part of the Dispatch Screening Tools in order to make sure that both the individual in crisis and the staff are safe.

As stated above, the Dispatch Screening Tool has a section for the clinician to identify any of the following safety concerns regarding the location of the current crisis:

- Abusive person on site,
- Environmental concerns such a crowd,
- Dangerous animals,
- Weapons, or
- Other category.

If one of the above situations exists, the mobile crisis team may request law enforcement to meet them at the crisis location. The mobile crisis team may also call law enforcement when they arrive at the scene if any of the above situations exits but were not previously reported. 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.

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 17 service commitments, a rating of partial compliance for one requirement, 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 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. *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.* Evidence from interviews from the on-site reviews continue to report that the crisis hotline provides the following:

triage and the identification of full service partnership clients on a 24/7 basis, and has a clinician available to support crisis hotline services 24/7.

3. *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.* Evidence was found through documents and interviews that there is no wrong door for accessing ACBHD's services.
4. *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.
5. *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.* ACBHD is collecting timely in-person response as evidenced by staff interviews and review of the ACBHD report.
6. *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).* The Independent Reviewer interviewed mobile crisis staff, the crisis system of care management staff, reviewed mobile crisis program information, and related data. Evidence was found through interviews and review of documents on the purpose of mobile crisis services.
7. *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 has expanded to 17 teams and continues to operate with 15 teams.
8. *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.* ACBHD contracted with the Indigo Project to conduct the Mobile Crisis Assessment, and the final version was provided on January 31, 2025.
9. *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, 2026, and is posted on ACBHD's website.

10. *Each mobile crisis team shall include at least one mental health clinician*. There was evidence that the Mobile Crisis Teams include two clinicians, Mobile Engagement Teams pair a clinician with a police officer, and Community Assessment and Transport Teams (CATT) pair a clinician with an Emergency Medical Technician.
11. *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 and reviewed related documents.
12. *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.* ACBHD has met this requirement and has sustained this requirement.
13. *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 based provider staff.
14. *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.
15. *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 contractor's scope of work, the community based providers Operation Manual, tours of the facilities, and interviews with staff.
16. *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.
17. *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. *FSPs will provide crisis intervention as set forth in section II2.m in this Agreement*. Because this requirement is tied to section II2.m of the Settlement Agreement, the Independent Reviewer will continue to monitor ACBHD's compliance with this requirement for sustainability and durability.

ACBHD achieved Not Applicable for the following:

1. *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.* ACBHD reported that it has expanded to 15 teams and continues to operate with 15 teams. The results of the Mobile Crisis Assessment stated that "the County has fulfilled the addition of 2.5 – 5 FTE mobile crisis teams necessary to address mobile crisis needs". The Settlement Agreement includes a footnote (#2) that states that "...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)."
2. *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 has contracted for 6 additional peer respite beds and is making reasonable efforts to contract for 32 additional CRT beds (a combined expansion of 38 beds). The Independent Reviewer will continue to monitor ACBHD's best efforts to contract for the additional CRT beds for sustainability and durability.

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.

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. ACBHD provided the list below of community based providers and the number of FSP slots. ACBHD also provided contracts for these community based providers which includes the number of slots in the Contract Deliverable and Requirements section. The addition of 100 additional slots has a deadline of two years from the effective date of the Settlement Agreement. ACBHD has already complied with this requirement in advance of the Settlement Agreement's timeline: 50 slots were added in January 2024, and another 100 additional slots were added in December 2024, for a total of 1,195 slots.

The Settlement Agreement required a total of 1,105 FSP slots and ACBHD had a total of 1,195 FSP slots. The Settlement Agreement timeline was met prior to the established deadline and has been in effect for more than six months. The Independent Reviewer interviewed ACBHD's Deputy Director, Plan Administration, who reported that there are no plans to change the number of FSP slots and ACBHD will retain the current number of FSP slots even with the changes in funding due to BHSA implementation.

The table below lists the community based providers who provide FSP services and the number of slots for each:

Provider	Program	Population	Slots
Abode	Greater HOPE	Adults	150
BACS	CARE Court	Adults	100*
BACS	Circa60	Older Adults	100
BACS	HEAT	Adults	150
BACS	LIFT	Forensic	100
BACS	PAIGE	TAY	50
BACS	RISE	TAY	50*
Fred Finch	STAY	TAY	100
Fred Finch	WRAP	Child (ages 8-18)	20
Seneca	MHS Child	Child (ages 0-8)	20
Telecare	Assisted Outpatient Tx	Adult	30
Telecare	Community Conservatorship	Adult	25
Telecare	CHANGES	Adult	100
Telecare	JAMHR	Forensic	100
Telecare	Strides	Adults	100
Total			**1,195**

* The BACS CARE Court and RISE slots were added after the effective date of the Settlement Agreement and reflect expansion beyond that specified under section II.2.b.

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 report 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 for their review. The FSP Assessment determined the number of additional FSP slots needed outside the children's system of care. The Settlement Agreement specifies estimating FSP slots for individuals ages 16 and older in order to ensure the assessment includes transition aged youth (TAY) FSP program slots even if those slots can be used by TAY individuals that are 16 and 17 years old. In Alameda County, TAY FSP programs generally serve individuals ages 18 to 24, so the County's TAY FSP capacity is not impacted by the needs of 16 and 17 year olds. Individuals under 18 years are served in ACBHD's Children's FSP program. The FSP Assessment did appropriately address this issue in the report and did not make any additional adjustments (Footnote 37, Page 29). The FSP Assessment's focus is consistent with the original investigation, which focused exclusively on access to care for adults.

In accordance with the Settlement Agreement, the Final FSP Assessment was posted on ACBHD's website on July 11, 2025.

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 Final FSP Assessment stated the following:

> This assessment focuses on the Full Service Partnership program, specifically on the needs and gaps in FSP services for individuals ages 16 years and older. (Page 1).

> This assessment does not include any evaluation of existing FSP programs and therefore does not assess quality and outcomes of existing FSP programs. While this assessment does use local service utilization data from hospital, crisis system of care, and community-based behavioral health services within Alameda County's continuum of services, this assessment does not include any assessment or evaluation of the capacity or quality of any other programs that an FSP-eligible individual may access, including crisis, housing, and other residential and outpatient services (Page 1).

The Final FSP Assessment included some of the data described above along with community and stakeholder feedback. However, Indigo reported some challenges and limitations as follows:

> During the assessment process, Indigo made minor methodology adjustments in response to emerging data trends as well as data limitations or availability (Page 10).
>
> Some quantitative data was not available or had quality concerns. FSP programs do not track outreach and engagement contacts in the EHR before the individual has enrolled in FSP. As a result, it was not possible to explore the associations between outreach and engagement and FSP enrollment quantitatively, and this was instead assessed through stakeholder interviews. Housing status is often difficult to assess from administrative datasets because many people experiencing homelessness use a mailing address, such as a friend or family member or homeless service provider location. Within the dataset available for the assessment, the housing status indicator was largely unreported for referred individuals and was unreported for one-third of FSP episodes, making it difficult to examine trends in referral, enrollment, and service participation between the housed and unhoused populations. From the data available to this assessment, it is reasonable to assume that many of the FSP clients experience homelessness. Lastly, to comply with HIPAA and protect client anonymity, demographic groups with fewer than 12 clients are either aggregated or are not reported. (Page 11).

The Final FSP Assessment also 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).

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 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 December 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 Final FSP Assessment report was made public on July 11, 2025, and appropriately incorporates the feedback that was provided to ACBHD.

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 released the final FSP Assessment on July 11, 2025. The conclusion of the FSP Assessment was as follows:

> A total of 2,016 individuals were determined to meet FSP inclusion criteria and a need for an FSP level of care, including:
>
> - 605 ACBH FSP clients in FY22-23
> - 230 ACBH Service Team clients in FY22-23
> - 1,181 ACBH clients not open to FSP or Service Teams in FY22-23
>
> Of these individuals, 180 need TAY FSP, 1,615 need Adult FSP, 156 need Older Adult FSP, and 65 were in Assisted Outpatient Treatment (AOT) or Community

Conservatorship FSP. Of the TAY, approximately 50 may need Forensic FSP while approximately 900 of the adults and older adults may need Forensic FSP. Individuals were determined to need forensic FSP services if they were participating in an ACBH forensic FSP program in FY22-23 or if they met FSP inclusion criteria through jail bookings and incarceration only.

The group of 2,016 individuals identified likely reflects needed capacity over a period of years and is larger than the annual capacity needed. (Page 35).

Based on these results, the actual total FSP capacity needed is approximately 1,400 FSP slots, this includes an additional 300 slots beyond the existing 1,100 slots. (Page 36).

ACBHD added 50 slots in January 2024, and another 100 additional slots were added in December 2024, for a total of 1,195 slots.

The Independent Reviewer interviewed ACBHD's Deputy Director, Plan Administration, who reported that ACBHD plans to retain the current number of FSP slots even with the changes in funding due to BHSA implementation. The Independent Reviewer will not render a compliance determination regarding the reasonableness of any expansion, consistent with footnote 3 in the Settlement Agreement.

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 ACBHD contracts with the community providers. Previously, the Independent Reviewer reviewed client records of clients receiving FSP services, and interviewed four clients currently receiving FSP services in a virtual setting.

