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 April 1, 2026, through September 30, 2026

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

October 13, 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. On September 16, 2026, the United States withdrew as a party to the Settlement Agreement, including withdraw from further participation in or the enforcement of, the Settlement Agreement. 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, the fourth review occurred twenty-three months after the effective date and the fifth report occurred after thirty-two 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, a tour of an Institution for Mental Diseases (IMD) and interviewing the staff and clients of the IMD. The fifth report is a comprehensive list of all the evidence found regarding the compliance with the Settlement Agreement Service Commitments. The fifth report contains the most recent data from ACBHD.

A draft of this report was due to the parties on August 31, 2026. However, the Independent Reviewer requested a two week extension in order to review and analyze last fiscal year's data from the County. The draft report was submitted to the parties on September 11, 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 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 June 8, 2026, the Independent Reviewer emailed ACBHD a request for documents, and a list of staff and clients to be interviewed. The Independent Reviewer requested to review the client records that were interviewed by the Independent Reviewer during the fifth review. On July 19, 2026, the Independent Reviewer emailed ACBHD a list of data to be reviewed for the fifth report.

During the months of May 2026 through September 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.

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 June 22, 2026, through July10, 2026. On-site reviews in Alameda County occurred on July 1st, 9th and15th. During the on-site review the Independent Reviewer interviewed a total of 14 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 functions.

OVERVIEW OF THE SERVICE DELIVERY SYSTEM

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

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	19	0	0	1	20
2. Full Service Partnership	12	0	0	4	16
3. Service Teams (Intensive Case Management)	4	0	0	0	4
4. Outreach, Engagement, Linkages, and Discharge Planning	26	0	0	0	26
5. Culturally Responsive Services	6	0	0	0	6
Totals	**67**	**0**	**0**	**5**	**72**

Percent of Each Rating for Reporting Period

Ratings	First Report	Second Report	Third Report	Fourth Report	Fifth Report
Substantial Compliance	0*	42%	61%	83%	93%
Partial Compliance	62.5%	22%	25%	13%	0%
Non-Compliance	0	0	0	0	0
Not Applicable	37.5%	36%	14%	4%	7%
Total	**100%**	**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 Acting 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).

ACBHD continues to offer a countywide crisis system. The County continues to contract with providers for crisis intervention services and crisis support services, Crisis Residential Treatment (CRT), and Psychiatric Emergency Services (PES). The crisis services system of care includes the following:

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

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

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

- Crisis Stabilization Units which are provided through a contract with Amber House (Bay Area Community Services/BACS) and John George Psychiatric Emergency Services (PES). There are plans with La Família to open another CSU in Hayward in July 2027.
- Crisis Residential Treatment which includes contracts with Amber House (BACS), Woodroe Place (BACS), and Jay Mahler (Telecare).
- Acute services through John George Psychiatric Hospital and Herrick Hospital.

The chart below indicates the number of crises calls and the location of the call for the following: Fiscal Year 2022-23, Fiscal Year 2023-24, and Fiscal Year 2024-25.

Region	Crisis City	Number of Calls Fiscal Year 2022-23	Number of Calls Fiscal Year 2023-24	Number of Calls Fiscal Year 2025-26
1. North	Alameda	129	150	204
1. North	Albany	24	23	*
1. North	Berkeley	286	260	310
1. North	Emeryville	54	62	95
1. North	Oakland	3,511	4,080	3,902
1. North	Piedmont	17	18	*
2. Central	Castro Valley	104	108	222
2. Central	Hayward	1,083	1,164	987
2. Central	San Leandro	726	769	575
2. Central	San Lorenzo	56	109	38
3. South	Fremont	334	235	307
3. South	Newark	84	76	115
3. South	Union City	153	140	196
4. East	Dublin	75	109	151
4. East	Livermore	130	164	186
4. East	Pleasanton	77	76	72
5. Out of County	Out of County	807	834	755
6. Unknown	Unknown	25	24	*

*Data was redacted due to ACBHD privacy protocols.

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

The Independent Reviewer interviewed the ACCESS Division Director and the Acting Director of the Crisis System of Care for each report. For the fifth report, they confirmed that services required in the Settlement Agreement have continued and are maintained.

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 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. The Independent Reviewer reviewed ACBHD's policy and procedures and reviewed ACBHD's policy titled "Adult/Older Adult Outpatient Level of Care Determination which states the following: "Individuals new to ACBHD services are initially assessed to determine if they meet medical necessity." There is a decision tree that crisis services use when out in the field to determine the appropriate level of care.

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 interviewed both the Acting Director, Crisis Services System of Care and the ACCESS Division Director regarding this requirement for each written report. The Acting 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. The Independent Reviewer reviewed the written procedures for the crisis hotline to provide triage and the identification of full service partnership clients. 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 Acting Division Director for Crisis Services reported that this process has been successful, and that ACBHD is continuing with this procedure.

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 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.*

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

Fiscal Year	Responded Number of Calls
2023-24	38,288
2024-25	48,338
Q1-Q2 2025-26	23,387 (Partial Year)

The CCS Mid-Year Report for 2025-26 reported that the volume of call has increased by 15.5 percent compared to the same time last year. ACBHD provided data graphs from 988 for July 1, 2025, through May 31, 2026, that identified the following top 15 presenting issues:

- Anxiety/stress/worry,
- relationship/family issues,
- suicidal desire,
- loneliness/isolation,
- depression,

- other social issues,
- anger,
- medical/physical illness,
- trauma/PTSD,
- financial problem,
- bereavement/grief,
- psychiatric services/mental health professional,
- jobs/employment, and
- housing.

Data reported from ACBHD stated that for 988 calls, the mean call duration is approximately 11.49 minutes.

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.

Crisis Support Services of Alameda County reported that the last conference was held on September 19, 2025, and over 300 people attended. The conference topics were as follows:

- Suicides in Alameda County: Understanding the data to inform action,
- Panel: best practices in suicide prevention throughout the Bay Area,
- Community violence prevention as suicide prevention,
- Responding to Suicidal Crisis in Youth,
- Panel: Meet your local 988 counselors (moderated by Amanda),
- Climate Grief, Anxiety & Distress,
- Understanding the Fight: 2025 and Trans Youth,
- Panel: Mental health practitioners as activists,
- The Power of Storytelling,
- Panel: Incorporating spirituality into the conversation about suicide,
- Connected and Safe: Preventing Suicide Through Compassionate Conversations, and
- Panel: Culturally Responsive Suicide Prevention in the Native Community.

ACBHD continues to meet monthly with EMS to discuss high utilizers of the services and develop plans to provide the appropriate level of care. ACBHD receives a monthly report of 988 calls along with documentation of planned and provided interventions. ACBHD provided 988 data which included date and time of the call, call duration, any safety risks, reason for the call, and the intervention for the time of July 1, 2025, through May 31, 2026.

The ACBHD Acting 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 at 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).

The Independent Reviewer reviewed ACBHD's policy and procedures and data collected from the ACCESS line. ACBHD did report the demographics on the calls they received which include the following: age, sex, ethnicity, preferred language, and location of the caller. ACBHD also collects the following data: average wait time for the call to be answered, number of abandoned calls, and average time spent on the call. In addition, the Crisis System of Care implemented the cloud-based telephone system, Fire 9, which will allow ACBHD to track the number of calls, hold times, and the time of the call. 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.

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. 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.

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

Evidence reviewed support compliance with this requirement.

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

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

The Independent Reviewer interviewed the ACBHD Acting Division Director for Crisis Services for each report, who reported that ACBHD is strategic in response to calls when the call is received at the main crisis line or from 988. This Acting 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 assessments, 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 reasons, and
- Language or accessibility needs.

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

Evidence reviewed support compliance with this requirement.

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 as follows:

- Mobile Crisis Teams (MCT) that includes two clinicians and law enforcement, if needed. This team is available Monday through Friday, from 8am to 6pm. This team can respond to requests from the general public, 988, and 911. ACBHD has three of these teams.
- Mobile Engagement Teams (MET) that pairs a clinician with a police officer in Oakland and operates from Monday to Thursday, from 8am to 3pm. The Hayward MET operates from Monday to Thursday, from 8am to 4pm. These teams respond to 911/988 generated and Crisis System of Care mental health calls. ACBHD has two of these teams
- Community Assessment and Transport Team (CATT) pairs a clinician with an Emergency Medical Technician. This team focuses on crisis intervention and medical clearance. This service operates 7 days a week, from 7am to 11pm. ACBHD currently has contracted 12 CATT teams.

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 Acting 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 reports that the average response time is 28 minutes for the last six months. The ACBHD Acting 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. For Fiscal Year 2025-26, the overall response time under 60 minutes was 97.2 percent.

[1] 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.

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 chart below shows the number of involuntary holds (5150) for the three fiscal years.

Service	Clients Fiscal Year 2022-23	Clients Fiscal Year 2023-24	Clients Fiscal Year 2025-26
5150 Danger to Others	238	167	184
5150 Danger to Self	255	161	152
Gravely Disabled	241	204	242

This chart indicates that the highest number of 5150's for last fiscal year was gravely disabled followed by danger to others and danger to self. While the number of 5150's increased slightly this past fiscal year from Fiscal Year 2023-24, the number of 5150's continues to be lower than those in Fiscal Year 2022-23.

The ACBHD Acting Division Director for Crisis System of Care provided the following as possible reasons for the increase of 5150s for grave disability:

- Senate Bill 43 pocket guides were distributed to law enforcement agencies throughout the county. Historically, grave disability has been a challenging criterion for law enforcement to interpret, and the updated guidance and training may have improved understanding. This bill expanded the definition of "gravely disabled" to include because of a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder, is, unable to provide for their personal safety or necessary medical care.
- Crisis Intervention Training (CIT) materials were updated to incorporate SB 43 information.
- The California Mental Health Services Authority (CalMHSA) 5150/Law and Ethics Training was updated to include SB 43. This training is required for all designated 5150 designated facilities and certified staff.

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

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).

Evidence reviewed support compliance with this requirement.

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

Evidence was found regarding the purpose of mobile crisis services to reduce interactions with law enforcement, reduce 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 to:

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

The ACBHD Acting 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.

The chart above includes the 5150 data for several fiscal years. The number of 5150's continues to be lower than those in Fiscal Year 2022-23. ACBHD did identify the following as possible reasons for an overall decrease in the number of 5150's:

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

Evidence reviewed support compliance with this requirement.

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 Acting Division Director for the Crisis System of Care for mobile crisis services who discussed the number of mobile crisis teams. 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.

Evidence reviewed support compliance with this requirement.

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 Fiscal Year 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 ACBHD 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).

Evidence reviewed support compliance with this requirement.

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.

Evidence reviewed support compliance with this requirement.

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 Acting Director of Crisis Services System of Care and the Mobile Crisis Supervisor. The Acting Division Director reported that staff have been hired and trained for the expanded teams. In addition, the county added 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.*

The Independent Reviewer undertook the following activities to determine compliance with FSPs providing crisis intervention services:

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

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

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

This requirement is tied to section II2.m of the Settlement Agreement which states the following:

> *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.*

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. Evidence of compliance with this requirement was obtained through interviews with clients, ACBHD staff and community-based provider staff, review of client records, review of ACBHD's FSP policy and procedures, and review of community-based provider contracts scope of work.

The Independent Reviewer interviewed the ACCESS Division Director and the Acting Director of the Crisis System of Care for this report, and they confirmed that services required have continued and are maintained.

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).

For the fifth report, the Independent Reviewer interviewed the ACCESS Division Director and the Acting Director of the Crisis System of Care, reviewed the data from ACCESS, reviewed both the Crisis Support Services Annual Report Fiscal Year 2024-25 and the Crisis Support Services Semi-Annual Report 25-26 as evidence of continual compliance with this requirement.

Evidence reviewed support compliance with this requirement.

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. (ACBHD website)

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. ACBHD reported that they have nine peers on staff.

The Peers Organizing Community Change (POCC) is a program of the ACBHD's Office of Peer Support Services and reported that there are 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. We provide a strong consumer voice in the mental health system and in the community. (POCC website)

The Independent Reviewer interviewed three peer support specialists for the second report, 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.

For third report, 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 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 the provision of 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.

