Alameda County Behavioral Health

Recommendation Template March 2024

Inclusion Criteria

- **Accuracy**: Is this recommendation factual and/or an accurate assessment of current practice?
- **Mission-Driven**: Will it reduce the number of people with mental illness in Santa Rita jail?
- **Racial Equity**: Will this recommendation help reduce the racial disparities in incarceration at Santa Rita jail?
- **High Utilizers**: Will this recommendation support people who are repeatedly touching the system, i.e. people who cycle between jail, homelessness, and other informal family supports?
- **Level of Effort**: How complete or effort-ful is the recommendation in its current state? Is there a fully fleshed out recommendation that we need to consider as a group, or is this a brief phrase or string of words?
- **Data-Driven:** Is the recommendation data-driven?
- **Actionable**: is the recommendation "actionable" or "implementation-ready"? Does the recommendation identify the people/agency/CBP/other entity that will do the work and be held accountable for the outcome? Does the recommendation set forth achievable and quantifiable metrics and a time table by which progress can be measured?
- **Avoid Net-widening**: Does this recommendation help "shrink the net" for the number of people who are falling into the CJ system?

DRAFT

2. Collaboration/ Case Management/ Reentry

Context:

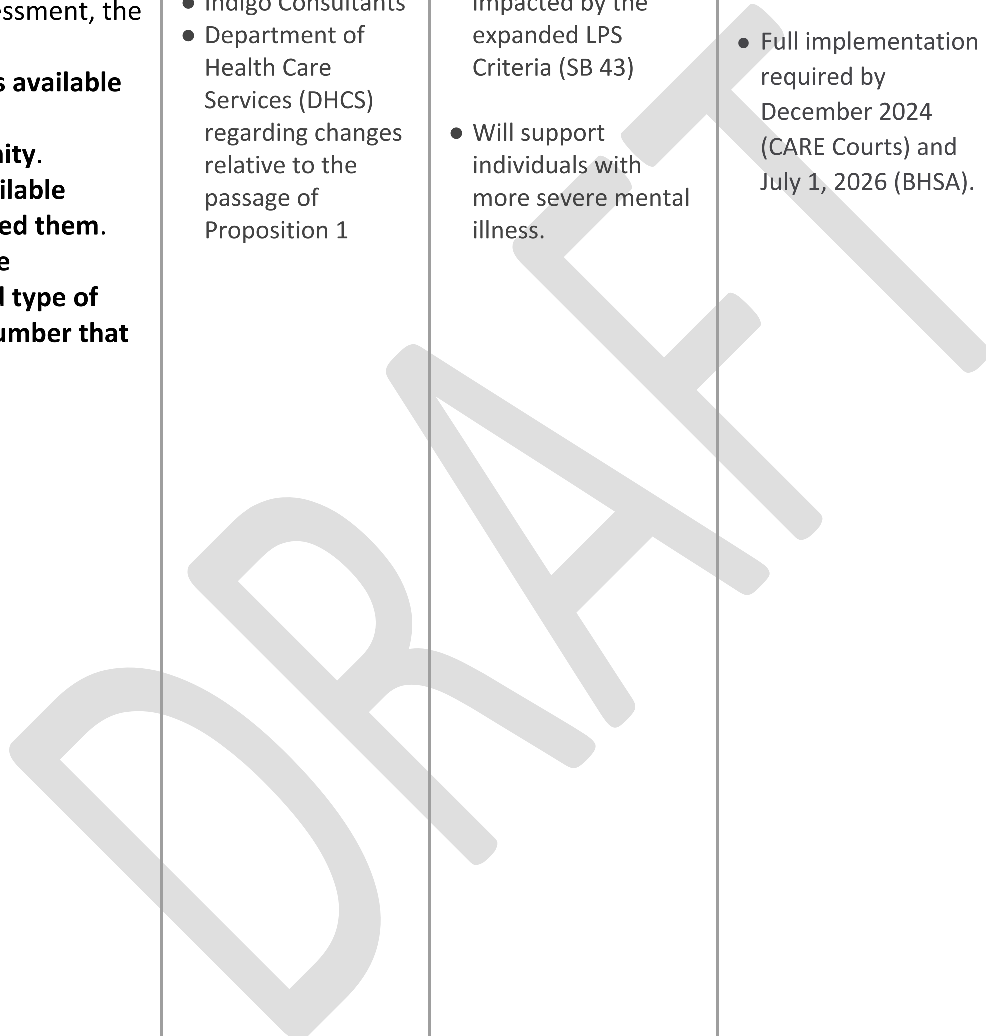
Collaboration and case management are crucial for justice-involved individuals with mental illness for several interconnected reasons:

a. **Complex Needs**: Individuals at the intersection of the criminal justice system and mental health services often have complex, multifaceted needs that include treatment for mental illness, substance abuse rehabilitation, housing, employment, and social support. Addressing these needs holistically can improve outcomes.
b. **Continuity of Care:** Collaboration ensures continuity of care as individuals transition between the justice system and community-based mental health services. This seamless transition is vital to prevent relapse, rehospitalization, or recidivism.
c. **Improved Outcomes**: Collaborative care approaches, which consider all aspects of an individual's life, are linked to better health outcomes, reduced involvement with the criminal justice system, and improved quality of life.
d. **Reduction in Systemic Burdens:** Effective case management and collaboration can reduce the burden on criminal justice and emergency health services by providing more appropriate and cost-effective interventions.
e. **Promotion of Recovery and Rehabilitation**: Focusing on rehabilitation and recovery, rather than solely on punishment, supports the individual’s reintegration into society, reducing the likelihood of re-offending.
f. **Respect for Human Rights:** These practices ensure that justice-involved individuals with mental illness receive the care and support they need, respecting their dignity and human rights.
g. **Tailored Interventions**: Through case management, interventions can be tailored to meet individual needs, considering each person's specific circumstances and challenges.

In essence, collaboration and case management reflect a more enlightened approach to dealing with individuals with mental illness in the justice system, focusing on rehabilitation and support rather than punishment alone. This approach is beneficial not only for the individuals involved but also for society at large, aiming to reduce recidivism, support recovery, and promote public safety and well-being.

Recommendation	Partner(s)	Problem that it Solves	Data needed? Budget request? Time to Implement?	Progress/ Outcome, and Racial Equity measures	Notes
2A: There are several initiatives in motion to increase the number of Full-Service Partnerships (FSP) in Alameda County (Disability Rights California/Department of Justice Settlement, Forensic Plan Implementation, Proposition	**Key Partners**: • CBO Providers • Housing Services • Interagency County Partners/Agencies	• Additional expansion (beyond what is already planned through CARE Courts and other requirements)	• No additional funding required. BHD MHSA (BHSA) allocation will serve as basis for increase of FSPs per requirements already	• Outcomes, fidelity, health equity, and quality reviews are already implemented and planned pursuant to FSP	• Expansion of FSP slots countywide is already underway.

DRAFT



1/MHSA reform). The DRC settlement requires assessment of the number of FSPs by November 2024. Based on the DRC mandated assessment, the recommendation to ACBH is to: • ensure that the **number of FSPs available in Alameda County meet the demand/needs of the community**. • make any **unused FSP slots available to/filled by individuals who need them**. • provide a **monthly report to the community on the number and type of available FSPs, including the number that are unused.**	**Consult with**: • Indigo Consultants • Department of Health Care Services (DHCS) regarding changes relative to the passage of Proposition 1	can provide support to individuals impacted by the expanded LPS Criteria (SB 43) • Will support individuals with more severe mental illness.	established by Proposition 1. • Full implementation required by December 2024 (CARE Courts) and July 1, 2026 (BHSA).	regulation established by the State of California. • Evaluative comparison of CBO performance measures may be needed in determining expansion protocols (between agency performance assessment). • Regarding Recommended item "provide a **monthly report to the community on the number and type of available FSPs, including the number that are unused" –** BHD is currently working to improve real-time systemwide access to programs, including "FSP slots." This process will also assist with	• FSP system assessment for capacity and community need already completed. Additional planning and assessment will be needed once requirements associated with Proposition 1 are implemented (2026). • FSP expansion will only serve a particular segment of the community with severe behavioral health needs, additional assessment will be required to ensure others not eligible for this serve are provided with alternative supports and/or referred to other state or local programs given legislative changes.