For the third report, the Independent Reviewer interviewed eighteen clients, which included eight FSP clients, interviewed three community based provider staff, and reviewed additional client charts. The clients said that their case manager talked to them about their goals and review their progress on these goals periodically. One client reported that when they are reviewing their goals, the case manager will provide suggestions on how to accomplish that goal and then they come to agreement on the next steps.

For the fourth report, the Independent Reviewer interviewed 11 clients currently receiving FSP services. The clients reported on the support and services received from the community based provider staff. The clients stated that the staff were supportive and helpful in obtaining their needs and goals. The clients reported having therapy and

meeting with their case manager on a regular basis and as needed. Clients reported that services provided are flexible and are provided where and when they are needed.

The progress on the client's goals was found in the progress notes. Progress notes include the services provided to the client that are necessary to attain their goals. Clients interviewed reported that they do talk to their case manager regarding their goals and progress on their goals. Based on client interviews, review of the client records, and interviews with community based provider staff, it is determined that FSPs are in fact providing the necessary services.

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.*

California Code Regs. Title. 9, § 3200.180 defines the ISSP as follows:

> "Individual Services and Supports Plan" means the plan developed by the client and, when appropriate the client's family, with the Personal Service Coordinator/Case Manager to identify the client's goals and describe the array of services and supports necessary to advance these goals based on the client's needs and preferences and, when appropriate, the needs and preferences of the client's family.

California Code of Regulations, Title 9, Section 3620(a) provides that the County may provide the full spectrum of community services necessary to attain the goals outlined in the ISSP. Section 3620(g) states that each county is to ensure that an ISSP is developed for every client and Section 3620(h) requires that the county's Personal Service Coordinator or Case Manager develops the ISSP with the client.

Consistent with DHCS guidance, the ISSP is documented in a problem list and progress notes.[4] Client records contain a form titled "Problem List" which includes the following information:

- Problem description,
- Diagnosis,
- Status,
- Date reported,
- Date resolved, and
- Staff title.

DHCS issued Behavioral Health Information Notice No: 23-068 and removed the client treatment plan requirements or ISSP. This was part of the California Advancing and

[4] DHCS no longer requires a static ISSP, but instead requires a problem list and progress notes that fulfill the ISSP requirement.

Innovating Medi-Cal (CalAIM) initiative to reform behavioral health documentation requirements. This Information Notice states that the care plan is no longer required and that the intent was to change care planning for a one-time event to an ongoing, interactive component of service delivery. In addition, the Department of Health Care Services Behavioral Health Services Act County Policy Manual (Version 1.3.0, June 2025) states the following:

> Static treatment plans such as the Full Service Partnership (FSP), Individual Services and Support Plan (ISSP) are no longer required by DHCS.
>
> Care planning is an ongoing process that is documented flexibly in the clinical record, including through the problem list and progress notes.

Previously, the Independent Reviewer reviewed policy and procedures for FSP and reviewed client records. The Independent Reviewer previously 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 interviewed the Clinical Director for two different FSP providers for both the third report and the fourth report. Both Clinical Directors stated that they utilized both the Problem List and progress notes to meet this requirement. The Independent Reviewer also reviewed additional client records for both the third and fourth report. The Problem List was found in each of the client records. FSP client records listed the issues that the client identified, individualized goals, and the Problem List were consistent with the assessment. Progress notes were used to record client's progress with their identified goals. The client records indicated that the services provided, and the issues were being addressed.

ACBHD issued a memo to their FSP providers dated November 2, 2022. This memo is on the ACBHD website. The memo states that a sperate treatment plan is no longer required and a simplified client plan within a progress note is for targeted case management services. The memo further states that there is no standard template for an ISSP and that providers are free to create a template that meets their needs.

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. The Independent Reviewer previously reviewed client records for clients receiving

FSP services and reviewed another twenty FSP client records for this report. Client records indicated that a variety of services were being provided in several settings, and were based on client preference. The Independent Reviewer previously 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. Previously, the Independent Reviewer interviewed another eight FSP clients face-to face, interviewed three community based provider staff, and reviewed additional client records.

For this report, the Independent Reviewer interviewed 11 clients currently receiving FSP services and reviewed twenty FSP client records. A review of the client records indicated that clients and their FSP staff discussed frequency of contact. Clients reported that services were based on their needs. They reported having therapy on a regular basis sometimes once a week and sometimes every other week depending on their needs. The clients also reported meeting with their case manager weekly and sometimes daily depending on the client's wishes. Clients reported that services provided are flexible and are provided where and when they are needed. For example, clients were seen in the home or wherever the client requested and at a time that worked for the client. This was also found in the review of the client records. Clients from the interviews have stated the following:

- "If this program wasn't here, people would be in a bad place".
- "I can call my case manager at all times and we talk about everything".
- "They care, and they make you feel like somebody".
- "I feel unconditional love from the staff".
- "The staff have really helped me, and I feel ready for independent living".

The Adult and Older Adult System of Care Director reported that the Adult and Older Adult System of Care continues to hold monthly meetings with each FSP provider to discuss high need and high intensity clients within the program and transition assistance for other clients. These meetings ensure outreach and engagement by FSPs, and serve as continuous quality reviews on FSPs. The County uses a number of tools to ensure FSPs meet their contracted requirements and provide quality services, aside from ACT Fidelity Assessments. For example, ACBHD provided the internal report, monitoring each FSP community based provider on a number of metrics such as the following:

- Percent of clients who receive a face-to-face program visit within seven calendar days of a qualifying event,
- Percent of clients who receive an average of four or more program visits per month during the fiscal year (new and existing clients), and
- Percent of clients with a reduction in John George Psychiatric Hospital Crisis Stabilization Unit (CSU) or inpatient services, or an emergency department visit for mental illness.

The results are discussed with each community based provider at the monthly review meetings.

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 included specific requirements for community based providers providing FSP services which are listed out in previous reports.

The Independent Reviewer previously reviewed client records, interviewed clients currently receiving FSP services, and interviewed community based provider staff. For this report, the Independent Reviewer interviewed 11 clients currently receiving FSP services and reviewed twenty client records. With both reviews, clients reported 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. Clients reported that staff are available to talk to when clients are experiencing a crisis in order to deescalate the crisis. Staff instruct the clients on a number of techniques such as deep breathing to reduce the stressful feelings they are experiencing. Many of the clients reported past stays at John George and Villa Fairmont. One client stated that the stay at a State Hospital was the lowest point in their life. But then they obtained stability on their medications and were doing so much better. Overall, the clients were grateful for the help and support they were receiving. Review of client records also supported that services are provided 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. Client records indicated numerous examples of clients reaching out to their case mangers or therapists to assist with an issue and that the staff provided needed interventions. Clients interviewed also reported that they knew which staff to contact if they were experiencing a crisis.

ACBHD provided an internal report on FSP performance metrics for Fiscal Year 2024 to 2025. Both the aggregate and individual based provider data was provided. A discussion regarding the outcomes for housing, can be found later in this section. Although section II2.k focuses on the design of FSP services, the Independent Reviewer notes that the favorable outcomes tracked in these reports reinforce that these programs are appropriately designed consistent with the objectives of this provision.

Regarding the reductions in psychiatric emergency, inpatient, and crisis stabilization days, the report included the following:

Eligible Episodes	Episodes with Reduction	Percent with Reduction
287	190	66%

Regarding the connection to primary care providers, the report included the following:

Eligible Episodes	Clients with Primary Care Visits	Percent with Primary Care Visits
855	686	80%

Regarding reduction in jails days, the following was reported:

Eligible Episodes	Episodes with Reduction	Percent with Reduction
174	125	72%

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.*

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 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 Adult and Older Adult System of Care Director reported that the Adult and Older Adult System of Care has monthly meetings with each FSP to discuss high need and high intensity clients within the program and transition assistance for other clients. These meetings ensure outreach and engagement by FSPs, and serve as continuous quality reviews on FSPs.

The Independent Reviewer previously reviewed ACT Fidelity Assessments (2024) 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.

Under the Behavioral Health Services Act (BHSA), county FSP programs are now required to have two levels of coordinated care for BHSA eligible adults and older adults: FSP ACT and FSP intensive case management. For purposes of evaluating the requirements under section II.2 of the settlement agreement, the Independent Reviewer only assesses ACBHD's FSP ACT programs, while ACBHD's FSP ICM programs are evaluated under the requirements in section II.3 of the settlement agreement.

For this report, the Independent Reviewer also reviewed updated (Fiscal Year 2025-2027 or Fiscal Year 2024-2026) ACBHD community based provider contracts scope of work for the provision of FSP services. Each contract obligates the provider to furnish FSP services "using fidelity to the Assertive Community Treatment (ACT) evidence-based practice."

For this report, the Independent Reviewer reviewed the results of the ACT Fidelity Assessment for 2025. There were three reports for community based providers for TAY services and six for adult services which included Forensic FSP services. The Settlement Agreement does not require a specific ACT fidelity score only that FSP programs will be implemented using high fidelity to ACT and that services are provided by a team of multidisciplinary mental health staff and that the teams operate at a 1:10 mental health staff to client ratio.

The fidelity assessments were conducted from July to September 2025. The overall scores for the FSP TAY providers were from 3.5 to 3.8 out of 5. Some of the strengths listed in the results were the number of face-to-face contacts in the community, involvement in discharges from inpatient settings, low turnover of staff, and the

provision of crisis services. An example of areas for improvement were the intensity of services and in providing substance use treatment.