According to the policy and procedure, Peer Support Service Components are as follows:

a. Educational Skill Building Groups: A supportive environment in which clients and their families learn coping mechanisms and problem-solving skills to help

them achieve desired outcomes. Groups promote skill building in the areas of socialization, recovery, self-sufficiency, advocacy, self-advocacy, behavioral health education, developmental milestones, system navigation, stigma reduction, development of natural supports, and maintenance of skills learned in other support services.
b. Engagement: Activities and coaching to encourage and support clients and family members to participate in behavioral health treatment. Family members may be defined broadly, to encompass parents, caregivers and other significant support individuals. Engagement may include supporting clients and family members in transitions between levels of care and supporting family members in developing their own recovery and parenting goals and processes.
c. Therapeutic Activity: A structured, non-clinical activity to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the client's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the client, promotion of self-advocacy, resource navigation and collaboration with clients and family members.

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.

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 reviewed 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 regarding 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 Acting Division Director for Crisis Services reported that the facility is currently under construction and is anticipated to open early in 2027. This Acting Division Director reported that the official name of the facility is to be determined but that the facility 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. Evidence reviewed support compliance with this requirement.

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.*

Over the course of the Settlement Agreement, the Independent Reviewer has toured the following facilities:

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

These tours confirmed that the facilities are not locked.

During the first on-site review, the Independent Reviewer toured Amber House which has the CRT on the bottom floor and crisis residential on the top floor. The Independent Reviewer was able to review client records who had received CRT services, community-based contracts scope of work and the community-based providers Operation Manual. There was evidence found that the goal of CRT facilities is to de-escalate or avoid a crisis and reduce unnecessary hospitalization

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

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

The Independent Reviewer also 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.

For third report, the Independent Reviewer interviewed four clients at Jay Mahler and four clients 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 were and how the staff are not judgmental. One client stated, "It has been amazing to be here, I feel like a normal person and am treated with respect and dignity."

The Independent Reviewer interviewed the ACCESS Division Director and the Acting Director of the Crisis System of Care for this report, and they confirmed that the purpose of CRT facilities and peer-respite homes continues to operate as required.

Evidence reviewed support compliance with this requirement.

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.

Evidence reviewed support compliance with this requirement.

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

The Independent Reviewer reviewed client records of clients who had received CRT services, community-based contracts scope of work and the community-based providers Operation Manual. Both ACBHD staff and community-based provider staff confirmed that housing is not a condition for admission to a CRT.

During the second on-site review the Independent Reviewer toured Woodroe Place and Jay Mahler and interviewed staff. Both ACBHD staff and community-based provider staff confirmed that housing continues not to be a condition for admission to CRT. The Independent Reviewer also 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. The BACS Operation Manual reported the following inclusion criteria for one of their CRT's:

a. Adults must be between the age of 18+, with special permission from licensing for adults over 64.
b. Adults must be part of the BACS system of care.
c. Adults must have a DSM-IV diagnosis and meet medical necessity for crisis residential services.
d. Are currently hospitalized and/or assessed as an individual who would benefit from CRT.
e. Meet Alameda County's "high priority" specifications
f. Be referred from John George, other local hospitals, TAT, AC Service Teams, FSP's
g. Co-occurring participants are accepted.
h. Adults must have full scope Medi-Cal eligibility or be indigent. (Page 19).

Both ACBHD staff and community-based provider staff reported that housing is not a condition for admission to CRT.
Evidence reviewed support compliance with this requirement.

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

Admissions to a CRT may be made directly by MCT as reported by ACBHD staff and community provider staff.

The Independent Reviewer toured Amber House, Woodroe Place, and Jay Mahler and interviewed the staff to confirm this. Evidence was also found in the Operating Manual of the community-based providers. The Independent Reviewer was also provided with client records of clients who had received CRT services. There was evidence to support admissions directly from mobile crisis teams.

Evidence reviewed support compliance with this requirement.

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

Crisis intervention services are offered during business hours, and a contract provider provides coverage overnight, weekends and holidays but they can also contact 911 or CATT for any crisis intervention services.

The Independent Reviewer interviewed ACBHD staff, community-based provider staff, reviewed policy and procedures and community-based Operations Manual, indicating that the crisis services are designed in the manner stated.

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 to make sure that both the individual in crisis and the staff are safe.

For the second review, the Independent Reviewer interviewed ACBHD staff and mobile crisis staff. ACBHD did provide a policy and procedure and a daily checklist for the on-duty clinician for the mobile crisis team. The role of the on-duty clinician is to triage the crisis calls received and determine the most appropriate response from Crisis Services using the Dispatch Tool. ACBHD provided a copy of the Dispatch Screening Tool which includes the following:

- a screen for medical issues,
- a safety assessment,
- screen for under the influence of substance and alcohol,
- reason for the call
- screen for location safety, and
- dispatch decision.

The Dispatch 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 exist 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.

The Independent Reviewer interviewed the ACCESS Division Director and the Acting Director of the Crisis System of Care for this report, and they confirmed that services required have continued and are maintained. Evidence reviewed support compliance with this requirement.

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 19 service commitments, and a rating of not applicable for one service commitment. 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. *FSPs will provide crisis intervention as set forth in section II2.m in this Agreement.* Evidence was found in client records, client interviews and provider staff that FSP staff provide crisis intervention services.
11. *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.
12. *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.

13. *The County will provide crisis residential services. Maintain 45 crisis residential treatment (CRT) beds.* ACBHD has met this requirement and has sustained this requirement.
14. *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 facility is currently under construction and is anticipated to open in early 2027.
15. *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.
16. *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.
17. *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.
18. *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.
19. *The County's crisis system will be designed to prevent unnecessary hospitalization, IMD admissions, law enforcement interactions, and incarceration.* Evidence was found through interviews with ACBHD staff, community-based provider staff, reviewed policy and procedures and community-based Operations Manual.

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)."

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 for this fiscal year 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	**15**		**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.

Evidence reviewed support compliance with this requirement.

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 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.

Evidence reviewed support compliance with this requirement.

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).

Evidence reviewed support compliance with this requirement.

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.

Evidence reviewed support compliance with this requirement.

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 ACBHD FSP clients in Fiscal Year 2022-23
> - 230 ACBHD Service Team clients in Fiscal Year 2022-23
> - 1,181 ACBHD clients not open to FSP or Service Teams in Fiscal Year 2022-23
>
> 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 chart above indicates that 40 of those slots are reserved for children, which includes ages 16 to 18.

The Independent Reviewer interviewed ACBHD's Deputy Director, Plan Administration, who reported that ACBHD plans to retain the current number of FSP slots for this fiscal year 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 number 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. For the second report, the Independent Reviewer reviewed client records of clients receiving FSP services and interviewed four clients currently receiving FSP services in a virtual setting. The clients reported that they are receiving the necessary services to achieve their goals.

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 and another 11 clients for the fifth report. 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 clients 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. One client reported during the fifth review

that they “loved this place” and how this place has helped them. Another client reported how the staff helped them go back to school and another client stated how grateful they are to the program and the staff who have helped them.

Evidence reviewed support compliance with this requirement.

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 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

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

Services Behavioral Health Services Act County Policy Manual (Version 1.5.0, June 2026) 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. (Page 211)

The Independent Reviewer reviewed policy and procedures for FSP and reviewed client records. The Independent Reviewer interviewed a total of 34 clients receiving FSP services to confirm that they receive services consistent with their wishes. Clients spoke about 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 helped 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, and one Clinical Director for the fifth report. The 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 the third, fourth, and fifth reports. 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.

The review of the client records for all of the reports contains the client's goal and the services needed to obtain those goals. These goals were developed with the client and their case manager. There was evidence of a periodic review of these goals. There was evidence in the client records and through the client interviews that the services provided were based on client needs and there was evidence of client's progress in achieving their goals.

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.

Evidence reviewed support compliance with this requirement.

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.

For the initial report, the Independent Reviewer reviewed ACBHD's policies and procedures for FSP and reviewed two client records. Client records indicated that the services were being provided in multiple ways.

For the second report, the Independent Reviewer reviewed client records for clients receiving FSP services. Client records indicated that a variety of services were provided in several settings and were based on client preference. The Independent Reviewer also interviewed four clients receiving FSP services in a virtual setting. The clients reported that their FSP staff did work with them on setting their goals per the client's preference. Clients also verified that services are flexible and provided at the frequency and location of their choosing.

For the third report, the Independent Reviewer interviewed eight FSP clients face-to face, interviewed three community-based provider staff, and reviewed additional client records. Clients reported that services were based on their needs. They reported having therapy and meeting with their case manager. Clients reported that services provided are flexible and are provided where and when they are needed. One client stated, "If this program wasn't here, people would be in a bad place". Clients were also very pleased with the staff and talked about how they were treated with respect. One client stated, "They care, and they make you feel like somebody".

For the fourth 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:

- "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".

For the fifth report, the Independent Reviewer interviewed another 11 clients currently receiving FSP services and their client records. Clients continue to report that services were based on their needs. Clients reported that services provided are flexible and are

provided where and when they are needed. The Independent Reviewer also reviewed the client files for the clients that were interviewed. There was consistency with what the clients reported and what was found in the client record. Progress towards the clients' goals was evident in the client's record.

One client reported starting work soon and another talked about going to school. Other clients reported the following during the interviews:

- I like this program; I like how they help me.
- The staff are good and the support is good.
- I am blessed to be in this program.
- They are good people and helped me get a dentist appointment and are helping me with getting glasses.

ACBHD provided the following information for the past fiscal year regarding the level of intensity based on the needs of the client, the frequency of service contacts and duration of each service contact.

Fiscal Year	Clients	Hours Received	Visits	Average Hours Per Visit	Average Visits Per Month
2025-26	1,448	95,937.5	87,235	1.1	7.3

Data reported in the FSP Performance Metric Progress Report for the past two fiscal years reported the following:

Fiscal Year	Number of Clients	Average of 4+ Visits per Month per Client	Success Rate
2024-25	988	624	63%
2025-26	1,014	791	78%

The chart below indicates the locations where FSP services were provided for several fiscal years.

Treatment Location	# Clients Fiscal Year 2022-23	# Clients Fiscal Year 2023-24	# Clients Fiscal Year 2024-25	# Clients Fiscal Year 2025-26
Field	1,072	1,078	1,164	1,266
Office	1,128	1,067	1,057	1,194
Telephone	1,073	762	571	1,209
Client's Home	815	672	668	574
Telehealth	549	587	425	424

Treatment Location	# Clients Fiscal Year 2022-23	# Clients Fiscal Year 2023-24	# Clients Fiscal Year 2024-25	# Clients Fiscal Year 2025-26
Other Community Location	225	333	379	345
Group/Boad and Care	*	302	394	454
Inpatient - Psychiatric	286	282	69	324
Satellite Office	**	214	250	283
Health/Primary Care	145	128	182	161
Psychiatric Residential	133	124	119	128
Inpatient (non-psychiatric)	*	77	69	65
School	53	67	53	67
Community Mental Health	*	66	83	52
Skilled Nursing Facility	*	63	51	54
Unknown Location	*	48	37	131
Prison/Correctional Facility	52	45	74	88
Homeless/ER Shelter	32	41	48	47
Temp Lodging (hotel, camp)	*	38	74	69
Emergency Room	*	36	24	35
SUD Residential	*	34	53	67
Public Health Clinic	*	24	*	*
FQHC	*	17	31	38

* Data was redacted due to ACBHD privacy protocols ** Not reported

This chart indicates that the majority of services continue to be provided in the field, at the office, and over the telephone. There was a slight increase in the number of field based services, and the number of office and home visits for the past fiscal year.

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. For the fifth report, the Adult and Oler Adult System of Care Director reported that these meetings are continuing and that they continue to work closely with the contracted providers.

Evidence reviewed support compliance with this requirement.

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

The Independent Reviewer reviewed ACBHD's policy and procedures for FSP services. ACBHD contract language included specific requirements for community-based providers providing FSP services which are as follows:

A. Program Goals – Contractor shall provide services to accomplish the following goals:

i. Improve the ability of clients to achieve and maintain an optimal level of functioning and recovery;
ii. Improve the ability of clients to secure and maintain stable permanent housing needs and preferences;
iii. Reduce criminal justice involvement and recidivism;
iv. Reduce client hospitalizations and utilization of emergency health care services for mental health and physical health issues;
v. Ensure that clients obtain and maintain enrollment in health insurance and other public benefits programs for which they are eligible;
vi. Connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers;
vii. Increase educational and/or vocational attainment among clients;
viii. Help clients to increase their monthly income and financial assets;
ix. Increase client participation in meaningful activities;
x. Decrease social isolation among clients; and
xi. Assist and empower clients to transition into the least intensive level of service appropriate to meet their needs.