				the timely implementation of CARE Courts by December of 2024 as stipulated by law.	
2B: Interagency Communication and Coordination: In the interest of non-duplication of efforts and prevention of individuals falling through the cracks of services, the Taskforce recommends the following actions to increase collaboration between agencies: • **Each county agency to assign a delegate** to be the inter-agency communication liaison. If it is not possible to have a dedicated staff person, then establish a communication strategy. **(All Agencies)** • **Create a central contact point for triage and communicating** to clients and Public Defenders about services so programs don't get overbooked. **(ACPD)** • **Community MH providers contacted by custody staff upon intake** and during service coordination to plan for possible referral to service providers for collaborative courts or appropriate discharge and service coordination. **(ACSO)** • ACBH/AFBH, ACSO/Wellpath to implement **coordinated service assessment and connection** to in custody services and referrals for CBO providers. (**ACBH**, ACSO)	**Key Partners**: • County • ACSO • ACPD • Alameda Health System (AHS) • SSA • Wellpath **Consult with**: • DHCS • Family and Client/Peer based organizations	• Improved care coordination, including a reduction in unnecessary incarceration, hospitalization, unemployment, and homelessness. • Improved quality of care for clients and families.	• Use of Health Equity Division dashboard (June 2024) to evaluate trends in serve delivery and care, systemwide. • No additional funding required as already in progress/budgeted. • **Service Roadmap**: completed via interagency agreements and newly developed policies and procedures within Santa Rita Jail (SRJ). Visual outward-facing roadmap planned in tandem with new legislative requirements (Proposition 1, CARE	• Forensic, Diversion, & Re-Entry System of Care, Director/ designee will serve as the interagency liaison. • BHD (ACBH) Offices of Clinical Operations (Mental Health, SUD, and Forensics), Integrated Services (Health Care & Crisis Services), and Health Equity Division will continue to monitor system need, capacity, and implementation of regulatory and other requirements informed by county litigation.	• Coordinated service assessments and connection with custody services and system already in place. Referrals to other BH systems and providers, including health care providers by county or contracted CBOs implemented. • Office of Family Employment Services, within the Division of Health Equity has expanded staff to implement more effective coordination with forensic/ justice-involved system partners and other agencies, including social services,

DRAFT

• ACBH/AFBH, ACSO/Wellpath to implement **coordinated discharge efforts** and central point of contact for CBO providers. (**ACBH**, ACSO) • Assign personnel to **family liaison roles** within ACBH FSC or Alameda County Sheriff's Office (ACSO) in order that family caregivers are able to provide what can be vital information on the medical and psychiatric history and current needs of the incarcerated person. (**ACBH**, ACSO) • **Service roadmap**: ACBH to develop a roadmap from Santa Rita Jail (SRJ) to the programs and facilities providing treatment and re-entry support. **(ACBH)** • **Evaluate the implementation of all elements of a No Wrong Door policy**, as required by CalAIM, in Alameda County, and determine needed next steps that ensure access to care. **(ACBH)** • Conduct a **comprehensive assessment and redesign of ACBH ACCESS line** that ensures access to services consistent with CalAIM, No Wrong Door policy, and clinical need. **(ACBH)** • **Non-clinical public safety database at county level of high-contact individuals**; LE, DA's Office, Probation/Parole communication too. (**ACSO**)			Courts, SB 43, CalAIM, etc.). • **ACCESS Line Comprehensive Assessment & Redesign**: Assessment November of 2021 Redesign currently underway, including bringing 'in-house' referrals to substance use provider organizations, and improving coordination with Alameda Alliance and other private health care agencies responsible for Mild-Moderate populations. Also evaluating additional methods by which to enable providers to increase real-time access and referral coordination.		healthcare organizations, and other public/non-profit advocacy groups.

DRAFT

2C: The Safe Landing Project (SLP), located in a recreational vehicle parked on the grounds just outside of Santa Rita Jail and operated by Roots Community Health Center, provides re-entry support services to just-released incarcerated individuals. The SLP seeks to connect individuals leaving Santa Rita with a variety of services, including transportation to appropriate treatment facilities. **ACBH should engage with Roots Health Center and explore how SLP can be expanded** to: • Provide services 24/7; • Operate out of a permanent structure; and • Have a presence inside the jail so staff have an opportunity to engage with incarcerated individuals prior to their release. • Provide Emergency Medication Screening and Prescription & Physical medications	**Key Partners**: • ACSO • Roots Community Health Center • County General Services Agency (GSA) • Wellpath – Medications • Courts, ACPD, DA **Consult with**: • Department of State Hospitals (DHCS)	• Continuity of Care & Improved Outcomes • Decrease recidivism to SRJ & Locked Facilities (i.e., John George Psychiatric Hospital - JGPH)	• Additional operating data required from provider (Roots) to determine capacity for 24/7 coverage, beyond 100% increased program expansion already authorized by BHD (ACBH). • Roots & ACSO are currently working with support by BHD to identify SRJ location inside the jail as planned. Facilities. Additional data from GSA needed in consultation with ASCO to formally develop permanent, internal SRJ space required.	• The Forensic, Diversion, and Re-Entry System of Care will complete an assessment for the potential for expansion with all noted providers by December 31, 2024 (pursuant to the availability of Proposition 1 funding and county approved budget process.	• BHD has already allocated funding to increase the SLP program by 100%. • Emergency Medical Screening has already been implemented (Wellpath/Adult Forensic Behavioral Health - AFBH). • Emergency Psychiatric Medications administered by Wellpath and prescribed by County AFBH have already been implemented. BHD (ACBH) has increased support to SRJ through the purchase of additional non-reimbursable to Medi-Cal medications to treat Opioid Overdose and treatment. Expansion of Medical Assisted Treatment (MAT) already in progress