The overall scores for the Adult FSP providers ranged from 3.2 to 3.9 out of 5. ACBHD provides a report of findings that includes the scores in each requirement. The report indicates where improvements have been made from the previous year and where improvements are still needed. Some of the strengths identified were small caseloads, low staff turnover, and having a psychiatrist on staff. Some areas for improvement included intensity of services and frequency of contacts.

The Independent Reviewer was able to confirm that ACBHD continues to implement FSP programs using high fidelity to the ACT evidence-based practice and also satisfies the two specific requirements in the Settlement Agreement because (i) FSP programs are provided by a multidisciplinary mental health staff who, together, provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals; and (ii) FSP teams operate at a 1:10 mental health staff to client ratio. ACBHD implements its FSP programs through its contracts with community based providers, and those contracts demonstrate ACBHD's sustained implementation of the FSP programs using high-fidelity to the ACT evidence-based practice. The fidelity assessments likewise reinforce community-based providers obligations to furnish FSP services with high-fidelity to the ACT evidence-based practice, confirming that the contractual obligations of ACT fidelity are meaningful. Finally, the Independent Reviewer's evaluation of sampled client records 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.*

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.

For the third report, the Independent Reviewer interviewed eight FSP clients, interviewed three community based provider staff, and reviewed additional client charts. The clients reported that staff were available if they were experiencing a crisis and that the staff would provide crisis intervention services at their location. The clients also spoke about how staff would work with them to prevent any crises from occurring.

For this report, the Independent Reviewer interviewed 11 adult clients currently receiving FSP services and reviewed twenty FSP client records. Again, adult clients reported that staff were available if they were experiencing a crisis and that the staff would provide crisis intervention services at their location. However, the Fidelity Assessment for TAY FSP reported that one of the community based providers needed improvement in responding to crisis after hours. In addition, there was one Adult FSP community based provider that also needed improvement with responding to crises after hours.

Interviews with the community based provider staff and ACBHD staff confirmed that ACBHD has expanded its FSP notification system to ensure that the FSP case worker is promptly notified when an FSP client had contact with the mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis. This is accomplished through their electronic health record system. The staff from the community based providers also reported that they will receive an email and a voice message regarding the contact with their FSP client. The Interim Director of Crisis Services reported that prompt notification continues to be made when an FSP client received crisis intervention services.

The Independent Reviewer will continue to monitor the County's compliance with this requirement for sustainability and durability.

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 previously provided three IPS Supported Employment Fidelity reports for 2024 and details of the results were provided in the third report. ACBHD also previously 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 to provide a roadmap that will help IPS programs provide effective services and to provide a snapshot of current practices.

For the third report, ACBHD provided ten client records from clients receiving IPS services. Evidence of services provided was found in the client records. Some examples of the services provided were as follows:

- Assistance with the job application,
- Assistance with managing anxiety for interviews and starting a new job,
- Transporting the client to job interviews,
- Contacting potential employers regarding application status,
- Helped look for employment that aligned with client goals, and
- Role playing job interviews.

For this report, the Independent Reviewer interviewed 11 clients currently receiving FSP services and reviewed client records. Five of these clients are unable to work, four currently have employment and two are looking for employment. These clients did report on how staff was assisting with their job search. Clients reported staff helping them with the job application process. Often staff will transport the client to the interview and will role play the interview process with the client to prepare them for the interview.

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 provides for or 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.*

Alameda County Health (formerly Health Care Services Agency) Office of the Agency Director, manages Housing and Homelessness Services (H&H), which oversees the Coordinated Entry Services (CES). These services are managed outside of ACBHD and ACBHD has no mechanism to oversee H&H services and housing prioritization.

Previous reports have discussed that this requirement focuses on (1) the housing needs assessment for FSP clients and (2) the support and assistance provided to FSP clients to secure and maintain temporary or permanent housing, as needed.

Previous reports outlined background information about the CES housing assessment process and scoring for those clients with housing needs (separate from the FSP housing needs assessment discussed below). For the second report this Independent Reviewer interviewed two staff from CES, the CES Manager and the H&H Director of Systems Access Equity who reported that client voice is important.

For the third report, the Independent Reviewer conducted interviews with the following individuals:

- Director of Alameda County Health H&H,
- Deputy Director of Alameda County Health H&H, and
- CES Manager.

Previously, the H&H CES Manager reported that there are 13 Housing Resource Centers throughout the county where a client can receive support and assistance to secure and maintain housing. The clients are asked about their housing goals and housing resources are examined in order to locate the appropriate housing for the client. The CES Manager provided this list to the Independent Reviewer which included the telephone number of the facility and hours of operation. It is also posted on the Alameda County website. In addition, the CES Manager reported that they have housing navigators through CES to provide support and assistance with securing and maintaining housing. They also contract with 24 community based organizations and will contact their case managers if a client is in need of additional assistance and support.

The staff from Housing and Homeless Services Unit of Alameda County Health reported that Alameda County does have the following housing resources:

- Alameda County's Homelessness Prevention Framework outlines the actions and resources needed to significantly prevent homelessness in Alameda County.
- The Home Together 2026 Community Plan is a 5-year strategic initiative which identifies the strategies, activities and resources needed to dramatically reduce homelessness in Alameda County.
- Home Together 2030. This is the creation of a new, refreshed five-year strategic plan that will integrate new system modeling, update and expand racial equity

analysis, incorporate feedback from a wide variety of stakeholders and the latest Point-in-Time Count and systemwide data.

For previous reports and for this report, evidence of housing needs and wishes of the FSP client was found in the client records. FSP client interviews also revealed that their housing wishes were reported. There are additional ways that FSP programs support and assist their clients' housing needs. For example, FSP staff will transport clients to the Housing Resource Centers for an in person Coordinated Entry Assessment and follow up appointment. FSP staff can obtain information on housing status from the Homeless Management Information System (HMIS) system and can also contact the Housing Resource Center (HRC) for the information/updates to better serve their clients.

The FSP contracts also state that the FSP programs have the goal of improving clients' abilities to secure and maintain stable permanent housing in the least restrictive and most integrated living situation appropriate to meet their needs and preferences. Furthermore, the FSP contracts state that the FSP programs assist clients with accessing housing, including through the use of Housing Navigation services. FSP programs also are able to use their flex funds for housing-related services and assistance. FSP programs are required to have housing specialists staff to work with clients.

ACBHD also provided the following two housing assessment forms used by FSP staff to document the housing needs assessments they conduct with each FSP client. These forms are found in the ACBHD electronic health record, Clinician's Gateway, and are required to be completed by FSP providers.

- Partnership Assessment Form (PAF) where the client's current housing situation is assessed along with their housing for the past 12 months, and
- Key Event Tracking Form (KET) for any changes in the clients housing situation.

This is consistent with the FSP contracts which require use of the PAF and KET in housing assessments to track changes in client status.

It is noteworthy that ACBHD was initially 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.

Although there are challenges in providing housing in Alameda County, these challenges do not preclude ACBHD's compliance with the requirements of section II2.o.i. This requirement pertains specifically to housing needs assessments for FSP clients, and the support and assistance provided to FSP clients to secure and maintain, as needed, temporary and permanent housing. ACBHD contractually requires FSP providers to assess FSP clients' housing needs and provide support and assistance consistent with the settlement agreement. Evidence FSP clients receive housing needs

assessments, support, and assistance was found in the client record, interviews with clients and interviews with community based providers and ACBHD staff.

The Independent Reviewer will continue to monitor ACBHD contracted FSP providers' provision of support and assistance to secure temporary and permanent housing (through H&H or otherwise) in the least restrictive and most integrated setting that is appropriate to confirm the sustainability and durability of compliance.

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 continue to report that there are a number of priority factors based on the assessment that determine if the client is placed in the housing queue. CES reported that while FSP clients are not identified as a priority factor, clients are given priority based on their diagnosis, current housing, income, and psychiatric history that CES receives from providers and clients. 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)

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 ACBHD originally included a Housing Services Division, but that the oversight and funding was transferred to the Alameda County Health, Office of the Agency Director around 2019. The Senior

Executive Team acknowledged that this change has made it more complex while serving clients who require housing services coordinated through H&H (as opposed to working directly through the behavioral health system of care).

The ACBHD 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.

Previously, the Independent Reviewer interviewed the Alameda County Health Director of Housing and Homeless Services, Deputy Director of Housing and Homeless Services and the CES Manager. These leaders reported that emergency shelters are utilized through Social Services. The community based provider staff reported using creative avenues in order to locate housing. One staff provider spoke about reaching out and maintaining a good relationship with the hotels and single room occupancy facilities. They have also increased their housing budget, which has also helped with locating temporary housing. One community based provider reported that they have a MOU with landlord who just opened up a new facility that has provided more beds for their clients. Another provider talked about using a long-term shelter which is different than the other homeless shelter. For this long-term shelter, clients are guaranteed a bed and do not have to stand in line every night waiting to see if there is bed availability. These are examples of initiatives that ensure the prompt provision of temporary housing while FSP clients wait for permanent housing.

The ACBHD contracts with the FSP community based providers also state that FSP programs assist clients with accessing housing services, including through the use of Housing Navigation services, and that FSP programs may use flex funds for housing-related services and assistance. FSP programs are required to have housing specialists on staff as well.