Performance Improvement Activities Contractor shall provide performance improvement activities to accomplish the following goals:

i. Improve client access to care;
ii. Increase quality;
iii. Improve outcomes;
iv. Ensure program accountability; and
v. Increase program efficiencies.

For initial report, the Independent Reviewer reviewed two client records and interviewed community-based provider staff. All indicated that services are designed to reduce hospitalization, utilization of emergency health care services, reduce criminal justice involvement, and improve individuals' ability to secure and maintain stable permanent housing.

During the second review, the Independent Reviewer reviewed client records, interviewed four clients in a group virtual setting currently receiving FSP services, and interviewed community-based provider staff. The clients reported that they have had help with finding stable housing, working through a crisis without hospitalization or emergency health care and reducing criminal justice involvement.

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. Clients continue to report 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. One client talked about starting college in the fall which is happening due to services they are receiving. The clients talked about their current housing or working on obtaining housing and wanting to stay with FSP services or transition to a lower level of care.

The Independent Reviewer interviewed 11 clients currently receiving FSP services and reviewed twenty client records for the fourth review. Clients continue to report 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. 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.

For the fifth report, the Independent Reviewer interviewed another 11 clients currently receiving FSP services and reviewed their client records. Clients continue to report 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 the services provided helped them with their employment, housing, transportation, medical and dental appointments, and medication. One client reported that they felt blessed to be in the program. Another client reported that they were homeless prior to being in the program and that the program obtained housing for them. Another client reported that they probably would have ended up in jail if it was not for the program and the services provided.

Clients continue to report how grateful they are 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.

ACBHD provided an internal report on FSP performance metrics for Fiscal Year 2024-25. The number of clients with a primary care visit was 686 or 80 percent of the total number of clients. The FSP Performance Metric Progress Report for Fiscal Year 2025 - 26 indicated that the number of clients with a primary care visit was 643 or 78 percent of the total number of clients.

The chart below is ACBHD outcomes for FSP clients related to housing at discharge during Fiscal Year 2025-26. A discussion regarding the outcomes of housing can be found later in this section.

Housing Program Types	Fiscal Year 2025-26	Min Days to Housing	Max Days to Housing
Coordinated Entry	14	6	317
PH – Supportive Housing	6	133	317
PH – Rapid Re-Housing	3	60	252
Transitional Housing	4	6	271

ACBHD reported the following data regarding the reduction in psychiatric hospitalization, utilization of emergency health care services, and reduction in incarceration.

Discharge Years	Discharge	Percent Change Inpatient	Percent Change Emergency Department Days	Percent Change in Incarceration
Fiscal Year 2022-23	523	-237%	-48%	-36%
Fiscal Year 2024-25	587	-136 %	-22%	-40%
Fiscal Year 2025-26	719	-54%	-63%	-52%

Although section II2.k focuses on the design of FSP services, the Independent Reviewer notes that the favorable outcomes for inpatient, emergency department and incarceration tracked in these reports reinforce that these programs are appropriately designed consistent with the objectives of this provision

Evidence reviewed support compliance with this requirement.

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.*

Under the Behavioral Health Services Act (BHSA), county contracted 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 assessed ACBHD's FSP ACT programs, while ACBHD's FSP ICM programs are evaluated under the requirements in section II.3 of the Settlement Agreement.

The Settlement Agreement acknowledges that FSP programs are "implemented using high fidelity to" ACT, but 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 (which is evidenced by the latest County assessments conducted in 2025, as discussed below).

ACBHD was an early adopter of ACT principles and one of two counties utilizing the Dartmouth Assertive Community Treatment Scale (DACTS). Furthermore, ACBHD works closely with its FSP providers through mechanisms like regular meetings to provide feedback and to ensure high quality services are continually provided, particularly to clients with very high needs. By way of additional background on ACT, the Department of Health Care Services Behavioral Health Services Act County Policy Manual (Version 1.5.0, June 2026) states the following:

> ACT is an evidence-based practice to support individuals living with complex and hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT is one of the most established and widely researched evidence-based practices in behavioral health care for individuals living with significant mental illness. (Page 158)

The Executive Summary of ACBHD's Integrated Plan 2026 – 2029 states the following on their website:

> BHSA requires that county's implement FSP programs to fidelity, the term fidelity means that services must show evidence that they are helping the individual improve. Alameda County has partnered with the Center of Excellence, an outside organization, to ensure that the ACT/FACT, HFW [High Fidelity Wrap], IPS, programs have a path to ensure fidelity and offer stepdown in levels of care.

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

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

For the fourth 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." This contract also requires the community-based provider to achieve a minimum fidelity score of 80%, evidencing high fidelity to the ACT model. The County continues to require this minimum fidelity score and continues to work with FSP providers to achieve it.

ACBHD staff and community-based provider staff reported that the FSP program design in Alameda County is based on the ACT model. Community-based providers staff reported that ACBHD conducts a fidelity assessment of the ACT model annually. The fidelity assessments 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.

The ACT Fidelity Assessment tool describes the meaning of the ratings as follows:

- 4.4 to 5.0 – Exemplary fidelity
- 4.0 to 4.3 – High fidelity
- 3.7 to 3.9 – Moderately high fidelity
- 3.4 to 3.6 – Moderate fidelity
- 2.7 to 3.3 – Low fidelity
- Below 2.7 - Not ACT

The ACT Fidelity Assessment tool further states:

> Studies have shown that ACT teams that achieve High to Exemplary Fidelity will experience significant improvements in areas such as:
>
> - Housing stability,
> - Reductions in hospitalizations & crisis,
> - Employment outcomes, and
> - Quality of life
>
> Our goal is to move teams to score 4.0 or higher over time.

For the second report the Independent Reviewer was able to review the 2024 fidelity review assessment from nine programs providing FSP services. The programs were assigned an overall total fidelity score, and those scores translated to a description of fidelity. The results of the community-based providers are as follows:

- Two providers scored high fidelity,
- Six providers scored moderately high fidelity, and
- One provider scored moderate fidelity.

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.

For the fourth 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 but does require 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. Regarding the provision of services by a multidisciplinary team, 4 adult community-based providers scored 5 and two providers scored a 4 or this requirement. Regarding the staff to client ratio, all six of the adult community-based organizations scored a 5 on this requirement.

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 was 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 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.

For the fifth report, the Adult and Older Adult System of Care Director reported that ACBHD will not be conducting the 2026 fidelity assessments. The ACT teams are currently transitioning to the Tool for Measurement of Assertive Community Treatment (TMACT) model. This transition is supported by the UCLA Performance Management and Health Policy (PMHP). UCLA will conduct the annual fidelity reviews, with the initial baseline assessment anticipated in November 2026 or later. ACBHD also met with its FSP providers regarding the transition, and the FSP providers are now meeting with UCLA and completing its training process.

As noted above, the Independent Reviewer was able to confirm that ACBHD contracts with community-based FSP providers continue to require the implementation of FSP programs using high fidelity to the ACT evidence-based practice. This also satisfies the two specific requirements in the Settlement Agreement that (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. The fidelity assessments 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.

Although the County providers satisfied the two sub requirements named in the Settlement Agreement (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), none achieved am overall score of 4 or higher on the fidelity assessment.

However, due to the transition to the TMACT model and the fact that UCLA will now conduct the fidelity assessments later this year, the Independent Reviewer does not

have the necessary information to fully evaluate this requirement for sustainability and durability. The Independent Reviewer defers to the results of the TMACT assessments to determine whether FSP providers are currently achieving high fidelity to ACT.

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 are 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 the fourth 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 reported that there was one Adult FSP community-based provider that needed improvement with responding to crises after hours.

For the fifth report, the Independent Reviewer interviewed another 11 clients currently receiving FSP services and reviewed their client records. Clients reported that staff are available to them when they are experiencing a crisis and that they know who to contact if a crisis occurs. ACBHD provided an internal report on FSP Performance Metrics for Fiscal Year 2025-26, reported a 73 percent reduction in psychiatric emergency, inpatient, and crisis stabilization days.

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 Acting Director of Crisis Services reported that prompt notification continues to be made when an FSP client receives crisis intervention services.

Evidence was found in the client records and with the client interviews that the FSP staff 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. ACBHD did expand their notification system when an FSP client receives crisis intervention from another ACBHD contracted provider, such as mobile crisis teams, or other crisis programs.

Evidence reviewed support compliance with this requirement.

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. For the initial review, 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.

For the third report, ACBHD provided three IPS Supported Employment Fidelity reports for 2024. These reports can result in a rating of Exemplary Fidelity, Good Fidelity, Fair Fidelity, and Not Supported Employment depending upon the total points received for the requirements. with a maximum of five points per requirement. ACBHD also provided two IPS Quality Improvement Reports for two community-based providers. These reports are not fidelity reports but can be used between fidelity reviews when annual reviews are not possible. The intent of these quality improvement reviews is 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 the fourth 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 reports on how staff were 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.

For the fifth report, the Independent Reviewer interviewed another 11 clients currently receiving FSP services and reviewed their client records. Client reported receiving assistance with finding employment and evidence of this was found in their client records.

For the fifth report, ACBHD provided four IPS Supported Employment Fidelity reports for 2026. All four providers scored in the fair fidelity range meaning that none of the providers achieved good or exemplary fidelity. ACBHD did provide the Independent Provider with an IPS action plan in order to improve the IPS fidelity.

ACBHD contracts with community-based providers to deliver IPS services based on the client's individualized interests, skills, and needs. The requirement for IPS in the Settlement Agreement requires that IPS services be provided based on client choice. Evidence of this requirement was found in the client records and as reported by the clients. 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 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.

Evidence reviewed support compliance with this requirement in providing or arranging for appropriate Individual Placement and Support (IPS) supported employment services for FSP clients based on their choice, and on engaging a person in competitive employment based on their individualized interests, skills, and needs.

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.

For the second report this Independent Reviewer interviewed two staff from CES, the CES Manager and the Housing and Homelessness Services 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 Housing and Homelessness Services,
- Deputy Director of Alameda County Health Housing and Homelessness Services, and
- CES Manager.

The Housing and Homelessness Services CES Manager reported that there are 12 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 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 needs 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.

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.

For the fifth report, the Independent Reviewer interviewed 11 FSP clients, reviewed their records, and interviewed FSP Supervisors. All of the 11 FSP clients interviewed had housing either living with family, independently, or at a Board and Care. There was evidence in the client record of housing needs and the work with CES to obtain housing out in the client's community. Their client records were consistent with what the client reported.

The community-based provider FSP contracts 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, this contracts states 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. An example of this is that BACS and Telecare had over $1,168,000 and $992,000 in housing expenditures with flex funds for Fiscal Year 2025-26. FSP programs are also required to have a housing specialist 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 community-based 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.

Section ll2.o i's requirements pertain 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. There is evidence that FSP clients receive a housing assessment and the support needed to maintain the housing as needed. There is also evidence from interviews with the clients and with the providers that there is temporary housing within the county.

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

The MHSA Annual Plan Update (Draft) for Fiscal Year 2024/25 states that CES began in 2017, underwent significant changes that started in Fiscal Year 2022 and was fully implemented in Fiscal Year 2023. In discussing the broader context of housing challenges, the Housing Solution for Health Program (Alameda County Health Care Services Agency Office of Homeless Care and Coordination (OHCC)) Housing Services Office (HSO) and multiple subcontractors) stated in the report:

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

The Alameda County Coordinated Entry Policies list the following information regarding the assessment to determine priority:

> The Crisis Assessment incorporates information from the participant profile and the Coordinated Entry enrollment, as well as additional questions for determining relative priority. Questions associated with the following factors are used to establish a Crisis Assessment score.
>
> • Prior Living Situation and length of time homeless–longer durations and multiple episodes of homelessness, including chronic homelessness, are assigned more points.
>
> • Household Information – larger households, households with younger children, and heads of household under age 25 or over 55 are assigned more points than other households.
>
> • Combined household income –households with little or no income are assigned more points than higher income households.
>
> • Health – households in which one or more members of the household has a disability (including HIV/AIDS) or health condition are assigned more points than other households.