DRAFT

					through provider contracted by BHD (AFBH/BHD -ACBH). ● AFBH/ BHD-ACBH is currently planning to implement EASS program (Early Access and Stabilization Program) to improve coordination and availability of care for SRJ clients. County also exploring use of Involuntary Medications to support individuals DSH treatment plans (restoration), decrease periods with lack of needed psychiatric medication, and brief/cycling trips to JGPH.
3. Community Based Support/Outreach/ Education					

DRAFT

Context:

Community-based support including family support, outreach, and education play a crucial role for those living with serious mental illness including justice-involved individuals for several compelling reasons:

a. **Reduced Stigma:** Community-based initiatives help reduce the stigma associated with mental illness and criminal justice involvement. By raising awareness and providing education, these efforts foster a more understanding and supportive environment for individuals re-entering society.
b. **Enhanced Access to Services**: Outreach programs can connect individuals with essential services, including mental health care, substance abuse treatment, housing, and employment opportunities. This accessibility is vital for those who might otherwise face barriers to receiving the help they need.
c. **Continuity of Care:** Community-based support ensures continuity of care for individuals transitioning from incarceration to community living. This seamless care can prevent relapses, reduce the risk of reoffending, and support overall health and well-being.
d. **Tailored Interventions:** Community services are often more flexible and can provide more personalized support tailored to each individual's unique needs, taking into account their specific challenges and strengths.
e. **Building Support Networks:** Community engagement helps build essential support networks of peers, healthcare providers, and mentors. These networks can offer encouragement, advice, and assistance, which are critical for successful reintegration and long-term recovery.
f. **Empowerment:** Community-based programs often emphasize empowerment, helping individuals develop the skills and confidence to manage their mental health, navigate societal challenges, and make positive life choices.
g. **Prevents Cycling Through Systems:** Providing targeted support and education in the community can prevent individuals from cycling between the criminal justice system, emergency departments, and homelessness, which is common among those with untreated mental health issues.
h. **Promotes Public Safety and Well-being:** Successful reintegration of justice-involved individuals into the community, into family and supported by mental health services, contributes to the overall safety and well-being of the community by reducing recidivism and promoting healthier lifestyles.

In sum, community-based support, outreach, and education address critical gaps in care and support for justice-involved individuals with mental illness, leading to better outcomes for these individuals and society as a whole.

Recommendation	Partner(s)	Problem that it Solves	Data needed? Budget request? Time to Implement?	Progress/ Outcome, and Racial Equity measures	Notes

DRAFT

3A: Peers must be provided with adequate training, support, and compensation to serve in front line, promotional, decision-making, and leadership positions. Training/support should include: • Specialty and diversion programs, resources, and outreach information to improve grassroots coordination including linkages in threshold languages (**all Agencies**); • Court operations, legal language, and making decisions (**Court, PD/DA**); • interventions to facilitate peer support groups, family collaboration, street outreach, and de-escalation services (**ACBH**); • Jail services, in-reach, and advocacy (**ACSO,** ACBH); • access to decision-making meetings and validate (uplift?) peer expertise (**all Agencies**); • Medi-Cal billing and other charting to expand peer tasks/positions (**ACBH**); • Support/subsidies to help peers obtain certifications, credentials, and on the job experience (**all Agencies**); • Fair pay for lived expertise as equitable to professional and educational experience (**County and Agencies**).	**Key Partners**: • County • ACSO **Consult with**: • DHCS • California Mental Health Services Authority (CalMHSA) •	• Improves quality of care • Increases application of more intentional culturally, linguistic, and experiential care provided by individuals and family members with lived experience.	• No additional funding needed. • Health Equity Division Data to be utilized to coordinate more effectively across locked setting, including SRJ & JGPH.	• CBO Contracts, currently employing Peer Workers, will have the opportunity to bill MediCal (MH & SUD) services to expand system wide services. • County Progress will be monitored by full implementation of Data Dashboard (no later than December 2024). • Peer & Family Member System Expansion & Assessment to be completed no later than 3rd Quarter of Fiscal Year 2025-2026.	• BHD (ACBH) has already increased staffing to its office of Family Empowerment. The increased staffing and new leadership will offer the county an opportunity to pivot towards the full implementation of MediCal Billing through Peer services. • BHD's (ACBH) Workforce, Education, & Training Unit is also being transferred to the department's Health Equity Division to better improve the department's expansion of peer specialist designated positions able to bill Medi-Cal. Existing county positions (Mental Health Specialists) will be enhanced by the addition of a professional position/designation