Although there are multiple ways that FSPs are promptly providing and securing temporary housing, the Independent Reviewer will continue examine this requirement further for durability and sustainability

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*.

Interviews conducted with the ACBHD contracted community based provider staff who serve ACBHD clients and the Housing and Homeless Services staff, CES Manager and clients, all reported that housing is provided in the least restrictive and most integrated setting that meets the client's needs and preferences. The clients interviewed also confirmed this. One of the Clinical Directors for a community based provider of FSP services, reported that they do focus on safe housing and that they provide wrap around

services to the FSP client to support and maintain housing. FSPs have a number of resources they utilize for housing. If a problem does arise, they try to intervene early in order to maintain the housing placement.

The staff from Alameda County Health Housing and Homeless Services talked about a Community Health Record that they can access to review client information and the number of services they have received in the entire continuum of care. They also reported that housing is provided to their client population, not inclusive of FSP clients as a priority, in the least restrictive and most integrated setting based on client's preferences.

One of the guiding principles in the Alameda County Health Coordinated Entry Policies is as follows:

> Participants are experts in their own lives and will make choices about what is right for them. Such choices may be constrained by the availability of resources but will not prevent the participant from being served. (Page 4).

According to community based provider staff, H&H staff, the CES manager, CES policy, and clients, permanent housing is provided in the least restrictive and most integrated setting that is appropriate to meet clients' needs and preferences. FSP client interviews further confirm ACBHD's compliance with this requirement, notwithstanding the inherent challenges in locating permanent housing in Alameda County. The Independent Reviewer will continue to monitor ACBHD's compliance with this requirement for sustainability and durability.

Summary of Full Service Partnership Findings

Overall, there are sixteen service commitments in the Full Service Partnership section. There were eleven service commitments that received a rating of substantial compliance, four with a rating of partial compliance and one requirement received a non-applicable rating. There were no non-compliant ratings given in this section.

ACBHD achieved Substantial Compliance for the following requirements:

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").* The Draft FSP Assessment was completed within the established deadline. The FSP Assessment's focus is consistent with the original investigation, which focused exclusively on access to care for adults.

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. The Final FSP Assessment included some of the data described above along with community and stakeholder feedback.
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. 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 Final FSP Assessment incorporates the feedback that was provided to the ACBHD.
5. *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).* Clients interviewed reported that they do talk to their case manager regarding their goals and progress on their goals. The Independent Reviewer reviewed client records and found evidence of necessary services and the clients goals. Based on that information, it is determined that FSPs are in fact providing the necessary services.
6. *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 additional client records and conducted additional interviews with clients to confirm that services were provided to meet the client's goals.

7. *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 Adult and Older Adult System of Care Director reported that the Adult and Older Adult System of Care continues to hold monthly meetings with each FSP provider to discuss high need and high intensity clients within the program and transition assistance for other clients.

8. *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*. Data reviewed, interviews with clients and community based provider staff and review of client records confirmed services provided meet this requirement.

9. *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 2025 fidelity review assessment reports.

10. 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.

11. *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, clients are given priority based on their diagnosis, current housing, income, and psychiatric history.

ACBHD achieved Partial Compliance for the following requirements:

1. 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.* Because this system has not been the subject of review for more than six months, the Independent Reviewer will continue to monitor this requirement for sustainability and durability and will report on the status in subsequent reports.

2. *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 FSP clients receive housing needs assessments, support, and assistance was found in the client record, interviews with clients and interviews with community based provider and ACBHD staff. Although staff and clients report that housing is very difficult to find in Alameda County, this does not preclude ACBHD's compliance with this requirement. The Independent Reviewer will continue to examine ACBHD's compliance for sustainability and durability.

3. *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.* Although there are multiple ways that FSPs are providing and securing temporary housing, the Independent Reviewer needs to examine this requirement further for sustainability and durability.

4. *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 needs to continue examining this requirement for sustainability and durability.

ACBHD achieved Not Applicable for the following:

1. 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 added 50 slots in January 2024, and another 100 additional slots were added in December 2024, for a total of 1,195.

SERVICE TEAMS (INTENSIVE CASE MANAGEMENT)

Service Teams, also known as Intensive Case Management (ICM), 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.

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 2,304 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.

ACBHD provided this list of providers and the number of slots for each.

Service Team Provider	Slots (FY 2024-25)
STARS TAY Program	100
Asian Health Services	286
BACS ICM ST	150
Felton Older Adult	90
La Clinica	142
La Familia	150
Telecare Visions	140
West Oakland	180
Bonita House	166
Tri City (ACBHD Program)	150
Valley Service Team (ACBHD Program)	90
Oakland Service Team (ACBHD Program)	390
Eden Service Team (ACBHD Program)	270
TOTAL	**2,304**

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

The FSP Assessment was an opportunity to explore community needs regarding FSP and Service Teams services. The FSP Assessment includes data from Service Teams and included the Service Team staff as subject matter experts.

The FSP Assessment includes data from Service Teams and included the teams as subject matter experts. One of the findings in the FSP assessment is as follows:

> …there are a number of individuals currently enrolled in an FSP program that are likely ready to step down to a less intensive service as evidenced by meeting the clinical stability threshold with a lower frequency of service akin to a service team or outpatient program. The estimate of the number of slots needed assumes that individuals who no longer require an FSP level of care are given the opportunity to step down into a less intensive service thereby creating capacity for new enrollments.

Previously, ACBHD provided a tracking log of the number of clients being served by the community based providers. The report indicated that there is capacity with the community based providers to incorporate FSP clients who are ready to step down to a lower level of care. ACBHD Deputy Director reported that clients receiving FSP services who are clinically appropriate will be transitioned through their normal process to a lower level of care.

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.*

The Independent Reviewer previously interviewed service team clients in a virtual group setting. The clients previously reported that they are receiving services that are flexible and that assist with their autonomy. They listed several services that were provided that included mental health services, plan development, case management, crisis intervention and medication support. These clients reported having a positive experience with the services they are receiving. These clients talked about how supportive their case manager is and how the case manager is helping them achieve their goals. Overall, all the clients had very positive things to say about the services they were receiving.

Previous evidence included a review of the contracts with community based providers, policy and procedures, interviews with community based provider staff and supervisors, interview with clients, and review of client records. The third report included a chart of the top treatment locations for Fiscal Year 2024-25. All the above serve as evidence of compliance with this requirement.

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 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 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.

While housing is a complex issue in Alameda County, Service Team clients do receive support and assistance to access temporary and permanent housing, through the CES and other available programs. This was evident in the review of the client records and through client interviews, with both previous and current reviews.

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 four 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.The County will explore community needs and opportunities for expanding Service Teams as appropriate. The FSP Assessment includes data from Service Teams and included the Service Team staff as subject matter experts. Report from ACBHD indicated that there is capacity within the current number of Service Teams slots.
3. 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. Evidence reviewed support compliance with this requirement.
4. *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 that support compliance with this requirement.

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. The County staff answer the ACCESS line from 8:30am to 5pm, Monday through Friday. ACBHD contracts with Crisis Support Services of Alameda County (CSS) for coverage of the telephone line after hours, weekends and holidays.

The Independent Reviewer previously interviewed ACCESS staff, the ACCESS Division Director, and reviewed ACCESS client records. ACCESS is staffed internally by ACBHD, and the SUD access line is currently staffed by Center Point, a nonprofit county contractor. ACBHD staff reported that there are plans to integrate the telephonic ACCESS line for mental health and substance use disorder information, screening, and referrals. The goal is to integrate by July 2026. This will create one system-wide point of access for mental health and substance use disorder. ACBHD leadership wants to change the name of the ACCESS division and gathered community input on the new name. Leadership will review the suggested new names and will make a final decision in 2026.

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 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 ACBHD ACCESS Division Director previously reported that ACBHD continues to make meaningful efforts to provide real-time appointments scheduling. This involves technological and other back-end improvements that would be the foundation for system changes and data collection. In addition to information previously provided, on February 4, 2025, ACBHD received County Board of Supervisors approval to begin contract negotiations in pursuit of 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's approval.
- 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 ACBHD Departments.

With respect to the EPIC project, ACBHD reports that it anticipates finalizing the contract for Board of Supervisor review and approval in April 2026, which would complete Phase I of the EPIC project, and that Phase II is simultaneously underway.

ACBHD operated a pilot with Pathways to Wellness where ACCESS coordinated a call with Pathways to Wellness staff and provided the client with a warm handoff to Pathways to Wellness in real time. In addition, ACBHD has this as a Performance Improvement Project for their External Quality Review, and was listed in their Quality Improvement Work Plan FY2024-25. ACBHD also provided the contact with the community based provider for this service.

The ACCESS Division Director reported that ACCESS contacts a community based provider to conduct the time-in-the-filed assessment. In addition, ACCESS utilizes Oakland's Community Support Center (OCSC) for in-person services. Beginning in July 2025, ACBHD started a pilot program where an ACCESS clinician is now onsite at the OCSC. While at OCSC, ACBHD clinicians offer real-time, in-person screening, and referral for clients walking into the clinic seeking mental health services. OCSC was chosen as the site for this pilot as this is the busiest county operated clinic, conveniently located in the Eastmont Town Center which serves as a hub for community resources. This in-person ACCESS program has now moved past the pilot phase, and the expanded program is now permanent.