CES provided the following information regarding client preferences for housing:

- Interest in short-term and/or long-term resources,

- Unit size/type (such as studio, shared, etc.),
- Geographic location, and
- People can and do opt out of matches for a range of reasons.

After completion of the assessment and obtaining client preferences, CES will match the client and make a referral. According to the Alameda County Health, Housing and Homeless Unit, Coordinated Entry Policies regarding matching and referral:

> Matching and Referral are the steps used by Coordinated Entry to identify open and available resources for participant households on the Crisis or Housing Queues that fit their eligibility and expressed preferences.
>
> - Regional Matching is the process of matching participant households to available or anticipated resources based on the region in which they have sought services. Regional matching is used for Crisis resources and for most Rapid Rehousing and is conducted by Alameda County Coordinated Entry. Some Rapid Rehousing programs may be matched to by Alameda County Health's Housing and Homelessness(H&H) staff.
>
> - County-wide matching is the process of matching participant households to available or anticipated resources anywhere in the County based on their eligibility and preferences. County-wide matching is primarily used for non-time limited permanent housing resources such as Permanent Supportive Housing and Dedicated Affordable Housing and is conducted by the Management Entity. (Pages 20-21).

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. Thus, in practice, individuals who qualify for FSP are nonetheless given priority, due to their diagnosis, housing status, income, or history, as opposed to by nature of being an FSP client. This is consistent with this requirement that "individuals with serious mental illness…receive priority."

As described above, the policy and procedures for CES were provided and it states the following:

> The Coordinated Entry process uses specific Assessments to obtain information about both the immediate and long-term needs of persons and households seeking services. Portions of these assessments are weighted and assigned points leading to a score which is used, along with eligibility information, for placing participants on queues for referral to crisis and housing resources.

> Because of the lack of sufficient resources, prioritization in the Alameda County system is based on a range of factors to determine who among the population experiencing homelessness has the greatest number or level of critical needs and/or lesser likelihood of being able to become rehoused without assistance. Factors that are considered include age and size of household, current and past housing situations, length of time homeless, disabilities and health conditions, barriers to rehousing such as past housing loss and criminal legal interactions, and risk of or vulnerability to exploitation and violence. Factors used for crisis prioritization are a subset of those used for housing prioritization. (Page 11)

The Housing and Homeless Service staff also provided information on No Place Like Home program that represents over 500 permanent supportive housing units for those suffering from a severe mental illness or substance use disorder and are experiencing homelessness.

There is a Memorandum of Understanding (MOU) between Alameda County Health Housing and Homelessness and the No Place Like Home Developer that outlines principals for marketing, application, selection process and supportive services. Some of these principles are as follows:

- Tenant screening and selection practices that promote accepting applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services;
- Applicants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions unrelated to tenancy, or behaviors that indicate a lack of “housing readiness”; and
- Using Alameda County’s coordinated assessment and entry system that prioritizes eligible tenants based on criteria other than “first-come-first serve”, including, but not limited to, the duration or chronicity of homelessness vulnerability to early mortality, or high utilization of crisis services.

The staff from Housing and Homeless Services Unit of Alameda County Health reported that Alameda County does have the housing resources outlined above.

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 reported during the initial review, 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 department).

The ACBHD community-based providers 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.

For the third report, 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.

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. As noted above, BACS and Telecare, for example, had over $1,168,000 and $992,000 in housing expenditures with flex funds for Fiscal Year 2025-26.

For the fifth report, the Independent Reviewer interviewed the Housing and Homelessness Services CES Manager, interviewed FSP clients, reviewed their records and interviewed FSP Supervisors. The CES Manager reported that the housing assessments are kept in the Homeless Management Information System. This CES Manager reported that they continue to meet monthly with ACBHD and that they work in close coordination. This Manager also provided a report from Alameda County titled “Homeless Prevention Framework: A Companion to the Home Together Community Plan” as the county’s overall plan for addressing homelessness. This Manager also provided information on the Home Together Plan 2030. The county established a Home Together 2030 Task Force to gather technical consultants, stakeholders, people with lived experience, city and county representatives and housing providers to develop this plan.

ACBHD provided the report on FSP Performance Metrics for Fiscal Year 2024-25 and for Fiscal Year 2025-26. The housing data reported is as follows:

Fiscal Year 2024-25

Housing Status	At Intake	Percent At Intake	At Latest Assessment	Percent At Latest Assessment	Net Change
Community Living	482	20%	376	16%	-106
Homeless	246	10%	186	8%	-60
Institutional Setting	213	9%	367	15%	154
Other/Unknown	1,435	60%	1,447	61%	12
Totals	**2,376**		**2,376**		

Fiscal Year 2025-26

Housing Status	At Intake	Percent At Intake	At Latest Assessment	Percent At Latest Assessment	Net Change
Community Living	482	18%	375	14%	-107
Homeless	249	9%	189	7%	-60
Institutional Setting	213	8%	367	14%	154
Other/Unknown	1,710	64%	1,723	65%	13
Totals	**2,654**		**2,654**		

The FSP Performance Metrics for Fiscal Year 2025-2026 provides more detailed information regarding FSP Outcomes - Housing Setting (Data Source: PAF/KET).

Residential Setting	At Intake	At Latest Assessment	Net Change
Community Living:			
Apartment/House	89	94	5
With Family (non-foster care)	29	20	-9
Single Room Occupancy	30	19	-11
With adult family other than parents	20	8	-12
With biological parent(s)	76	61	-15
Unlicensed/supervised congregate	99	78	-21
Licensed Board and Care	87	65	-22
Unlicensed/supervised individual placement	48	24	-24
Homeless:			
Emergency Shelter/Temporary Housing	76	61	-15
Homeless	173	128	-45
Institutional Setting:			
Jail	38	98	60
Acute psychiatric hospital	61	104	43

Residential Setting	At Intake	At Latest Assessment	Net Change
Long-term Institutional (IMD, MHRC)	35	44	9
Licensed Residential Treatment	63	44	-19
Other/Unknown:	1,684	1,695	11
Unknown			

* Data and categories were removed due to ACBHD privacy protocols.

This chart indicates that there was a decrease in the number of homeless FSP clients, a decrease in community living, an increase in institutional settings, and significant increases in FSP clients in jail, acute psychiatric, and skilled nursing facilities. Both charts indicate a large number of clients in the "Other/Unknown" category which provides a challenge with fully evaluate this requirement.

ACBHD's BHSA Integrated Plan 2026-2029 (Approved) stated the following:

> Alameda County will expand interim housing units that offer
>
> intensive on site behavioral health services and invest in supporting housing models like the FSP Homeless Engagement Action Team (HEAT) and Services for Transitional Age Youth (STAY) programs, which serve high need populations including transitional age youth, veterans and older adults. Residential treatment and detox facilities will be expanded to support those experiencing acute behavioral health crises. Housing interventions through MCP transitional rent, BHSA Housing Interventions, Behavioral Health Continuum Infrastructure Program, Opioid Settlement and Measure W (local Alameda County funding) will fund housing and services for those who are homeless or at risk and struggling with SMI or SUD. (Page 34)

There was evidence in the client interviews, client records, provider staff interviews, and contract with FSP providers, that FSP clients were promptly provided temporary housing until permanent housing is secured. The Settlement Agreement does not require the county to secure a particular number of housing placements. However, ACBHD data shows that only 3 clients received Rapid Re-Housing and only 4 received Transitional Housing in 2025-26. (Per chart on page 43). In addition, the FSP Performance Metrics for Fiscal Year 2024-25 and for Fiscal Year 2025-26 show decreases in community living placements and increases in institutional settings for FSP clients. Data also indicates that FSPs do not know or do not report where 65% of their clients live. This provides a challenge to being able to fully evaluate this requirement.

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 preference*.

The Independent Reviewer heard in numerous interviews with ACBHD staff and community-based provider staff that permanent housing is a challenging issue in Alameda County. There are a number of examples that highlight this issue, which are as follows:

- MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, states a reoccurring theme in the community listening session was "address basic needs such as insecure housing" (Page 65). The report also states that housing and homelessness ranks as the number one concern for adults and older adults (Page 87).
- During the community input period for this MHSA Three Year Program and Expenditure Plan Fiscal Year 2023 through 2026, community members were asked to complete a 21-question survey. The following barriers to accessing mental health services from the survey were identified:
    1. Resources, ranging from basic needs such as food and housing to behavioral and mental healthcare treatment, are in short supply.
    2. If these resources are somehow available, then accessing them can be an arduous and difficult process.
    3. Their responses speak to an overloaded, unfriendly system that does not currently meet their needs;
    4. They also speak to a desire for a more friendly, efficient, and transparent method to access care.
- Great Hope FSP (Adobe Services) reported the barriers to services:
    - Difficulty in securing units under the changing Fair Market Rates (FMR). There was a decline in available and viable units within Alameda County. Landlords' unwillingness to work with subsidized housing was also a challenge, discriminatory language or behaviors with landlords towards subsidized housing recipients was a contributing factor" (Page 132).
- In addition, the loss of Board and Care homes in the County and the subsequent loss of those beds, has also had an impact on the housing situation.
- Community-based providers also reported on the difficulty in finding permanent housing for their clients. One example provided was there is an affordable housing list but it has a minimum salary requirements which their clients cannot meet and thus do not have access to that housing.

ACBHD's BHSA Integrated Plan 2026-2029 (Approved) stated the following:

> Alameda County's 2024 Point in Time (PIT) Count rate for people experiencing
>
> homelessness was 58.3 per 10,000 which is higher than the statewide rate of 48. Disparities are evident across multiple demographic and clinical subpopulations. Most individuals experiencing homelessness are between ages 25-64. Alameda County's PIT rate for Severe Mental Illness was 12.6 per 10,000 which is above the statewide rate of 11.5. There were 2,040 individuals with SMI, 88%, and were in emergency/unsheltered settings. (Page 33)

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 to maintain the housing placement.

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)

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, inclusive of FSP clients as a priority due to having serious mental illness, per their assessment, in the least restrictive and most integrated setting based on client's preferences. 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 that staff work with them to secure housing, notwithstanding the inherent challenges in locating permanent housing in Alameda County. Although FSP clients reported that securing permanent takes a long time, this Settlement Agreement requirement pertains to whether permanent housing, when provided, is done in the least restrictive and most integrated setting that is appropriate to meet individuals' needs and preferences. There is no timing requirement regarding the provision of permanent housing.

ACBHD's BHSA Integrated Plan 2026-2029 (Approved) stated the following:

> Alameda County will also utilize funds from local tax Measure W to fund supportive housing programs such as prevention, shelter, housing, access & coordination, and one time capital projects. ACBHD used funds from the Behavioral Health Continuum Infrastructure Program (BHCIP) to fund partners to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. BHCIP facilities in development: Adult Crisis Residential and Stabilization, Sobering and Detox Residential, Felony IST Diversion, Mental Health Rehabilitation, Medical/Psychiatric Hospital Units, and Medical Detox. (Page 202)
>
> Alameda County Behavioral Health Department (ACBHD) and Alameda County

> Housing and Homelessness Services (H&H), both within the Alameda County Health Agency, are in coordination and planning of implementation of a Flexible Housing Subsidy Pool (Flex Pool) to expand scattered-site permanent housing resources for clients experiencing homelessness. The Flex Pool will leverage multiple funding sources including BHSA for the expansion of landlord engagement, dedicated units, provision of rental subsidies, and linkages to supportive services. Additionally, the Flex Pool will embed Transitional Rent as a bridge to a longer term housing resource. (Page 203)

Implementation of the new Flexible Housing Subsidy Pool (Flex Pool) has added an additional 120 units of housing (representing 139 total household members) since its start in October 2025. This is scattered site for permanent supportive housing, of which 72 households are expressly behavioral health identified and connected to housing. The advent of the Flexible Housing Subsidy Pool has resulted in a reduction to an average of 45 days from referral to securing permanent housing.