DRAFT

					of Peer Specialists as defined by DHCS and recent legislation (SB803). NOTE: Alameda County (BHD/ACBH) was the first county statewide to opt in to SB803.
3B: Expansion of peer workforce must include placement in key spaces and uplifting of their expertise in front-line and leadership roles. These positions/locations include: • **School liaison to support families**, provide respite, and mitigate conflicts (**ACBH** and Center for Healthy Schools); • **Family case manager/liaison for John George and Cherry Hill** to respond to early MH episode situations (**ACBH** in partnership with AHS); • **Outreach in high-contact areas** (e.g., hospitals, respite, etc.), community, and community hubs (HCSA**, ACBH**, AHS, ACSO, ACPD); • **Jail in-reach** inside intake, units, and releasing (**ACSO** and AFBH); • **Peer-led interventions in housing program**s and other spaces to address vicarious trauma and practice restorative practices (**ACBH** and OHCC);	**Key Partners**: • County • CBO Providers • AHS • ACSO • ACPD • OHCC (Alameda County Health Housing Services) • Center for Healthy Schools (Alameda County Health) **Consult with**: • DHCS •	• Improves systemwide care coordination, particularly through individuals with lived experience. • Improves quality and outcomes.	• Additional funding will be needed to increase # of county positions assigned within the offices of Peer Support Services & Family Empowerment (Health Equity Division) given that funding to these areas is limited following the passage of Proposition 1. The county (BHD/ACBH) is committed to maintaining current funding levels. Expansion will require alternative funding sources, beyond	• CBO provider contracts are currently expanding system wide to enable (and encourage the use of Peer-based coordination). • The Workforce, Education, & Training (WET) Unit will also monitor and establish system wide goals for the implementation of this recommendation (including the establishment of actionable metrics).	• Alameda Health System currently employees Social Worker and other Case Management staff to support family members. BHD (ABCH) also supports Patients' Rights Advocates (Mental Health Association of Alameda County - MHAAC) onsite at JGPH. • Current CBOs terms and conditions (contractual terms) will require review by the Office of Health Equity to determine ability to

DRAFT

DRAFT

• **Placement within the court systems** to help families understand processes, navigate, and connect to service (Court and **PD**); • **Clinical peers to conduct street health** and on first responder teams (HCSA, **ACBH**, LEA); • **Peer inclusion at County and Agency decision-making**, policy, and funding meetings (**all Agencies**).			departmental resources. • Expansion of CBO provider contracts will also require fiscal analysis given reductions to this area, c/o the restrictions in funding associated with Proposition 1. Individuals currently enrolled or eligible for enrollment in FSPs will most readily be able to access this support, without required funding/additional CBO contractual expansion.		implement.
3D: Alameda County Public Information Campaign with loved ones, caretakers, school personnel and neighbors being the primary audience. Information must be provided about: • Peers, the work of peers, where/how to find them, and how to become a peer;	**Key Partners**: • County • BHD (ACBH) Systems of Care, Office of Health Equity **Consult with**: • Indigo	• Increase community education and awareness of existing programs, pathways for access to care, as well as navigation of systems	• $0.5 Million dollars annually (over 5 years) has already been identified by BHD (ACBH) to secure a Public Media Campaign, specifically targeting individuals	• The Health Equity Division (BHD – ACBH) will continue to work within and across the department; and across CBO and county agencies.	• An extensive Crisis Intervention Training (CIT) program already exists and has been enhanced and now assigned to the BHD (ACBH) Crisis System of Care for

• Community centers, local resources, and how to find them; • Alternatives to calling police and crisis intervention teams; • Community meeting and advisory boards.	Consultants • Alameda County Health, Communications Office	(complex mental health/ substance use systems established by legislation). • Potentially decreases unnecessarily/repeated hospitalization and incarceration of individuals with mental health and substance use conditions.	at risk for Substance Use (Opioid addiction, risk, and overdose). This campaign will target and outreach to individuals and family members, specifically. • Additional funding will need to be identified, beyond resources also allocated to improving outreach, information, and engagement with peers and Family members (and WET) around system navigation and access to care ($0.5M in Fiscal Year 2025-2026).	• The Office of BHD Director; and Alameda Health's Communications Office to identify ways in which to expand public awareness.	ongoing oversight and quality improvement.
3E: ACBH/HCSA to identify a **staff or team responsible for engaging with Law Enforcement Agencies regarding MH diversion** and interventions. The team will: • Develop, update, and disseminate literature to law enforcement agency (LEA);	**Key Partners**: • County **Consult with**: • DHCS (Proposition 1)	• Improved awareness, outreach, training, and engagement.	• BHD (ACBH) will maintain current funding levels to support training and educational materials already supported through the Crisis System of	• Once Hired (May 2024) the BHD (ACBH) Workforce, Education, & Training Manager will spearhead the dissemination of updated and	• An extensive Crisis Intervention Training (CIT) program already exists and has been enhanced and now assigned to the BHD (ACBH) Crisis