The Independent Reviewer interviewed the ACCESS Division Director for this report to obtain a status update. This Division Director reported that certain technological and

other back-end improvements have been completed and that ACBHD now has a report that tracks the number of calls, hold times and the time of the call. ABCHD did provide the Independent Reviewer this report that indicated that during 10/22/2024 to 12/24/2025, there were a total of 1,098 calls with only 36 calls placed on hold for an average of one minute and 45 seconds

Requirement: *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, 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 had previously conducted the following activities for the first and second reports:

- Reviewed policy and procedures,
- Reviewed contracts with community based providers,
- Interviewed ACCESS staff,
- Reviewed client records, and
- Interviewed ACCESS Division Director.

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 Division Director 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 reported that they conduct the assessment.

The Independent Reviewer interviewed the ACCESS Division Director who reported that the majority of the referrals for services come through the ACCESS line. ACCESS staff are available to conduct a face-to-face screening if the individual walks-into the facility. Community based providers can open cases and contacts ACCESS to register the case into the electronic health record. The community based provider can conduct the assessment for this client.

The ACCESS Division Director reported that ACCESS clinicians are onsite at the Oakland Community Support Center (OCSC) and can conduct real-time assessments, as described in more detail above in connection with the prior requirement. The OCSC is the largest County-operated clinic in the county and is co-located with many others service and governmental organizations such as social services, Sheriff's Office, and other community based organizations.

For this report, the Independent Reviewer reviewed additional client records from ACCESS. There is evidence that the person's eligibility for community based behavioral health services is determined and that the community based provider conducts the assessment.

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. Previous interviews with ACBHD staff and the review of ACCESS client records confirmed that ACCESS does make appropriate referrals to community based providers. ACBHD also provided samples of the referrals from ACCESS. Previously, ACBHD provided a copy of the monthly ACCESS Capacity and Referral Report which lists each program name and current vacancies in each program. ACBHD staff reported that this report is reviewed monthly with the management team.

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 ACCESS Division Director previously reported that the ACCESS clinicians utilize the Level of Care Tool to determine the appropriate level of care for the individual. There are also several factors that can impact the case assignment such as location, language/cultural needs, age, and provider's specialty. ACCESS then sends a referral letter to the provider and the client to confirm that the referral was made. Contact information is also included on this referral letter.

For this report, the Independent Reviewer interviewed the ACCESS Division Director regarding the determination and eligibility for FSP services and the assignment process to the community based providers. This Division Director reported that the once the level of care has been determined, the staff examines the following factors to determine the appropriate community based provider:

- where the client lives,
- language the client speaks,
- age of the client,
- any special requests from the client, and
- specialized services offered by the community based provider.

The Independent Reviewer previously interviewed the Clinical Director for an FSP program who reported that for the referrals from ACCESS, they will visit the client at their current placement prior to discharge. They will conduct the assessment and complete the intake paperwork. The Clinical Director reported that the case assignments are a clinical decision based on the best fit. If a client does not follow through with services, they use the Community Health Records Online platform to report the attempts to engage the client in services.

For this report, the Independent Reviewer interviewed another FSP Supervisor from a different community based provider. This supervisor reported a similar procedure as above with clinically assigning cases to their staff who then conduct the intake and assessment.

There is evidence that support compliance with this requirement through review of contracts with community based providers, interviews with both ACBHD staff and community provider staff, review of reports, and with review of referrals from ACCESS.

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.*

Previous interviews with ACCESS staff plus the on-site reviews confirmed that ACCESS does make appropriate referrals to community based providers. ACCESS sends referral letters to the community based provider and the client, confirming that the referral was conducted and this letter includes contact information for each. ACBHD did provide a report on when assessments are completed by the community based provider and the number of hours of service provided.

Previously, the Independent Reviewer interviewed 18 clients during several of the onsite reviews and the clients reported that they did not have to wait to complete the intake and assessment and for services to begin. The Independent Reviewer also reviewed client records and there was no indication in the records of clients having to wait for services. Interviews with community based provider staff also reported that the assessment and assignment process is promptly completed.

The Independent Reviewer examined a contract with a community based provider that stated: “Upon receiving a referral from ACCESS, Contractor shall provide assertive outreach to secure treatment engagement.” It is important to note that the community based providers must meet federal Timely Access Standards which are outlined in DHCS Behavioral Health Notice 25-013. The requirement for outpatient non-urgent non-psychiatric specialty mental health services is that a client must be offered an appointment within 10 business days of request for services. The ACBHD website includes a report from Health Services Advisory Group (HSAG) titled “Assessment of MHP Network Adequacy Data, Methods, and Results Validation Rating by MHP and Indicator California Department of Health Care Services (DHCS) Contract Year 2024-25”. The results of this assessment for outpatient non-urgent non-psychiatry specialty mental health services offered an appointment within 10 business days of request for services is as follows:

Score is 100 with 19 elements rated as “met”, and no elements were rated “not met”.

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.*

Previously, the ACCESS Division Director reported that ACCESS utilizes their electronic health record to identify when there are no FSP Teams or Services Teams available. Their data system generates a weekly report that is distributed to the managers for review. The ACBHD staff also reported that they meet on a weekly basis with the Adult and Older Adult System of Care, the Adult Forensic Behavioral Health System, the Behavioral Health Courts, the Crisis System of Care and the Child and Young 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 Division Director stated that the client remains on the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer was provided a copy of this report.

ACBHD staff also reported that ACCESS, Adult and Older Adult System of Care and the Forensics Services meet quarterly to review the following factors:

- Review the report of unavailability of FSP or Service Team,
- System capacity,
- Provider relationship including the managed care plans,
- CalAim initiatives,
- Impact of federal, state and local policies, and
- Community trends.

In a sample set of meeting minutes reviewed by the Independent Reviewer, three specific clients were discussed, and referrals were made with action items to follow up with the relevant FSPs. Following this review, problems and possible solution are identified.

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.*

The Independent Reviewer interviewed the Adult and Older Adult System of Care Director reported that ACBHD has hired staff as Critical Care Managers. Previously, the Independent Reviewer interviewed one of the Critical Care Managers who reported on that the services listed below that are provided.

ACBHD contracted with BACS for the ACCESS Care Coordination Team (ACCT) program in June 2025, and ACCT began operations in Fall 2025. ACCT services include outreach and engagement, outpatient mental health services, case management, crisis intervention, and other client and program support with the goals of enhancing timely supportive transitions, improving linkages across the behavioral health system, support client stabilization, and reducing criminal justice involvement and hospitalizations, among others. ACCT is comprised of two teams: an outreach and engagement team and the case management team, providing interim short-term mental health, core case management, and co-occurring SUD services, and other services, as appropriate.

Since this requirement has a recent effective date, the Independent Reviewer will continue to monitor for sustainability and durability.

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 ACBHD has Outreach and Engagement (O&E) teams. Mobile crisis staff reported that there are three community based providers who provide outreach and engagement services. 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.

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 individuals not connected to existing ACBHD services.

ACBHD continues to have the following three outreach and engagement teams:

- Crisis Connect/Post Crisis Follow-up Team (CC/PCFT): Six-person team who provide in-reach at JGPH and anywhere else in the county to individuals in need of assessment for and linkage to ongoing Behavioral Health 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 individuals that need more support and are not already connected, CC/PCFT conducts 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 individuals, 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 are 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 System of Care recidivism, and
- Continuous participation in services for 6 to 12 months.

ACBHD provided the outreach and engagement data. Overall, there was a 70 percent success rate in connecting individuals to the appropriate level of care. with an average of 20.2 days from the referral to the successful connection.

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.

For all providers, warm handoffs were especially helpful in connecting with the individual to begin the outreach and enrollment process. Often, community based providers reach out to the referring party to connect or meet the person at a specific location. Additionally, community based providers reported that people who are referred from an IHOT or Crisis Residential program that are being connected to an FSP may be more likely to engage because they have been stabilized in the prior service. Community based providers spoke of how contact with IHOT often facilitates a successful transition to FSP. Community based providers reported that when a person is not connected to any other providers or system partners, outreach and engagement can be difficult.

If ACCESS is contacted, the clinicians utilize the Level of Care Tool to determine the appropriate level of care for the client. They immediately send the referral to the appropriate FSP or Service Teams to inform them that a client has been assigned to them. For community based referrals, the clinicians utilize the DHCS mandated screening tools to determine medical necessity. DHCS issued the Transition of Care Tools for when the referrals are from the managed care plans.

The ACBHD continues to contract with those community based providers and continues to require that the staff conduct the outreach in the client's natural environment. The Independent Reviewer previously interviewed the Associate Director of IHOT & HOPE Outreach Programs from a community based provider that has the following three outreach and engagement teams:

- Mobile Access Point – this is a new team that is referral based for both the serious mentally ill and substance use population,

- IHOT, and
- Hope Outreach – a team of 11 staff that are out in the community

The new Mobile Access Point team is comprised of two staff, and they try to engage individuals into services and will outreach to those individuals who drop out of services.

The programs described in this section have target populations identified through the use of program specific factors including contacts with crisis services (including PES), frequent inpatient hospitalizations, and incarcerations of individuals receiving services.

For the adult system of care, anyone in the community can refer an individual to an IHOT team through the ACCESS Unit. The AdROC team works closely with the ACBHD Care Connect team. Individuals that are willing to receive services as follow up after a PES or inpatient stay are referred by the Care Connect team directly to AdROC for intensive outreach and engagement while still in John George or immediately after discharge.