Overall, Alameda County has significantly expanded its permanent housing inventory over the course of the Settlement Agreement. The most recent available data shows that the full range of permanent housing inventory throughout the County totals 8,786 units, an increase of 3,094 units from the fiscal year preceding the Settlement Agreement Effective Date (Fiscal Year 2021-22). The permanent supportive housing inventory has increased by nearly 60% over these years, with over 1,000 units added to permanent supportive housing inventory between Fiscal Year 2023-24 and Fiscal Year 2024-25 alone. Additionally, nearly 1,500 units of permanent supportive housing and dedicated affordable housing units are anticipated to be added to the homelessness response system by Fiscal Year 2027-28. In Fiscal Year 2025-26, the Board of Supervisors approved Measure W allocations for permanent housing construction and operating reserves for six projects, located throughout the County, that will bring on 950 affordable homes, including 310 units for households experiencing homelessness.

The County does have a number of coordinated housing resource centers located throughout the county. ACBHD provided documentation of housing training from the Alameda County Office of Homeless Care and Coordination.

However, FSP clients reported that securing permanent takes a long time. In addition, ACBHD data reported indicated a decrease in community living placements and increases in institutional settings for FSP clients. Data also indicates that FSPs do not know or do not report where 65% of their clients live**.** While data from ACBHD does indicate an increase in housing, it is difficult to determine the number of FSP clients who have obtained permanent housing and the number of FSP client who require a permanent housing solution.

Summary of Full Service Partnership Findings

Overall, there are sixteen service commitments in the Full Service Partnership section. There were 12 service commitments that received a rating of substantial compliance,

and four requirements 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.* ACBHD has 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.
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.

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 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. *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. Evidence was found in the client records and with the client interviews that the FSP staff provide crisis intervention 24/7 and ACBHD did expand their notification system when an FSP client receives crisis intervention from another provider.
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. 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.
12. *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 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.
2. 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.
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.
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.

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 Fiscal Year 2025-26
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**

For the fifth report, ACBHD reported that 2,073 clients were served with an average of 2.77 contacts per month for the Fiscal Year 2025-26.

Evidence reviewed support compliance with this requirement.

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.

For the fifth report, ACBHD provided the current tracking log (dated 6/16/2026) 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.

Evidence reviewed support compliance with this requirement.

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 for the second report interviewed four service team clients in a virtual group setting. The clients reported that they are receiving services that are flexible and that assist with their autonomy. They listed several services that were provided that included mental health services, plan development, case management, crisis intervention and medication support. They reported that they did not have to wait for services to begin. They reported that they receive help with their housing, food and clothing. They also received help with their medication and with staying on their

medication. The staff will call to remind the client of a scheduled appointment and will provide transportation to the appointment. The staff also help clients with finding a job and will help the clients with writing their resumes. If the client has a crisis after regular business hours, the staff are available to provide crisis intervention services. They reported that the staff will also come to their house to check on them. One client stated that the Service Teams are “my lifeline”. 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 of the clients had very positive things to say about the services they were receiving.

For the fifth report, the Independent Reviewer interviewed three service team clients at the Oakland Community Support Center. The clients reported on the support they had received from the staff and how the staff have helped them reach their goals. The clients stated that the staff can help calm you down when having a bad day. The clients stated that the staff really care and you can contact the staff anytime. Clients reported receiving therapy and case management services. The clients stated that they had received help with housing, food, clothing, finding and maintaining employment, obtaining SSI, and transportation. One client stated that the staff are always there to help. The Independent Reviewer reviewed the client records for the clients that were interviewed for the fifth report. There was consistency with what the clients reported and what was found in the client records.

The chart below are the top treatment locations for Fiscal Year 2023-24, Fiscal Year 2024-25, and Fiscal Year 2025-26.

Treatment Locations	Number of Clients Fiscal Year 2023-24	Number of Clients Fiscal Year 2024-25	Number of Clients Fiscal Year 2025-26
Office	1,567	1,670	1,835
Telephone	1,220	1,289	1,310
Field	1,039	1,119	1,065
Patient’s Home	623	694	754
Telehealth	587	511	457
Location Unknown/Other	114	105	152
Other Community Location	171	137	197
Group/Board and Care Home	152	241	250
Health/Primary Care	132	161	188
Satellite Office	138	225	259
Skilled Nursing Facility	50	75	70
Community Mental Health Center	61	114	76
Psychiatric Inpatient	56	64	66
Inpatient (Non-Psychiatric)	36	54	43
Homeless/ER Shelter	21	28	26

Treatment Locations	Number of Clients Fiscal Year 2023-24	Number of Clients Fiscal Year 2024-25	Number of Clients Fiscal Year 2025-26
Psychiatric Residential Treatment	27	13	31
Court	17	12	35
Public Health Clinic	14	19	35
Emergency Room Hospital	*	17	16

* Data was redacted due to ACBHD privacy protocols

Data for the services provided by ACBHD indicated that for Fiscal Year 2025-26 and Fiscal Year 2023/24, the frequency of contacts was 2.77 per month. In comparison to the Fiscal Year 2022-23, the frequency of contacts was just slightly higher with 2.9 contacts per month. Evidence was found in the contracts with community-based providers, policy and procedures, review of client records, and interviews with community-based provider staff and supervisors that a variety of services are provided to assist the client in attaining autonomy, and the services are provided in appropriate locations. A review of the contracts with community-based providers listed out the following services to be provided under Service Teams: mental health services, case management/brokerage, crisis intervention, and medication support. The contracts with community-based providers require that the services are as follows: “Assist clients in attaining a level of autonomy within the community of their choosing”.

ACBHD provided the following outcomes data for service teams clients in the chart below for several fiscal years.

Discharge Years	Discharge	Percent Change Incarceration	Percent Change Hospital Days	Percent Change in ED Days
Fiscal Year 2020-21 and Fiscal Year 2021-22	916	-74%	-84%	-13%
Fiscal Year 2022-23	340	1%	-223%	22%
Fiscal Year 2023-24	*	-42%	-162%	-8%
Fiscal Year 2024-25	671	-15%	-114%	14%
Fiscal Year 2025-26	807	-38%	-36%	10%

*Data was not reported.

ACBHD also provided outcomes data for these clients who completed six consecutive months during the 12-month fiscal year. For Fiscal Year 2025-26, there was a 71 percent reduction in psychiatric hospital or crisis stabilization unit when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. For Fiscal Year 2024-25, there was a 72 percent reduction and for Fiscal Year 2022-23, there was a 78 percent reduction.

Evidence reviewed support 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. Evidence was found in the contracts with community-based providers, policy and procedures, review of client records, and interviews with community-based provider staff and supervisors that assistance with housing needs is provided. 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. ACBHD provided contracts with their community-based providers regarding housing assistance funding.

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.

Evidence reviewed support compliance with this requirement.

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, and this is also a DHCS contract requirement. 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 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 October 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 reviewed the suggested new names and decided on First Step: Behavioral Health Connection, Screening, and Referral. ACBHD will conduct two stakeholder meetings in August 2026 for the public to learn more about this change. The County also has a media campaign to inform stakeholders and the public.

Evidence reviewed support compliance with this requirement.

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

ACCESS staff collect demographic information, current symptoms, and historical information from the caller and then utilize a screening tool to determine eligibility for services. ACCESS teams do not complete the formal clinical assessment. Currently, ACCESS writes up a referral and sends that referral to the community-based provider who then contacts the client to schedule an intake appointment. The community-based providers reported that they then complete the clinical assessment.

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).

For the second report, the ACBHD ACCESS Division Director 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. 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.

The Board of Supervisors approved the EPIC contract at the March 24, 2026, meeting which completes Phase I of the EPIC project. Phase II of the project is currently underway. Alameda County Health Information Systems is the lead on the EPIC project and has indicated that the project remains on target for a July 2027 completion. ACBHD provided the minutes of the March Board of Supervisors meeting for the Independent Reviewer.

The Independent Reviewer interviewed the ACCESS Division Director for the fourth 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 with 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.

The ACCESS Division Director was interviewed during each review period and reported that ACCESS staff contact 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 referrals 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. For the fifth review, the Independent Reviewer visited the OCSC facility. ACBHD reported that over 8,600 services were provided at that location during Fiscal Year 2025-26.

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. For the fifth report, the ACCESS Division reported that the process worked well for individuals who wanted real-time appointments. In addition, ACBHD had this as a Performance Improvement Project for their External Quality Review and was listed in their Quality Improvement Work Plan Fiscal Year 2024-25. ACBHD also provided the contract with the community-based provider for this service. The contract states that the contractor shall accept referrals from ACBHD Acute Crisis Care and Evaluation for System-wide Services (ACCESS). Clients may contact ACCESS to request services.

For the fifth report, the Independent Reviewer interviewed the ACCESS Division Director regarding the findings of this pilot project. This Director reported that the pilot worked when the ACCESS staff was able to connect the client with a community-based provider via three-way communication.

Evidence reviewed support compliance with this requirement.

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 conducted the following activities for the first and second reports:

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

ACCESS staff determines eligibility for specialty mental health services. 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 has reviewed. The interviews with the community-based provider staff reported that they conduct the assessment.

For the third report, 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 if the individual walks-in or contacts them directly for services. The provider contacts ACCESS to register the case into the electronic health record. The community-based provider can conduct the assessment for this individual.

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 the fifth review, the Independent Reviewer visited the OCSC facility.

For the fourth 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.

For the fifth report, the Independent Reviewer interviewed the ACBHD ACCESS Division Director reported that the process described above continues to be the current process. ACBHD reported that 1,012 individuals were referred to a community-based provider during the Fiscal Year 2025-26.

Evidence reviewed support compliance with this requirement.

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. 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.

For the second report, 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.

ACBHD provided a copy of this report for the Independent Reviewer to review for the fifth report. The current ACCESS Capacity and Referral Report was dated 06/16/2026 and was for the period of June 10, 2026, to June16, 2026. The report indicated that out of the 15 FSP programs, only one adult FSP program was over capacity by one slot and two adult FSP programs were at capacity. The report also indicated that of the 13 Service Teams programs, two programs were above capacity by three and six clients. All of the other service teams programs had capacity.

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 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 in this referral letter.

For the fourth 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 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.

For the fourth report, the Independent Reviewer 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 the fourth 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.

For the fifth report, the Independent Reviewer interviewed another FSP Supervisor from a community-based provider. This supervisor also confirmed the above procedure.

ACBHD reported that 935 clients were referred to either an FSP team or a Service Team during the Fiscal Year 2025-26. The average number of days from episode opening (referral) to first service was 6.29 days for Service Teams.

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.*

Interviews with ACCESS staff plus the on-site reviews confirmed that ACCESS does make appropriate referrals to community-based providers. ACCESS sends the referral letters to the community-based provider and to the client, confirming that the referral was conducted and this letter includes contact information for both the client and the community0based provider. ACBHD also provided a report on when assessments are completed by the community-based provider and the number of hours of service provided.

For second report, ACBHD provided a copy of the warm hand-off procedure from a contracted community-based provider. The procedure requires the community-based provider staff to contact the client within 24 hours of receiving the referral and offer an intake/assessment appointment within one week of receiving the referral. The Independent Reviewer examined another contract with a community-based provider that stated: “Upon receiving a referral from ACCESS, Contractor shall provide assertive outreach to secure treatment engagement.”

The Independent Reviewer interviewed eight clients during the second review, who reported that they did not have to wait to complete the intake and assessment and for services to begin.

For the third report, the Independent Reviewer interviewed 18 clients, interviewed 15 clients for the fourth report and interviewed 14 clients for the fifth report. 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.

It is also 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”.

Evidence reviewed support compliance with this requirement.

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

The initial report indicated that there have not been any situations where an FSP Team or Service Team were not available to take a case. This was reported by the community-based providers, ACBHD staff, and ACBHD Senior Executive Team. However, ACBHD staff reported that this has occurred in the past several months of 2024.

They reported that ACCESS now has a way to identify when there are no FSP Team or Services Team available in their electronic health records. Their data system can generate a weekly report that is distributed to the managers for review. The staff also reported that they meet on a weekly basis with the Adult and Older Adult System of Care, 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 has requested that the number of days on the waiting list be added to the report. The Supervisor also stated that the client remains on the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer was provided a copy of this report.