DRAFT

• Facilitate training/informational meetings with LEA about available options; • Evaluate LEA on their crisis intervention team (CIT) training.			Care and Health Equity Division/ WET Units. • Additional funding opportunities may enhance the additional dissemination of training and informational materials in alignment with Proposition 1 (available funding opportunities).	expanded materials (including system navigation tools) available to providers, agencies, county organizations, clients, and family members. An initial phase of updated materials will be disseminated no later than December 2024. • The Crisis System of Care will continue to serve as lead for Crisis work and coordination with law enforcement regarding education and the dissemination of literature (Crisis and utilization of outreach, and treatment centers/programs). • The Forensic, Diversion, and Re-Entry System of Care will also coordinate directly with law enforcement to	System of Care for ongoing oversight and quality improvement. • The BHD (ACBH) Forensic system currently participates across county systems and will continue to increase visibility and participation to promote increased awareness.

DRAFT

				increase availability of training and accessible information.	
3J: Develop a **service training program and collaboration between ACBH & local university, community college, and school-based (middle & high) health systems for early identification of mental illness** among older youth and transitional age youth (TAY). This service training program would train school-based mental health counselors on proper family notification, expedited referral pathways from school-based health systems to ACBH programs, and awareness about early warning indicators for other campus staff (residential advisors, educators, etc.).	**Key Partners**: ● County, Local colleges, universities. ● Oakland Unified School District ● Alameda County Health, Center for Health Schools **Consult with**: ● DHCS	● Improved client access, capacity & skill-building, and community engagement.	● Given the passage of Proposition 1, Prevention dollars are no longer funded by MHSA/BHSA. As such, the Department will explore current county and contracted programs available to support early intervention (which includes the early identification of mental illness) although the overall dollars available to the county system will decrease in 2026.	● The WET Unit (within the Office of Health Equity) will coordinate with the MHSA Division's Prevention & Early Intervention Unit to identify currently funded programs; and the capacity to programming that aligns with current (and Proposition 1) proposed regulatory requirements.	● BHD has already assigned the WET unit to perform and monitor training and other system need tasks. ● Elements related to primary or expanded prevention are no longer eligible through BHSA. These resources will be officially re-aligned to DHSA effective July 1, 2026 (when BHSA begins). The Department can identify new ways to recalibrate its training to address coordinated care and training of county and providers to improve care. See also previous

DRAFT

					sections.
3K: Assess the capacity of providers who work with TAY (such as at-risk 16–17-year-olds) who are homeless or at risk of homelessness on their **ability to connect youth to housing, workforce, and supportive services**, and fund them as appropriate to increase and scale services to meet any unmet needs.	**Key Partners**: • County Child and Young Adult System of Care – contracted CBOs • BHD (ACBH) Vocational Services Division • SSA • BHD (ACBH) Financial Services • Alameda Health, Housing Services **Consult with**: • Indigo Consultants	• Quality Improvement	• As the local Alameda County Mental Health and Substance Use Plans, BHD (ACBH) is already required to regularly evaluate provider capacity and performance, including rates available for payment as a community-based provider. • CalAIM supports pay for performance, and other quality metrics that will also inform reimbursement.	• BHD (ACBH) Financial Services is currently working to identify the funding available for Fiscal Year 2025-2026, which will include approved rates already submitted for review by the County. It is expected that the availability of BHD to increase rates (subject to county guidelines) will be established no later than July 15, 2024.	• BHD (ACBH) will ensure its compliance with county processes, related to procurement and the selection of potential single source providers to support the Transitional Age Youth (TAY) system.