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 in 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 has interviewed the Forensic, Diversion, and Re-entry Services Director multiple times. The Forensic Director reported that there are regular multiple meetings with the Sherriff's Office and that there are re-entry teams that work with the individual within 72 hours of booking to assist the individual with treatment services.

The Forensic, Diversion and Re-entry Services Director reported that there is a dedicated ACBHD re-entry team that provide connection to community based providers as alternatives to incarceration. This re-entry team works closely with the Public Defender's Office to connect clients to community based providers, which assists the Courts in making decisions related to the clients release from jail. The Director of Adult and Older Adult System of Care also reported the use of the IHOT team in addition to the other outreach and engagement teams to connect individuals to community based providers.

ACBHD staff continue to report meeting with the Sheriff's Office, prosecutors, public defenders, courts and law enforcement about available community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact.

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 reported 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 continue to 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.

This Director reported that the use of tablets for the re-entry staff to rapidly connect the individual with the community based provider is going well. The re-entry staff also works with ACCESS to conduct an assessment for FSP services and initiate a referral.

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

Previously, ACBHD provided a copy of the IHOT Operations Manual (Updated March 2024), the contract with a community provider for IHOT services, and interviews with IHOT staff. ACBHD continues to have 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 users 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.

Previously, the Independent Reviewer interviewed three IHOT staff who reported that they work with law enforcement and also receive referrals from ACCESS and crisis residential treatment programs.

The Independent Reviewer previously interviewed the Associate Director of a community based provider for IHOT teams. This Associate Director described the importance of meeting people where they are at in order to engage them into services.

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.*

The Independent Reviewer interviewed the ACCESS Division Director regarding co-occurring access for services via ACCESS. This Division Director reported that the caller can press a number when contacting ACCESS that will forward the caller to Center Point and they conduct the screening for eligibility of services. This Division Director also reported that staff are being trained on ASAM in preparation for full integration of the ACCESS line which is scheduled for July 2026.

The Independent Reviewer interviewed the ACBHD Director of Substance Use Disorder Continuum of Care who reported that this program began in January 2026. The services are being provided through a contract with a community based provider. The teams are comprised of a SUD counselor, peer support specialist, family support specialist, and a substance use navigator. One team is focused in Oakland, and the other team is focused on the rest of Alameda County. Anyone can refer to the program and referrals are filtered from ACBHD. Referrals for the program are also received from the following:

- Hospitals and Emergency Departments,
- The Helpline, ACCESS, ABCHD Crisis Connect and Post Crisis Follow Up Teams,
- Law Enforcement, Case Workers, Family/Caregivers,
- Harm Reduction Programs and Street Medicine teams, and
- Community-Based Organizations.

The outreach services provided are as follows:

- Assessment/Client Screening,

- Needs assessment to understand health disparities and overall needs of the client,
- Education on existing resources,
- Provide resources and discuss all options with participants to better understand what participants are looking for and what may be the best for their needs,
- Incentives for Client Participant,
- Discussion of incentives to continue engagement in IHOT (milestone incentives),
- Enrollment Support,
- Providing support with benefits enrollment and connection to point-of-contact (POC) to provide in-depth enrollment support,
- Group Meetings for Family, Caregivers and Support Systems, and
- Will address existing barriers, provide education, group sharing, and overall support.

The program model provides the following linkage services:

- Link each client with assistance based on identified needs,
- Warm hand-off to resources/treatment providers,
- Appointment scheduling, case management for stability,
- Coordination with mental health, primary care, and social services to address past experiences, and
- Re-engagement to existing resources/treatment providers.

Because this program has not been in operation for more than six months, the Independent Reviewer will continue to monitor for durability and sustainability.

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 previously interviewed the Adult and Older Adult System of Care Director who reported that UR pilot has been implemented, and it has been successful. This Director previously 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 Director was interviewed for this report and reported that the current length of stay has been reduced to approximately 85 to 90 days.

This Director reported that as part of their UR pilot program, they do meet with IMD staff as part of the peer to peer meetings. ACBHD meets weekly with Villa Fairmont and every other week with Gladman and Morton Bakar. Discussions regarding barriers to discharge are held at these meetings. These meetings also included a check-in to make sure providers are connected with the IMDs to assist with discharge planning, including taking the client to the new placement when possible. ACBHD staff also assist with reaching out to the community based provider to make sure they are involved. Providers are encouraged to see clients at the IMDs and to conduct in-reach particularly in the last 30 days of the stay. This is in addition to the weekly Care Coordination meetings where bed availability and discharges are discussed.

For the fourth report, the Independent Reviewer interviewed the Administrator and the Clinical Director for Villa Fairmont, and they confirmed participation in these weekly meetings. They reported that barriers to discharge, tracking of referrals to the most integrated setting, and client's progress are discussed at the weekly meetings. They reported that ACBHD staff weekly audits client records and engages in peer-to-peer meetings to assess appropriateness for discharge. They also reported that the length of stays has decreased with average for the subacute wings being 57 days and for the more intensive wing, a reduction to 124 days. For comparison the goal from the county is 90 days for the subacute wings and 180 days for the more intensive wing.

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 previously provided examples of contracts that require the placement 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. In addition, community based services are identified if appropriate for that level of care, as part of assisting clients to the most integrated setting. Interview with Adult and Older Adult System of Care Director indicated that there is an acute care coordination meeting every week. This meeting is attended by a number of community based providers that include FSP and Service Team providers, IMD staff, John George Social Worker, and ACBHD staff. 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. Previously, the Independent Reviewer was able to attend three of the acute care coordination meeting where discharge planning for specific clients was discussed.

Previously, the Independent Reviewer reviewed client records for clients placed in an IMD. Client records from Villa Fairmont, Gladman and Morton Bakar were provided. The client records did contain discharge planning that was in the most integrated setting appropriate to the individual's needs, and consistent with the individual's preferences.

For the fourth report, the Independent Reviewer interviewed the Administrator and the Clinical Director for Villa Fairmont, and they confirmed that discharge planning begins at intake. They reported that there are a number of weekly meetings where the clients and their discharge plans are discussed. These meetings are as follows:

- Inhouse weekly utilization management meetings with the social worker,
- Utilization review meetings with ACBHD,
- Recovery conference with the treatment team and the client, and
- One to one supervisory meeting with the Director of Social Work with the Villa Fairmont Social Worker and Discharge Planner.

The Administrator and Clinical Director also reported that clients are able to visit a placement prior to their discharge and client preference is considered when making a placement. Clients can refuse a placement if they feel that the placement is not a good fit for them.

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.*

Previously, the ACCESS Division Director reported that they continue to have meetings with the Adult and Older Adult System of Care clinical leads and the ACCESS staff every week. At these meetings, they work to facilitate, in conjunction with ACCESS, connecting and assigning individuals to the correct level of care. This Director also reported that this same group meet quarterly to review any trends.

Previously, the ACCESS Division Director reported that ACCESS utilizes their electronic health record to identify when there are no FSP Teams or Services Teams available. Their data system generates 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 Division Director stated that the client remains on the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer has previously been provided a copy of this report.

ACBHD previously provided the meeting minutes with ACBHD leadership regarding this requirement. The staff identify the issues and included action items to resolve the issues. In a sample set of meeting minutes reviewed by the Independent Reviewer, three specific clients were discussed, and referrals were made with action items to follow up with the relevant FSPs. The summary of the meeting was to continue day to day monitoring in the weekly ACCESS meeting and monthly with the community based providers.

For the fourth report, the Independent Reviewer interviewed the Administrator and the Clinical Director for Villa Fairmont. They stated that if FSP or Service Team is unavailable, other resources are examined in order to prevent longer lengths of stay. They confirmed that the unavailability of an FSP or Service Team does not result in a longer length of stay. They also confirmed that this issue is discussed in the weekly meeting with ACBHD and that they work closely with ACBHD to arrange such services as promptly as possible. They identified that workforce shortages are an example of when an FSP or Service Team may not be readily available.

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.*

Previous interview with the 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.

This Director also reported that the IMD's do contact the provider when an admission occurs and will coordinate with the case manager regarding discharge planning in order to resume services upon discharge. The Independent Reviewer was able to attend three of the acute care coordination meeting where discharge planning for specific clients was discussed. The meeting is attended by a number of community based FSP and Service Team providers, IMD staff, John George Social Worker, and ACBHD staff.

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. John George Psychiatric Hospital Social Worker at John George previously reported that she and the social worker staff communicates regularly with ACBHD and community provider staff to coordinate care.

ACBHD Senior Executive Team reported that ACBHD staff are invited to participate in the discharge process. ACBHD Senior Executive Team also reported that community provider staff are invited to participate in the discharge process.

Previously, the Independent Reviewer was given a tour of John George Inpatient Hospital 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 previously reviewed 40 client records for clients who had received services during the fiscal year of 2024 to 2025.

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.

Previously, the Independent Reviewer interviewed the John Geoge Director of Social Services and the Chief Administrative Officer. They reported that John George works closely with ACBHD staff and community based provider staff to determine whether the individual is eligible for and in need of FSP or Service Team services. They also promptly connect 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. Crisis Connect staff are at John Geoge daily to assist with coordination of care and to assist with the transition to a lower level of care. The staff at John Geoge will also work with ACCESS team for medication follow-up appointments and they do refer clients who are over the age of 55 to GART.