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

- Review of the report on 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 solutions are identified. One example of a change identified during the third review was to clearly identify the forensic cases in the report in order to better identify and prioritize those cases. In addition, it prompted the need to meet with the Public Defender regarding appropriate referrals.

For the fifth report, the Independent Reviewer interviewed the ACCESS Division Director regarding a status update. This Director reported that they continue to meet with the Adult and Older Adult System of Care to determine the appropriate team for the case assignment. If the appropriate team is not available, they can assign the case to BACS for the ACCESS Care Coordination Team (ACCT) to stabilize the client.

Evidence reviewed support compliance with this requirement.

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. The Independent Reviewer interviewed one of the Critical Care Managers for the third report, who reported on that the care coordination services are provided.

For the fifth report, the Independent Reviewer interviewed two Critical Care Managers. They reported that that each are assigned to specific programs. For example, one is

assigned to the IMD facilities and to John George Hospital and the other is assigned to the CSUs, CTRs, and state hospitals. The third Critical Care Manager is assigned to children and young people. These managers reported that they work with clients who are difficult to engage or have been identified as high risk to coordinate a transition to services. They reported that they continue to meet with the Adult and Older Adult System of Care, the Forensic system of care and the crisis system of care on a weekly basis to reviews identified clients.

ACBHD contracted with BACS for the 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 hospitalization, 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.

Evidence reviewed support compliance with this requirement.

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

The Adult and Older Adult System of Care Director reported that 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 Acting 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.

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 receives direct referrals from John George Psychiatric Hospital Social Workers. CC/PCFT conducts brief screening with clients and will refer the clients back to existing providers if they are already linked to services. For the fifth report, the Independent Reviewer met with two of the supervisors from CC/PFT. These staff confirmed that they work to improve transitions of care and to improve the linkages to community-based providers.

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 for the third report. 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.

For the fifth report, ACBHD provided data for the Fiscal Year 2025-26. There were 1,012 cases opened with a median of 17 days from the referral to the assessment.

ACBHD did provide their tracking log of high inpatient and subacute utilizers. ACBHD reported that 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 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. For the third report, 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 – 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.

For the fifth report, the Independent Reviewer interviewed three community-based provider supervisors for the outreach and engagement teams. These staff reported that they can work from 90 days up to one year to engagement an individual in treatment. They also reported working with families to assist with getting someone into treatment.

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.

Evidence reviewed support compliance with this requirement.

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.*

During the initial review, 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. For the fifth report, the Independent Reviewer interviewed two staff from the Public Defender's office who reported that trainings regarding community-based services that can provide alternatives to incarceration, arrest, and law enforcement contact are provided.

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. For third report, one community-based provider recently made the following presentations regarding their Diversion Triage Center:

- Pleasanton Police Department on 5/12/2025,
- Alameda County Sheriff Department on 5/14/2025,
- District Attorney on 7/16/2025, and
- Probation on 7/22/2025.

For the fifth report, ACBHD provided a power point presentation made to the Public Defenders, dated 9/17/2025 regarding the services provided at the jail and by the Forensics team.

Evidence reviewed support compliance with this requirement.

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*.

For the initial review, evidence was found on 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. *A*CBHD 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.

Available trainings continue to be posted on the ACBHD website. Some training topics are as follows: Helping system-involved youth and families understand the juvenile justice, Introduction to nonviolent crisis intervention training, and Mental Health First Aid training.

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.

For the fifth report, the Independent Reviewer interviewed two Critical Care Managers who reported that they work closely with the providers to rapidly connect individuals to appropriate services.

Evidence reviewed support compliance with this requirement.

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

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.

For second report, 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 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 in services.

ACBHD provided a power point presentation that reported the following IHOT outcomes for Fiscal Year 2025-26:

- IHOT averages a 48 to 56% connection rate which is the number of individuals that were referred to IHOT and have consented to receive mental health services, and
- Comparing hospitalizations, jail, and crisis rates twelve months before IHOT admission to twelve months after IHOT admission, there was an almost 30% reduction in admits.

Evidence reviewed support compliance with this requirement.

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 October 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.

For the fifth report, the ACBHD Substance Use Continuum of Care Director reported that the program continues to be operational. This Director provided a six month report regarding the goals and objectives of the program and that the program is meeting or exceeding their goals and objectives. ACBHD also reported that 91.6 percent of team clients with a co-occurring SUD disorder were served within 30 days after a mobile crisis episode.

Evidence reviewed support compliance with this requirement.

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

The Independent Reviewer interviewed the Adult and Older Adult System of Care Director who reported during second report, that UR pilot has been implemented, and it has been successful. This Director 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 second report, the length of stay at Villa Fairmont Mental Health Rehabilitation Center was an average of 120 to 130

days. This Director 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.

For the fifth report, the Independent Reviewer interviewed the Adult and Older Adult System of Care Director who reported that they continue to see a reduction in length of stays at the IMDs from the established contract requirements. ACBHD reported that for Fiscal Year 2025-36, a total of 382 clients were served in an IMD and 220 clients were discharged.

Evidence reviewed support compliance with this requirement.

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

Discharge begins at intake per community-based provider staff interviewed, and per the ACBHD contract. ACBHD provided examples of contracts that require the placement 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 in 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. The Independent Reviewer was able to attend three of the acute care coordination meetings where discharge planning for specific clients was discussed.

For third report, 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 can 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.

For the fifth report, the Independent Reviewer interviewed the Adult and Older Adult System of Care Director who reported that the acute care coordination meeting occurs every week where clients' transitions are discussed. ACBHD provided minutes from the Acute Care Coordination Weekly Meeting for the month of July 2026.

Evidence reviewed support compliance with this requirement.

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.*

ACBHD implemented a process to track this occurrence within their IT system. The ACCESS Division Director reported that there are meetings with the FSP teams and the ACCESS staff every week. This Director also reported that this same group meet

quarterly to review any trends. This Director reported that they do refer the client to another service while waiting for a slot to open in a FSP team. One barrier that has resulted in FSP being unavailable is workforce shortages and there is high turnover with this position.

For third report, 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. This Director reported that they do refer the client to another service while waiting for a slot to open in a FSP team. One barrier that has resulted in FSP being unavailable is workforce shortages and there is high turnover with FSP team positions.

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 in the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer has been provided with a copy of this report.

ACBHD provided the meeting minutes with ACBHD leadership regarding this requirement. The staff identify the issues and include 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 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.

For the fifth report, ACBHD provided a copy of the FSP and Service Team capacity report for the Independent Reviewer to review. The current ACCESS Capacity and Referral Report was dated 06/16/2026 and was for the period of June 10, 2026, to June16, 2026. The report indicated that out of the 15 FSP programs, only one adult

FSP program was over capacity by one slot and two adult FSP programs were at capacity. The report indicated that the other FSP programs had capacity.

Data for Fiscal Year 2025-26, reported the following for FSP:

Number of clients referred to FSP and no slots available	Average number of days to admission to FSP team	Number assessed for FSP and no slots available
72	30.08	0

Evidence reviewed support compliance with this requirement.

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.*

For second report, 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. For third report, 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.

For the fifth report, the Adult and Older Adult System of Care Director and the Critical Care Managers reported that they continue to meet on a regular basis regarding transitions of care. ACBHD provided minutes from the Acute Care Coordination Weekly Meeting for the month of July 2026.

Evidence reviewed support compliance with this requirement.

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 Director of Social Services reported that she and the other social worker staff communicate 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.

For second report, 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, Director of Social Services, and the Chair, Department of Psychiatry. The Independent Reviewer 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.

For third report, 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 the fourth 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 meetings where discharge planning for specific clients is discussed.

For the fifth report, the Independent Reviewer interviewed the Director of Social Services for John George Hospital who reported daily communication with ACBHD staff regarding discharge planning and care coordination.

Evidence reviewed support compliance with this requirement.

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 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 Director of Social Services 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 several fiscal years.

Service Modality	Fiscal Year 2022-23	Fiscal Year 2023-24	Fiscal Year 2024-25	Fiscal Year 2025-26
Crisis Stabilization	4,270	4,274	4,206	3,274
Hospital	1,564	1,714	1,654	Not reported

This chart indicates that the number of clients admitted to the crisis stabilization unit remained roughly the same from one fiscal year to the other.

Number of clients served at John George – Psychiatric Emergency Services (PES) and Inpatient Fiscal Year 2025-2026:

Agency	Number of Unique Clients Served	Number of FSP clients served	Number of ST clients served
John George	3,274	401	195

For the fifth report, the Independent Reviewer interviewed the John George Director of Social Services who reported that the notification system for admissions continues and that there continues to be regular communication with provider and county staff regarding discharge planning and transitions of care.

Evidence reviewed support compliance with this requirement.

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 records 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.

For the fifth report, the Independent Reviewer interviewed the John George Director of Social Services and the Critical Care Managers who confirmed that compliance with this requirement has continued and is maintained.

Evidence reviewed support compliance with this requirement.

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

For the initial report, 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 above. 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.

For second report, 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 in services and conduct outreach to those individuals who drop out of services.

For the fifth report, the Independent Reviewer interviewed three community-based provider supervisors for the outreach and engagement teams who confirmed that they continue to work with those who are difficult to engage with treatment services.

Evidence reviewed support compliance with this requirement.

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

The Adult and Older Adult System of Care Director reported during the initial report 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 Director of Social Services 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 for third report 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.

For the fifth report, the Independent Reviewer interviewed the John George Director of Social Services and the Critical Care Managers who confirmed they the county and John George continue to work collaboratively regarding this requirement.

Evidence reviewed support compliance with this requirement.

Requirement: *Linkages for Services Following Release from Santa Rita Jail. This Agreement does not govern the provision of mental health services or treatment at Santa Rita Jail and does not duplicate, modify, or override any provisions in the Babu v. County of Alameda Consent Decree (including section III.I, "Discharge Planning," page 49:13-51:18).The County will ensure that ACBHD collaborates with the County Sheriff's office and will use its best efforts to identify and implement appropriate strategies to improve warm handoffs of Behavioral Health Clients (as defined in the Babu consent decree) who are eligible for ACBHD services.*

The Forensic, Diversion and Re-entry Services Director reported that there are multiple meetings with the Sherriff's Office. For example, leadership meets twice a month, re-entry staff meet weekly, and suicide 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 Re-Entry staff reported that they problem solve daily with the jail staff.

The Forensic, Diversion and Re-entry Services Director for second report 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 provided the data below for Fiscal Year 2024-25, which indicates that only 6.27 percent of the individuals discharged were served in a new or existing community-based provider within 30 days of jail discharge.

Number of MHS Clients Released and Served in MHS in the Previous Year	Percent of MHS Clients Released from Jail Last Year	Number of Clients Served Within 30 Days of Jail Release by New Providers	Percent of Clients Served Within 30 Days of Release by New Provider	Number of Clients Served Within 30 Days of Jail Release by Old or New Providers	Percent of Clients Served Within 30 Days of Release by Old of New Providers
2,833	26.55%	335	3.14%	669	6.27%

ACBHD reported the following data for the Fiscal Year 2025-26:

Number of clients engaged in re-entry planning to any type of provider	Number of clients reconnected to their FSP or Service Team	Number of clients whose FSP or Service Team engaged in discharge planning	Number of clients served by FSP or Service Team within 30 days from release
1,548	511	141	350

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 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 and fifth 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.

Evidence reviewed support compliance with this requirement.

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 each 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 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.l.i, above, ACBHD continues to comply with its obligation to collaborate with the County Sheriff 's office to improve this process. For the fifth report, this Director reported that the Sheriff's Office is open to speeding up the process for clearances to provide re-entry planning and transitions of care for the individual.

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 referrals 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. The re-entry staff also reported that the jail does not always provide a set time of release but that they do try to connect with the individual immediately before they are released. This Director reported that the Post-Release Clinician does try to reach out the individual to assist them with transition back into the community.

For the fifth report, the Independent Reviewer interviewed both re-entry staff and the Forensic, Diversion and Re-entry Services Director. The re-entry staff described the services they provide, and they reported that they screen everyone. They also reported that there are booths at the intake section of jail where they can conduct a brief assessment. A level of care is then provided based on the brief initial assessment and clinical judgement. Those who score a certain range are then placed into the therapeutic housing units at the jail. The re-entry staff also confirmed that they receive

the daily booking list and a daily release list to provide re-entry planning and transitions of care for the individual.