DRAFT

3L: First Episode Psychosis: The standard of care for treatment of first episode psychosis (FEP) is Coordinated Specialty Care (CSC) – a team based, person-centered approach offering case management, recovery-oriented psychotherapy, medication management, family support and education, and supported education and employment.[1] Felton Institute runs two integrated CSC-FEP programs serving TAY-aged youth who have Alameda County MediCal or are MediCal eligible. The re (Mind) program specializes in schizophrenia-spectrum disorders, the BEAM program in bipolar and other mood disorders. Located in the City of Alameda, these programs have a combined capacity of 100 individuals. By one estimate, the need for specialty FEP care in Alameda County's MediCal-served population is 1,000 individuals per year [2] -- 10 times Felton's capacity. Felton's targeting of youth aged 15 - 25, while well-justified, misses a large number of individuals whose initial presentation of psychosis appears later. Their location in the City of Alameda likely poses barriers to potential participants. **Recommendations:** A. **Program evaluation –** Felton participates in U.C. Davis' statewide evaluation of FEP programs. Evaluation of Felton's Alameda program is expected toward the end of the year.[3] Felton and ACBH should make this evaluation public and available to the group designated to monitor the CFJL implementation.	**Key Partners:** • DHCS **Consult with:** • Felton Institute	• TBD	• TBD	• TBD	• Early intervention services have been approved for inclusion, following the passage of Proposition 1. However, BHD (ACBH) will require additional consultation with DHCS to ensure what is proposed will be aligned with the new legislative approach to service delivery. As is described, current programming may/not be in alignment with this newly approved legislation.

DRAFT

B. **Public awareness -** Develop a public information campaign to promote awareness of Felton's FEP programs. Rationale: The program is currently under-enrolled by 50 percent and among the general groupings of experienced volunteer family advocates and family organizational leaders, there's little awareness of families who've utilized its services. C. **Expand participation** - Age restriction and program location should be studied as limits or barriers to participation. The possibility of opening a second location, closer to areas of greatest need, should be considered .					
3M: ACBH should review its on-line directory of services for its accessibility to an average citizen, reading at a 6 grade level. Change language and description of services as needed for ease of navigation for both those with elementary reading skill and those who are reading proficient. Also, while ACCESS and the on-line directory are current and important services, the general public, and some providers, report being unaware of them. Initiate a public awareness campaign to make visible these critical resources.	**Key Partners**: ● County ITD ● BHD (ACBH) WET Unit, Health Equity Division, Systems of Care ● BHD (ACBH) Plan Administration ● Alameda County Health, Communications Unit **Consult with**: ● DHCS as needed.	● Increasing access and improving health equity.	● No additional data or budget needed.	● The department's Quality Management Program will review content and work in tandem with related offices. This review is ongoing but will center on the directory. BHD (ACBH) Plan Administrator will review contents of this page and develop an update plan (consistent with DHCS requirements) no	● BHD (ACBH) is required to regularly assess readability, including ensuring that public facing materials are published at a 5-grage reading level and translated, minimally, into the County's threshold languages (established by DHCS).

DRAFT

	• BHD (ACBH) Quality Management • External Quality Review (EQR) Organization/ DHCS.			later than October 1, 2024.	

4.5 Treatment Beds

Context:

Acute and sub-acute residential beds are essential for meeting the needs of individuals who have a serious mental illness (SMI) and, therefore, are a crucial part of the continuum of behavioral health care. The Task Force considered the question of whether there are enough acute and sub-acute residential treatment beds in Alameda County to serve the needs of individuals with serious mental illness effectively. Answering this question was difficult because, unfortunately, Alameda County has never assessed how many acute and sub-acute beds are needed for this population. Nevertheless, it appears to the Task Force that there is a shortage of acute and subacute treatment beds in the County. The Task Force bases this view on what appears to be a consensus in the psychiatric community that a community needs 50 in-patient adult psychiatric beds per 100,000 adults in the population (26 per 100,000 at the acute level and 24 per 100,000 at the sub-acute level).[1] Alameda County has approximately 1.3 million adults, and therefore, by this metric, Alameda County needs 338 in-patient adult psychiatric beds at the acute level and 312 in-patient adult psychiatric beds at the sub-acute level. The Task Force has concluded that in light of these metrics, there is a slight shortfall of acute beds and a much larger shortfall of sub-acute beds in Alameda County.[2]

The need for more sub-acute treatment beds is exemplified by the fact that at John George, a significant number of beds are occupied by patients who no longer need acute treatment, but due to the lack of beds at Villa Fairmont and other "drop-down" facilities, they stay longer at John George than they need to. Likewise, discharge planners at Villa Fairmont have reported that the dearth of licensed Board and Cares (Adult Residential Facilities) means that people who are ready to leave a sub-acute facility like Villa Fairmont cannot be dropped down to that lower level of care in community residential treatment. Identifying the source of these bottlenecks is crucial so that wise investments can be made.