For this report, the Independent Reviewer reviewed ten ACBHD client records and discharge planning was found in the documentation. Clients were also referred to services for their appropriate level of care as determined by the treatment team and the client.

Both staff from John George Hospital and ACBHD reported that the communication has improved greatly between the organizations. Additional ACBHD staff are at John George Hospital daily to assist with coordination of care and discharge planning. There are three positions to assist with transitions of care into and out of acute inpatient settings. Clients are promptly connected to an FSP team as reported by the clients and the community based provider staff. Data is being utilized and ACBHD now has access to John George's electronic health record, and they use this real-time access for care coordination purposes. There are weekly acute care coordination meeting where discharge planning for specific clients is discussed.

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 and community based providers, including Service Team and FSP 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 ACBHD 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 reported this regular communication.

The chart below shows the number of clients served at John George Psychiatric Hospital based on data for the last three 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	FY 2024-25 Number of Clients	FY 2024-25 Number of Episodes
Crisis Stabilization	8,584	4,270	8,404	4,274	4,206	8,476
Hospital	2,304	1,564	2,535	1,714	1,654	2,387

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.*

For the third report, the Independent Reviewer interviewed the John Geoge Director of Social Services and the Chief Administrative Officer. They reported that there is an automated system that sends an alert to the community based providers. 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. This Director also reported the use of the electronic health record and registration information are available for the community based providers.

The ACBHD Critical Care Manager also stated that they have access to the electronic health record to assist with transitions of care. They will also match the PES census for clients receiving FSP services and will email a notification to the assigned staff. This notification does occur within an hour or two of admission to PES.

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 Outreach and Engagement (O&E) teams. 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.

Previously, the Independent Reviewer interviewed three staff from the IHOT team. The staff stated that they are trying to engage a client throughout a 90 day period of outreach, which includes outreach within 72 hours. 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.

Staff from John George reported that they utilize Crisis Connect and the ACCESS team for referrals for clients who do not follow up for services. The Independent Reviewer interviewed the Associate Director of IHOT & HOPE Outreach Programs from a community based provider that has the following three outreach and engagement teams:

- Mobile Access Point – for both the serious mentally ill and substance use population,
- IHOT, and
- Hope Outreach – a team of 11 staff that are out in the community

The Mobile Access Point team is comprised of two staff, and they try to engage individuals into services and conduct outreach to those individuals who drop out of services.

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 reported that they do collaborate when clients are admitted, facilitating prompt resumption of FSP or Service Team services upon discharge.

The Independent Reviewer previously interviewed the John Geoge Director of Social Services and the Chief Administrative Officer. They reported that John George works closely with ACBHD staff and community based provider staff to determine whether the individual is eligible for and in need of FSP or Service Team services and promptly connects 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. Crisis Connect staff are at John Geoge daily to assist with coordination of care and to assist with the transition to a lower level of care.

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 Re-entry FSP teams that are through contracts with community based providers. The ACBHD re-entry team can also refer directly to community based re-entry treatment teams.

The Forensic, Diversion and Re-entry Services Director previously reported 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 three times to engage the individual into services.

ACBHD staff confirmed that the re-entry team will engage the community based provider if a client is already connected to that provider. For individuals not previously connected to services, the re-entry team makes the referrals with ACCESS or directly to community-based re-entry treatment teams. The ACBHD psychiatrist provides a 30-day supply of medication for any client currently taking prescribed medication upon release. In addition, ACBHD includes the re-entry plan as part of the client's release process. ACBHD staff, the medical provider and the re-entry teams have regular meetings in order to coordinate care for clients being released.

Several community based providers reported that people often agree to services while hospitalized or incarcerated, but then refuse to participate when they are released back into the community. For example, as one referring party mentioned, providers at Santa Rita Jail will try to connect a person to an FSP or Service Team and provide a warm handoff, but the person will not continue with those services post-release. In part this is because those that have the highest needs for an FSP service, are also the ones that struggle the most to seek help. Another barrier noted by referring parties is service providers' limited ability to engage with people in-custody and build rapport to facilitate service engagement post-release. ACBHD, however, continues to collaborate with the

County's Sherriff office to improve this process, consistent with the settlement agreement. To help address this challenge, ACBHD re-entry staff at Santa Rita Jail have tablets to connect people in custody to providers remotely while also working on getting clearance for providers to see clients while they are in custody. Several providers mentioned that the ability to offer a subsidy or access to housing can be a large incentive to participate in FSP services, especially for individuals being released from jail.

The Forensic, Diversion and Re-entry Services Director was interviewed for the fourth report. This Director reported that the re-entry teams have improved the warm handoff to ACBHD services and that the use of the tablets was working well with connecting individuals to 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.*

The Forensic, Diversion and Re-entry Services Director was interviewed for this report. This Director reported that they do evaluate the FSP and Service Teams regarding discharge and re-entry services. This Director reported that they monitor the new referrals to FSP services and monitor the linkages made. There are regular meetings where any challenges or barriers are identified in order to facilitate transition of care. This Director reported that the evaluation does include analysis of timeliness, trends, and causes of identified problem areas.

One issue identified was in obtaining clearances from the jail so that the staff can visit the client prior to release. The process for obtaining clearance can be a time consuming process. As discussed in connection with section II.4./.i, above, ACBHD continues to comply with its obligation to collaborate with the County Sheriff 's office to improve this process.

This Director reported that they do receive a daily booking list and a daily release list. Staff are able to identify if an individual being released has a release plan and if referral for services are still needed or if a reconnection of the individual with the service provider is needed. One challenge identified by this Director was length of incarceration and if the release was done quickly, there is not enough time to try to engage the individual in services. This Director reported that the Post-Release Clinician does try to reach out the individual to assist them with transition back into the community.

The Independent Reviewer will continue to monitor and will review results of the evaluation to verify the following requirements: (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.

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.*

ACBHD implemented a process to track this occurrence within their Information System (IS). 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 the use of tablets has helped with the coordination and warm handoff for the individuals being released.

Previously, the ACCESS Division Director reported that ACCESS utilizes their electronic health record to identify when there are no FSP Teams or Services Teams available. Their data system generates 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 the appropriate care and service needs of the client in order to either assign to an identified level of care or referral to other resources. 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 Division Director stated that the client remains on the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer was provided a copy of this report. ACBHD also provided the meeting minutes with ACBHD leadership regarding this requirement. The staff identify the issues and included action items to resolve the issues.

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 continue to conduct chart reviews on a regular basis. This Director reported that they also review the re-entry plans and continue to provide training responsive to the results of the quality reviews to the community based provider staff.

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.I.ii and II.4.I.iii and the Independent Reviewer will continue to monitor this requirement for sustainability and durability.

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 stated 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 three 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 22 service commitments, and a rating of partial compliance for four 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 ACBHD staff and supervisor, and in reviewing client records.
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 following an eligible individual's contact with ACCESS. ACBHD staff reported that the technological and other back-end improvements have been completed and that ACBHD now has a report that track the number of calls, hold times and the time of the call. ABCHD did provide the Independent Reviewer this report.
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 reviewed additional ACCESS client records to verify the sustainability and durability of this requirement.
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. There is evidence that support compliance with this requirement through review of contracts with community based providers, interviews with both ACBHD staff and community provider staff, review of reports, and with review of referrals from ACCESS.
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. Evidence was found in contracts, community based provider procedures, client records, interviews with ACCESS staff, interviews with clients, and the on-site review.
6. 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. ACCESS utilizes their electronic health record to identify when there are no FSP Teams or Services Teams available. The staff reported that they meet on a weekly basis with the Adult and Older Adult System of Care to review the weekly report. The Independent Reviewer was provided a copy of this report. The staff identify the issues and included action items to resolve the issues.
7. *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.* Evidence was found in

policy and procedures, data provided, interviews with community based providers, and interviews with ACBHD staff.
8. 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. The Independent Reviewer interviewed the ACBHD Directors regarding coordination with these entities to rapidly connect individuals to services as appropriate.
9. *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.
10. *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.
11. *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 has been successful. The length of stays at Villa Fairmont has decreased with average for the subacute wings being 57 days and for the more intensive wing, a reduction to 124 days. For comparison the goal from the county contract is 90 days for the subacute wings and 180 days for the more intensive wing.
12. *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 toured an IMD facility and reviewed additional client records.
13. *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*. IMD staff stated that if FSP or Service Team is unavailable, other resources are examined in order

to prevent longer lengths of stay. They also confirmed that this issue is discussed in the weekly meeting with ACBHD.

14. 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.

15. 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.* Evidence was provided through a review client records, interviews with clients and staff, and tour of the facility.

16. 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. 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. Evidence was found through a review client records, interviews with clients and staff, and tour of the facility.

17. *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.* Evidence was through a review client records, interviews with clients and staff, and tour of the facility.

18. 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.

19. 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.

20. 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 was interviewed and reported that the re-entry teams have improved the warm handoff to ACBHD services and that the use of the tablets was working well with connecting individuals to services.

21. 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 Independent Reviewer was provided a copy of the appropriate report and reviewed the meeting minutes with ACBHD leadership regarding this requirement. The summary of the meeting was to conduct monitoring in the ACCESS weekly meeting and in the monthly meetings with the community based providers.
22. 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.