This Director reported that as a result of these reviews, they redesigned the re-entry plan and that they have trained the staff in appropriate ways to engage the individuals. This Director reported that they do coordinate care with the treatment providers.

Evidence reviewed support compliance with this requirement.

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). The Adult and Older Adult System, Forensic Reentry system, and ACCESS continue to 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.

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 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 in the report until they have been officially connected to either an FSP Team or Service Teams. The Independent Reviewer was provided with a copy of this report. ACBHD also provided the meeting minutes with ACBHD leadership regarding this requirement. The staff identify the issues and include action items to resolve the issues. For the fifth report, ACBHD provided a copy of the FSP or Service Team capacity report for the Independent Reviewer to review.

Evidence reviewed support compliance with this requirement.

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.l.iii. Where appropriate, the results of the quality reviews under section II.4.l.iii will inform the County's FSP Assessment under section II.2.c.*

For second report, 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 for the community-based provider staff. One example of a change as a result of the quality reviews was to list medications on the re-entry plan. ACBHD did provide the assessment form and the re-entry form to the Independent Reviewer.

There is also the Multi-Disciplinary Forensic Team (MDFT) comprised of Alameda County law enforcement agencies, Alameda County District Attorney's Office, Alameda County Behavioral Health Care and allied service providers. The goal of MDFT is to provide assistance to individuals diagnosed with mental illness, substance abuse, and co-occurring disorders. MDFT is committed to reducing recidivism by assisting these individuals in obtaining psychiatric evaluation, treatment, and ongoing services leading to recovery and the wellness of the individual and the greater community. ACBHD provided a list of the MDFT meeting dates for all of calendar year 2025.

For the fifth report, the Independent Reviewer interviewed both re-entry staff and the Forensic, Diversion and Re-entry Services Director. The re-entry staff described the services they provide, and they reported conducting brief screenings. This Director reported that they do track those individuals assessed with a serious mental illness and their success regarding engagement in services upon release. This Director also reported that they review on a monthly basis those who have not engaged in services and work with the re-entry team for the status of the engagement with the individual.

Evidence reviewed support compliance with this requirement.

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

The Forensic, Diversion and Re-entry Services Director reported that there are two re-entry teams. The first is the ACBHD re-entry team based at the county jail who follow up with these individuals. The second re-entry team is located in the community, and services are provided by a community-based provider. For the fifth report, the Independent Reviewer interviewed the managers for both re-entry teams.

The re-entry team at the jail consists of two behavioral health clinicians and ten mental health specialists who 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. The re-entry managers reported that they will contact the person several times a week and keep monitoring them especially if the person is at risk. These managers reported that they can try to engage the person while still in the behavioral health housing unit at the jail. They can provide the video linkages to the community-based providers, and they confirmed that this procedure is effective. The managers for the community-based providers re-entry team reported that they work with person to connect them to treatment services and can work with them for up to 18 months to try to engage them in services.

Evidence reviewed support compliance with this requirement.

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 26 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 tracks the number of calls, hold times and the time of the call. ABCHD did provide the Independent Reviewer with 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 with a copy of this report.
7. *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.* ACBHD has hired three Critical Care Managers who provide coordination of care and transitions in care to improve linkages to services.
8. *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.
9. 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.
10. *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.
11. *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.
12. *The County will ensure that individuals 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.* ACBHD has implemented two SUD outreach teams and has operated for more than six months.
13. *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 and the length of stay at Villa Fairmont has decreased.
14. *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.
15. *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 to prevent longer lengths of stay
16. 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.
17. 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.
18. 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 of client records, interviews with clients and staff, and tour of the facility.
19. *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.
20. 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.
21. 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.
22. 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.
23. *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.* ACBHD monitors the participation in discharge and re-entry and the success in engaging individuals into treatment upon release. ACBHD has two dedicated Re-entry FSP teams that are through contracts with community-based providers.
24. 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.
25. *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.* ACBHS does track those individuals assessed with a serious mental illness and their success regarding engagement in services upon release.
26. 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.

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 showed ACBHD's ongoing efforts to ensure culturally responsive services.

The Integrated Mental Health and Substance Use Disorder Quality Improvement Work Plan for Fiscal Year 2025-2026, includes a focus on the following cultural and linguistic competence objectives:

a. Enhance Behavioral Health Access and Engagement for Asian American, Native Hawaiian and Pacific Islander (AANHPI) Communities in South County and Older Adult AANHPI Population, and

b. Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/Integration of Primary Care and Behavioral Health Care Services.

Alameda has five threshold languages as defined by DHCS as of March 2024.The threshold languages are as follows: English, Chinese (Chinese is the combination of

Cantonese, Mandarin, and Other Chinese Language), Farsi, Spanish, and Vietnamese. In the Cultural Competence Plan (December 2025), ACBHD identified the threshold languages based on regulatory requirements (5% of Medi-Cal population or 3,000 residents) as follows: English, Spanish, Chinese (Cantonese and Mandarin spoken; Traditional and Simplified written), Vietnamese, Tagalog, Arabic, and Farsi. Additional languages of focus (near-threshold or emerging needs): Korean, Khmer (Cambodian), Dari, and Pashto.

ACBHD developed a strategic plan dated May 13, 2024, with seven themes and strategic directions. There are two goals in this plan that are related to Culturally Responsive Services. The first goal is to uplift community assets for policy/program development, and the second goal is to increase equitable care for communities facing the greatest inequities through outreach, recruitment, and programs and opportunities for improvement especially for diverse Asian, Black, and LGBTQIA2S+ communities.

ACBHD has a Cultural Competence Plan (CCP), December 2025 Plan Update. The vision of the plan is as follows:

> We envision a community where all individuals and their families can realize their potential and pursue their dreams, where stigma and discrimination against those with mental health and substance use challenges are eliminated. This vision drives our strategic approach to cultural competence, which is not merely an aspiration but an operational imperative embedded in every aspect of our work.

The CCP identified the following eight Cultural Competency Plan Criteria and included in each criterion the response to goals, and identified areas of opportunity and solutions:

Criterion 1 Commitment to Cultural Competence which includes establishing organizational foundation for cultural competence, creating a dedicated health equity infrastructure and developing a strategic plan centering on health equity.

Criterion 2 Updated Assessment of Service Needs which includes conducting a comprehensive population assessment, assessing service utilization patterns and disparities, and evaluating community-identified needs through engagement

Criterion 3 Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities which includes reducing service access disparities for priority populations, implementing culturally specific programs and services, and addressing social determinants impacting mental health equity.

Criterion 4 Client/Family Member/Community Committee Integration which includes establishing representative cultural competence committee (CCC), integrating CCC into decision-making and planning processes, and establishing culturally specific community coalitions.

Criterion 5 Culturally Competent Training Activities which includes implementing comprehensive annual CLAS training, providing advanced cultural competency training, and developing population-specific cultural competency training.

Criterion 6 Alameda County Behavioral Health Department's Commitment to Growing a Multicultural Workforce which includes increasing workforce diversity to reflect client population, implementing pipeline programs to develop diverse future workforce, and enhancing recruitment and retention strategies.

Criterion 7 Language Capacity which includes ensuring comprehensive language access, building bilingual workforce capacity, and maintaining quality and accessibility of language services.

Criterion 8 Adaptation of Services which includes developing and sustaining client-driven and operated programs, ensuring cultural responsiveness of all services, and providing flexible, accessible service delivery

The CCP identifies the commitment to the following strategic priorities for 2026.

Priority 1: Accelerate Latino/Hispanic Workforce Development Target: 3% increase in Latino/Hispanic staff within 18 months through enhanced recruitment, partnerships, and retention strategies;

Priority 2: Operationalize African American Wellness Hub. Target: Complete design and begin construction with community input integrated throughout the process;

Priority 3: Achieve Data Quality Excellence Target: 85% SOGIE data collection, <5% unknown race/ethnicity, operational real-time Health Equity Dashboard;

Priority 4: Ensure Provider Network CLAS Compliance Target: 90% of contracted provider staff complete required annual training;

Priority 5: Expand AANHPI Service Capacity Target: Increase AANHPI penetration rate by 10% through HEAL program expansion and targeted outreach; and

Priority 6: Strengthen Older Adult Services Target: Achieve a 2.5% penetration rate through enhanced access and specialized programming.

The Behavioral Health Services Act (BHSA) replaces the Mental Health Services Act (MHSA) beginning on July 1, 2026. BHSA requires counties to submit three-year Integrated Plans (IP) for Behavioral Health Services and Outcomes. In accordance with the BHSA, the Integrated Plan provides a description of how Alameda County will deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for fiscal years 2026-2029. One section of the IP is devoted to a disparities analysis which included penetration rates from DHCS from Fiscal Year 2023-24.

Race/Ethnicity	ACBHD Penetration Rate
Hispanic/Latino	1.6%
Other	3.93%
Asian/Pacific Islander	1.2%
Black	5.8%
White	13.4%
American/Alaska Native	5.4%

Age	ACBHD Penetration Rate
Early Childhood (ages 0 to 2)	.9%
Ages 3 to 5	1.7%
Youth	4.6%
Adolescent (ages 12-17)	7.2%
Adults 65+	1.4%

Gender	ACBHD Penetration Rate
Female	2.8%
Male	3.6%

Findings in the IP were as follows:

> In conclusion, disparities by age, race/ethnicity, gender, and language reflect the need for early intervention, bilingual, and culturally responsive services, and improved system navigation. These efforts are vital to achieving equitable behavioral health care access across Alameda County. (Page 29)

ACBHD also conducts a Cultural Responsiveness Committee (CRC) and the community-based providers also reported that the County staff, community-based providers staff, and stakeholders attend these meetings. The Independent Reviewer reviewed the minutes for six committee meetings in 2025 and 2026. These meetings are facilitated by the Administrator, Office of Ethnic Services. During the meeting, the CCP is discussed along with updates from the various culturally responsive advisory committees, updates on BHSA, recruitment priorities, announcements of trainings and upcoming events of interest.

ACBHD provided contracts with their community-based providers which stated the following: “Contractor shall maintain staffing with professional experience and expertise

in providing evidence-based, culturally, and linguistically appropriate services, particularly for any designated priority populations that Contractor has agreed to serve."

Interviews with both ACBHD staff and community-based provider staff indicated that the services provided are culturally responsive and person centered. Since the effective date of the Settlement Agreement, the Independent Reviewer has reviewed over fifty client records where the client's goals are identified and were developed in a manner consistent with a person-centered approach. 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.

The Independent Reviewer also interviewed a total 55 clients since the effective date of the Settlement Agreement, and the clients confirmed that services are provided in a culturally responsive and person-centered manner. Clients spoke about receiving culturally appropriate services and 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.

Evidence reviewed support compliance with this requirement.

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

ACBHD provided an organizational chart that indicates that the Director, Office of Health Equity, reports directly to the ACBHD 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.

The Independent Reviewer interviewed the Director, Office of Health Equity during the first, second, third, and fifth review. The Director, Office of Health Equity, reported continued 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 provided minutes from the Culturally Responsive Committee from 2025 and 2026.

In December 2023, ACBHD conducted a listening session with the Executive Team at the LGBTQ Center in Oakland and learned more about the needs of its clients and the

LGBTQ Community. This was reported in the MHSA Annual Plan Update (Draft) for Fiscal Year 2024/25 which included the following:

> They are seeing a need for more programs to address social isolation in the elderly population. The housing being developed is not created with LGBTQ displacement from new developments. Also, needs for LGBTQ people in homeless encampments need to be addressed due to rising threats and violence. HIV is an ongoing problem that is receiving less resources but still needs to be addressed. Overall, the LGBTQ Center is looking to bring on a care navigator and would like to continue to participate in county programs. (Page 441).

The CCP, December 2025 Plan lists the number of coalitions/committees with stakeholder participation to provide feedback to the department. Some of these coalitions/committees are as follows:

- ACBHD Pride Coalition,
- Asian American, Native Hawaiian, and Pacific Islander Advisory (AANHPI) Committee for Health and Wellness,
- African American Steering Committee for Health and Wellness,
- Immigration/Refugee Wellness Coalition,
- Latinx/Latino Advisory Committee for Health and Wellness,
- Older Adult Advisory
- Transition Age Youth Advisory, and
- Veterans Coalition.

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.

For this report, the Independent Reviewer interviewed the Director, Office of Health Equity/Interim Workforce, Education, and Training Manager. This Director reported that the dashboard remains active on the ACBHD website.

Evidence reviewed support compliance with this requirement.

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 hired a Director of Health Equity and meets 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.

For this report, the Independent Reviewer interviewed the Director, Office of Health Equity/Interim Workforce, Education, and Training Manager who reported that she continues to meet with stakeholders as needed and continues to meet with the ACBHD Director weekly.

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.

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 were 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 provided 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.

The County has dedicated $19 Million dollars to this effort. ACBHD provided evidence of multiple listening sessions with stakeholders. At the Board of Supervisors meeting on 9/17/2024, the Board approved the following:

- The initial project budget for the African American Wellness Hub Project in the amount of $5,000,000;
- The use of Alameda County Health, Behavioral Health Department funds for the initial project budget for the African American Wellness Hub Project, in the amount of $5,000,000;
- Authorized the Director of the General Services Agency or her designee to issue Task Order No. 20115, in the amount of $3,866,861, with Vanir Construction Management, Inc., for the program and project management services for the African American Wellness Hub.

The Health Equity Division Director stated that the plan from the County's General Services is to tear down the existing building on the land and to build a new building. This Director reported that they meet with the stakeholders on an as needed basis. Some examples of the stakeholder meetings include topics such as CARE Court and Prop 1 implementation. This Director also reported that the county continues a commitment to this project.

For this report, the Independent Reviewer interviewed the Director, Office of Health Equity/Interim Workforce, Education, and Training Manager who reported this work

continues. This Director reported that they are still designing the building and have obtained the required permits. The ACBHD website includes the African American Wellness Advisory Committee meetings located under the Office of Ethnic Services Resources.

Evidence reviewed support compliance with this requirement.

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

Training is provided upon hire and throughout the year. The ACBHD Health Equity Division Director was interviewed in the initial report and reported that training is under the purview of the Office of Ethnic Services within ACBHD Department in collaboration with the Workforce and Education Team. The Health Equity Division Director also reported that the County has a contract with ONTRACK to provide the Culturally and Linguistically Appropriate Services (CLAS) training and offers training each month. The Independent Reviewer reviewed the new team member orientation and onboarding training memo that is provided to all staff and stakeholders.

For the community-based providers, the following language was found in their contract with ACBHD:

> "Contractor shall ensure annual training of all applicable employees, volunteers, board members, owners, and/or agents who are providing and/or supporting services under this Agreement on Administrative and Compliance Requirements, in areas including but not limited to: documentation standards, billing requirements, Culturally and Linguistically Appropriate Standards (CLAS), Annual Compliance/Code of Conduct, and Health Insurance Portability and Accountability Act (HIPAA)/Privacy and Security."

The CCP, December 2025 Plan Update included Culturally Competent Training Activities (Criterion 5) the following goals:

Goal 5.1: Implement Comprehensive Annual CLAS Training which includes 100% of staff and community-based provider staff complete a minimum of 4 hours of CLAS training annually, minimum 2 trainings per year offered by the behavioral health department, and training completion documented and tracked.

Goal 5.2: Provide Advanced Cultural Competency Training which includes offering a minimum of 25 culturally competent training opportunities annually, provide advanced training in 8+ evidence-based practices with cultural adaptations, ensure 75% of training courses offer CEUs/CMEs, and achieve average training satisfaction rating of 4.5/5.0

Goal 5.3: Develop Population-Specific Cultural Competency Training which includes provide specialized training for serving each priority population, include consumer/family voice in 80% of cultural competency training, offer training in trauma-informed care for 90% of staff, and ensure training accessibility (interpretation, multiple formats, convenient times per request).

The CCP, December 2025 Plan Update reported the following for training activities in Fiscal Year 2024-25:

- 71 training events offered,
- 2,469 individuals trained,
- Average satisfaction rating: 4.7/5.0, and
- 78% of training courses offered CEUs/CMEs.

Per the executed contract, Provider, Program and Staff Information:

> Contractor shall submit any needed updates to provider, program and staff information, as well as attestation of accuracy of information on file by the15th of each month as requested by ACBH to complete required publications, submissions and monitoring including but not limited to Provider Directory and Network Adequacy Reporting. Contractor's submission shall include but not be limited to Contractor's cultural and linguistic capabilities in service delivery and documentation of staff completion of cultural competence training and shall be in accordance with the format specified by ACBH and the California Department of Health Care Services (DHCS).

The Health Equity Division Director reported the following activities to ensure that the training requirements are met:

1. Sign-in sheets are collected at the training and reviewed as part of compliance.
2. Each contract with a community-based provided is required to provide CLAS training to all direct service staff and managers who are providing or supporting services through this Agreement. The staff are to complete at least four CLAS training courses annually. The community-based provider submits the following information by July 10th of the following fiscal year to the ACBHD Office of Ethnic Services:
    a. An electronic survey that demonstrates Contractor's implementation of CLAS Standards,
    b. A list of CLAS trainings attended by staff and managers who are providing or supporting services through this Agreement; and
    c. A summary or copy of a plan to further implement CLAS Standards throughout the organization.
3. The Office of Ethnic Services conducts a survey at the end of each year to assess and confirm attendance, plans and adherence to CLAS standards each year. A copy of the survey results was provided for review.
4. QA/QI team performs audits, and the CLAS standard portion of the contract is assessed.

Training also includes an evaluation form to be completed if CEUs are to be issued. Some training courses do include a post test. In addition, the Health Equity Division Director reported that they currently collect attendance at the class, but that ACBHD is moving toward a more efficient process where each CLAS training has an electronic sign-in sheet. This process will allow for the normalization of collected information. Office of Ethnic Services is also moving toward collecting data on ACBHD hosted CLAS trainings via the internal announcement portal in Fiscal Year 2025-26.

ACBHD provided an EXCEL sheet summarizing the topic of the training, date of the training, who attended, and the attendees' organization for review. Some of the trainings were as follows: Trauma informed and culturally responsive practices working with Asian American, Native American, and Pacific Islander clients, CLAS standard and stigma discrimination reduction in behavioral health, and Mental health services with Latinx populations.

Evidence reviewed support compliance with this requirement.

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 supports compliance with this requirement.

SUMMARY AND NEXT STEPS

This is the fifth report from the Independent Reviewer regarding the Settlement Agreement between the County of Alameda and ACBHD with Disability Rights California (DRC), which became effective on January 31, 2024. A rating of substantial compliance was given in 93 percent of the service commitments and a rating of not applicable was given for 7 percent of the service commitments. There were no non-compliant ratings given for any of the requirements in the Settlement Agreement for all 5 reports.

The draft of the fifth report was issued on September 11, 2026, to the parties. 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.

Over the course of the Settlement Agreement, the Independent Reviewer has conducted five on-site reviews, written five reports, interviewed a total of 55 clients (34 of these were FSP clients), reviewed 188 client records, reviewed 42 client records from John Geoge Psychiatric Hospital, toured 19 facilities, interviewed 64 community-based provider staff, and interviewed 35 county staff multiple times. ACBHD has been very cooperative in coordinating the site visits and in providing the information requested by the Independent Reviewer.

The final report is to be submitted 31 months after the effective date of the Settlement Agreement. This is the fifth and final report per the requirements 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**	**Fifth Report**
1.a. The County will continue to offer a countywide crisis system and expand crisis intervention services.	PC	SC	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	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	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	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	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	PC	SC	SC	SC	SC

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

emergency services (PES) placement rates, and increasing the use of voluntary community based services (including diversion, care coordination, transportation, and post-crisis linkages to services).					
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	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	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	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	NA
1.a.ii.(7) FSPs will provide crisis intervention as set forth in section II2.m. in this Agreement.	PC	NA	PC	PC	SC
1.a.ii.(8) Each mobile crisis team shall include at least one mental health clinician.	PC	SC	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	SC
1.b.i. Maintain 45 crisis residential treatment (CRT) beds.	PC	SC	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 based providers to add a mixture of 25 additional CRT and/or peer-respite beds.	NA	NA	NA	NA	SC
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	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	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	SC
1.b.vi. CRT facilities and peer-respite homes shall be able to accept admissions directly from mobile crisis.	PC	SC	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	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	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	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 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.	NA	NA	PC	SC	SC
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	NA	NA	SC	SC	SC

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.					
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	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	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	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	SC
2.k. FSPs serve the individuals described in 9 C.C.R. § 3620.05. FSPs will provide their	PC	PC	PC	SC	SC

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.					
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	NA
2.m. FSPs will promptly provide crisis intervention 24/7, including, as appropriate, crisis intervention at the location of the crisis as needed to avoid unnecessary institutionalization, hospitalization, or interactions with law enforcement. Beginning no later than **eighteen (18) months** after the Effective Date, the County will ensure the prompt notification of the applicable FSP provider when an individual served by an FSP receives crisis intervention from another ACBH contracted provider, such as mobile crisis teams, or other crisis programs, so that the FSP can respond to the crisis.	NA	NA	PC	PC	SC
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	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	PC	PC	PC	PC	SC

Services Agency's Coordinated Entry System ("CES"), or through other County and community resources.					
2.o.ii. As individuals with serious mental illness, FSP clients who are referred to the CES will receive priority, with the goal of securing and maintaining permanent housing.	PC	PC	SC	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	NA
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	NA
3. Service Teams (Intensive Case Management)					
3.a. The County will maintain 2,168 slots to provide intensive case management through Service Teams. The County will utilize these slots to serve individuals 18 and older who meet Service Teams eligibility criteria and may also use these slots for transitional age youth as appropriate.	PC	SC	SC	SC	SC
3.b. The County will explore community needs and opportunities for expanding Service Teams as appropriate.	NA	NA	SC	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	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	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	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	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	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 or Service Team's caseload to commence the provision of services.	PC	PC	PC	SC	SC
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	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,	NA	NA	SC	SC	SC

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

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.					
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	SC
4.h. The County will work with law enforcement to direct referrals to the In-Home Outreach Team ("IHOT").	PC	SC	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	SC
4.j.i and ii. In-Reach to, and Discharges to Community Based Services from, Medicaid Institutions for Mental Diseases ("IMDs"). "IMD" as used in this Settlement Agreement, refers to Villa Fairmont Mental Health Rehabilitation Center, Gladman Mental Health Rehabilitation Center, and Morton Bakar Center. Within 12 months of the effective date of this Agreement, the County will begin initial implementation of a utilization review ("UR") pilot program. The UR pilot program will be designed to ensure that individuals are transitioned to and live in the most integrated setting appropriate to the individual's needs and to reduce the length of IMD stays where appropriate. As part of the UR pilot program the County will review clinical records and engage in peer-to-peer meetings to assess appropriateness for discharge in light of community based services appropriate to the individual.	NA	NA	NA	SC	SC
4.j.iii. Promptly after an individual eligible for ACBHD services is admitted to an IMD in the	PC	PC	PC	SC	SC

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.					
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	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	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	NA	NA	PC	SC	SC

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.					
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	PC	NA	PC	SC	SC

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

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.					
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	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	SC
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	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	PC	SC	SC	SC	SC

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.					
5.b. The County will continue to operate the Office of Health Equity within ACBH, and the Division Director of the Office of Health Equity will continue to serve as the departmental Health Equity Officer, reporting to the Director of ACBH, and will oversee the existing Office of Ethnic Services. The Health Equity Officer will continue to work in collaboration with community stakeholders to promote social and behavioral health equity reform and inclusion, and to ensure clients receive high quality and client-centered care that considers the whole person and all their needs.	PC	SC	SC	SC	SC
5.b.i. No later than **fifteen months** after the Effective Date of this Agreement, the Health Equity Officer will host a stakeholder and community input meeting. In order to deepen meaningful community stakeholder engagement, no later than one month before the stakeholder and community input meeting, the Office of Health Equity will make a dashboard publicly available on the Office of Health Equity's public internet website setting forth aggregated data metrics on the populations served by ACBHD (including individual racial and ethnic groups broken down by geographic area within the County) and various communities' service needs (including racial and ethnic groups' needs for FSP, Service Team, and IHOT services in geographic areas within the County).	NA	NA	SC	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	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	NA	SC	SC	SC	SC

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