ACBHD achieved Partial Compliance for the following requirements:

*1. 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.* The Independent Reviewer will continue to monitor this requirement for sustainability and durability.
*2. 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.* The Independent Reviewer will continue to monitor this requirement for sustainability and durability.
3. *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.* The Independent Reviewer will continue to monitor this requirement for sustainability and durability.
4. *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.I.iii.* The Independent Reviewer will continue to monitor this requirement for sustainability and durability.

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 Alameda County Behavioral Health Director.

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.*

Information from client records, interviews with clients, interviews with community provider staff, and the Integrated Mental Health and Substance Use Disorder Quality Improvement Work Plan showed ACBHD's ongoing efforts to ensure culturally responsive services.

Alameda has five threshold languages as defined by DHCS Information Notice #20-070. The most prevalent threshold language is Spanish. The other four threshold languages are as follows: Cantonese, Farsi, Mandarin, and Vietnamese.

Previous reports from the Independent Reviewer outlined the strategic directions that are related to culturally responsive services in ACBHD's Strategic Plan dated May 13, 2024. The previous reports also listed important factors from their Cultural Competence Plan (CCP), December 2024 Plan Update which also included workforce capacity and needs. The results from the MHSA Annual Plan Update for Fiscal Year 2024 through 2025 related to culturally responsive services were also included in previous reports. During previous onsite reviews, the Independent Reviewer interviewed clients and staff from community based providers regarding culturally responsive services. The Independent Reviewer previously reviewed contract language for the community based providers, read client charts, and reviewed minutes from ACBHD's Culturally Responsive Committee.

The client records that were previously reviewed for past reports and client records for this report, did contain cultural issues. For example, one client record talked about the cultural differences between the client and the staff providing the services. Other records indicated the need for a Spanish speaking staff, and another discussed the need for a certain age or sex of the staff provider.

Clients interviewed during the on-site review also discussed that cultural issues were addressed by the staff providing the services. One client reported that the staff will get whatever you need, such as a holiday meal to celebrate a holiday. The Integrated

Mental Health and Substance Use Disorder Quality Improvement Work Plan (FY2024-2025) includes the following:

> Enhance health equity for AANHPI [Asian American, Native Hawaiian, and Pacific Islander] communities through increasing access and utilization of behavioral health services and improved health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions.

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 Behavioral Health 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.

Previous reports listed out the number of coalitions/committees with stakeholder participation to provide feedback to the department. The Director, Office of Health Equity, continues to work in collaboration with the stakeholders. The ACBHD website has a page for the Office of Ethnic Services which includes trainings, cultural activities and events for ACBHD staff and for contracted community based provider staff. ACBHD previously provided minutes from the Culturally Responsive Committee. All of the evidence reviewed support compliance with this requirement.

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.*

On January 17, 2025, ACBHD completed the dashboard and uploaded it to the ACBHD's website. ACBHD hosted a stakeholder and community meeting on March 6, 2025, and another on September 30, 2025, to obtain stakeholder feedback. The

Director, Office of Health Equity, reported that there have not been any changes to the dashboard since posting it on their website. The dashboard includes the following data:

- County Region,
- Race/Ethnic,
- Language,
- Age,
- Foster Care Status,
- Sex,
- Gender Identity,
- Clients Served, and
- Service Needs.

The Independent Reviewer listened to two stakeholder meetings and can confirm that the Director, Office of Health Equity repeatedly requested feedback from the stakeholders. The dashboard is posted on ACBHD's website.

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.*

The Director, Office of Health Equity, stated that she meets with the ACBHD Director on a weekly basis. This Director reported that the department does coordinate with the county's other diversity, equity and inclusion program and activities. Example of other county departments that coordinate their programs and activities include the following: Public Health, Social Services and Environmental Health. This Director reported that the County Administrative Office recently hired a Director of Health Equity and has already met with the Behavioral Health Department's Director, Office of Health Equity. The goal is to have all the County's Health Equity Officers meet on a regular basis. All of the evidence reviewed support compliance with this requirement.

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 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. Previous reports outlined the actions from the Board of Supervisors to approve the budget for this project and that the county continues to demonstrate a commitment to this project.

At the November 17, 2025, Behavioral Health Advisory Board, it was announced that ACBHD is hosting a series of community webinars focused on the design and development of the African American Wellness Hub. There will be five sessions beginning November 19, 2025, through February 18, 2026. Updates and insights from the African American Wellness Hub Advisory Committee, (a dedicated group of community members and professionals) will be shared. The sessions will provide recommendations to help shape the Wellness Hub's design and services. The goal continues towards a building that has dedicated space that will offer culturally responsive and whole-person care for African American residents. The Independent Reviewer attended one of the community webinars hosted by ACBHD in February 2025.

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*.

Previous reports outline the training that is offered upon hire and throughout the year. Previous reports also included requirements in the contracts for community based providers, the goals outlined in the CCP, December 2024 Plan Update, the activities to ensure that the training requirements are met and evaluations of the trainings.

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 all six 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. All of the evidence reviewed support compliance with this requirement.
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. All of the evidence reviewed support compliance with this requirement.
3. *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.* ACBHD completed the dashboard, and it was uploaded to their website and announced on January 17, 2025. ACBHD hosted a stakeholder and community meeting on March 6, 2025, and on September 30, 2025, which fulfills this requirement.
4. 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 Director, Health Equity Officer, stated that she meets with the ACBHD Director weekly. This Director reported that the department does coordinate with the county's other diverse, equity and inclusion program and activities.
5. 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 and will be hosting five webinar sessions to provide recommendations to help shape the Wellness Hub's design and services. The goal continues towards a building that has dedicated space that will offer culturally responsive and whole-person care for African American residents.
6. *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*. All of the evidence reviewed support compliance with this requirement.

SUMMARY AND NEXT STEPS

This is the fourth 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 83 percent of the service commitments; a rating of partial compliance was given in 13 percent and a rating of not applicable was given for four percent of the service commitments.

The draft of the fourth report was issued on February 24, 2026. 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 final report is to be submitted 31 months after the effective date of the Settlement Agreement.

Attachment I: Ratings of Service Commitments

SERVICE COMMITMENT	RATING[5]			
1. Crisis Services	**First Report**	**Second Report**	**Third Report**	**Fourth Report**
1.a. The County will continue to offer a countywide crisis system and expand crisis intervention services.	PC	SC	SC	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	PC	SC
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 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.	PC	PC	SC	SC
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	SC	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	NA	SC
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	PC	SC	SC	SC

[5] Due to the temporal limitations of this report, a rating of substantial compliance was not yet possible.

diversion, care coordination, transportation, and post-crisis linkages to services).				
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	SC	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 the need for crisis services in the County, which the County will collect and analyze as part of the Mobile Crisis Assessment process.	NA	SC	SC	SC
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	SC	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	NA	NA
1.a.ii.(7) FSPs will provide crisis intervention as set forth in section II2.m. in this Agreement.	PC	NA	PC	PC
1.a.ii.(8) Each mobile crisis team shall include at least one mental health clinician.	PC	SC	SC	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	SC	SC
1.b.i. Maintain 45 crisis residential treatment (CRT) beds.	PC	SC	SC	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	NA	NA	NA	NA

based providers to add a mixture of 25 additional CRT and/or peer-respite beds.				
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	SC	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	SC	SC
1.b.v. Individuals shall not be required to have identified housing as a condition of admission to a CRT facility.	PC	SC	SC	SC
1.b.vi. CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis.	PC	SC	SC	SC
1.c. The County's crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.	PC	SC	SC	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 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	NA	NA	SC
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	PC	PC	SC
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	NA	NA	PC	SC

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.				
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	NA	SC	SC
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	NA	NA	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	PC	SC	SC
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	SC	SC
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	PC	SC
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	PC	SC
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	SC	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	NA	NA	PC	PC

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.				
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	SC	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) 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	PC	PC	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	PC	SC	SC
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	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	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	PC	SC	SC	SC

Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.				
3.b. The County will explore community needs and opportunities for expanding Service Teams as appropriate.	NA	NA	SC	SC
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	SC	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	SC	SC
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	SC	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	PC	SC
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	PC	PC	SC
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	PC	PC	PC	SC

or Service Team's caseload to commence the provision of services.				
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	SC	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	SC	SC
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	NA	PC
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	NA	NA	SC	SC

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.				
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.	PC	PC	SC	SC
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	SC	SC
4.h. The County will work with law enforcement to direct referrals to the In-Home Outreach Team ("IHOT").	PC	SC	SC	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	NA	PC
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	NA	NA	NA	SC

meetings to assess appropriateness for discharge in light of community based services appropriate to the individual.				
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	PC	SC
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	SC	SC
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	SC	SC
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	NA	NA	PC	SC

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.				
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	PC	NA	PC	SC

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	PC	SC
4.k.v. The County will use programs designed to reach individuals who do not follow up regarding services.	PC	SC	SC	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	SC	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	PC	SC
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	NA	NA	NA	PC

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.				
4.I.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	SC	SC
4.I.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.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.	NA	NA	NA	PC
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	SC	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	SC	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	PC	SC	SC	SC

client-centered care that considers the whole person and all their needs.				
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	SC	SC
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	SC	SC
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.	NA	SC	SC	SC
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	PC	SC	SC	SC

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.				