[1] See, "Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California - 2021," McBain, et. al (https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html)
[2] In the acute category, Alameda County has 69 beds at John George (not including PES); 68 beds at Herrick; 148 beds at Fremont Hospital (but many of these beds are for Minors); 18 at Kaiser Fremont; and 26 at Heritage. This is a total of 329 acute beds (a "shortfall" of at least 9 acute beds).
In the sub-acute category, Alameda County has 93 beds at Villa Fairmont; 39 beds at Gladman; 78 beds at Morton Bakar; 20 beds at Garfield; and approximately 30 beds when the new Mental Health Rehabilitation Center (MHRC) at St. Regis comes online in 2027. This is total of 260 in the sub-acute category (a "shortfall" of at least 52 beds).

DRAFT

Recommendation	Partner(s)	Problem that it Solves	Data needed? Budget request? Time to Implement?	Progress/ Outcome, and Racial Equity measures	Notes
4.5A: The Task Force recommends that Alameda County **create more psychiatric treatment beds**, especially at the sub-acute level, to reach the numerical levels set forth above.	**Key Partners**: • Alameda Health System • County Contracted CBOs **Consult with**: • DHCS •	• Potential service delivery benefit for clients requiring hire level of treatment and support.	• BHD (ACBH) has already identified funding to increase the system's current capacity of acute psychiatric care and has increased the number of beds at Villa Fairmount. • BHD (ACBH) is also pursuing capital funding through the Behavioral Health Continuum Infrastructure Program (BHCIP) via DHCS to secure additional beds that may be dedicated to individuals suffering both from Acute psychiatric and medical needs. This opportunity is subject to CA State Budget and DHCS release of these	• BHD (ACBH) has already competed a system assessment regarding the beds required (including sub-acute) for the system and will be monitoring the implementation of the Villa Fairmont Expansion, and the expansion of beds already funded (aside from the prior column) and those planned. Current capital facility plans are anticipated for completion by 2028 (subject to state, local, and construction related requirements/ deliverables).	• Given the importance of patient's/client's right to the care at the lowest level, BHD (ACBH) will also continue to monitor system expansion in this area to ensure that it operates according to legislative and litigation agreements approved through the court process. As such, the department will continue to ensure compliance with these areas while navigating the need for increased serve options for individuals suffering from several mental illness and substance use

DRAFT

			funds (and subsequent approval of Alameda County). • Additional capital expansion dollars will be submitted in Round 6, to complete expansion of sub-acute beds to support the system (including implementation of SB43, expanded LPS definition and likely expected treatment; CARE Court, and the addition of more intensive services that may be delivered to the SUD population through the passage of Proposition 1.		conditions.

DRAFT

4.5B: The Task Force recommends that the County assess the unmet needs of individuals with serious mental illness to determine how many psychiatric treatment beds, at all levels of acuity, are needed in the County. Because the issues are so interrelated, this "Bed Assessment" should happen at the same time as the County is already doing the Full-Service Partnership Assessment and the Mobile Crisis Assessment pursuant to the settlement of the Disability Rights lawsuit.	**Key Partners**: ● DHCS ● CBO **Consult with**: ● Indigo	● Continuity of Care	● No Data/ Funding required. Already in process.	● Already in process. TBD	● Already in process pursuant to county planning for CARE Court, SB43, CalAIM, and Proposition 1 landscape/ funding changes.
10. Staff Training & Professional Development					

DRAFT

Context:

Training and professional development for staff who work with justice-involved individuals with mental illness are important for several reasons, each contributing to more effective, compassionate, and appropriate care for this vulnerable population. Here are the key reasons why such training is crucial:

a. **Enhanced Understanding of Mental Illness:** Training provides staff with a deeper understanding of mental health conditions, their symptoms, and how they can impact behavior. This knowledge helps staff to better identify the needs of people with mental illness and respond to those needs effectively;
b. **Improved Communication Skills:** Communication is critical when working with individuals with mental illness. Professional development can equip staff with the skills to communicate more effectively, ensuring they can offer support, de-escalate potentially volatile situations, and build trusting relationships with those in their care;
c. **Use of Evidence-Based Practices:** Training gives staff access to the latest research and best practices in the management and treatment of mental health conditions within the justice system. This ensures that individuals receive care that is based on the most current understanding and methods available;
d. **Increased Safety:** Proper training can significantly enhance the safety of both staff and the individuals they work with. Understanding how to de-escalate tense situations, manage crises, and intervene effectively can prevent harm and ensure a safer environment for everyone involved;
e. **Reduced Stigma and Discrimination:** Ongoing professional development can challenge and reduce stigma and discrimination against individuals with mental illness. Training programs often include components that address personal biases, fostering a more respectful and empathetic approach to care;
f. **Legal and Ethical Compliance:** Staff must be aware of the legal and ethical considerations when working with justice-involved individuals with mental illness. Training ensures that staff understand these responsibilities, helping to protect the rights of those in their care and reduce the risk of legal issues;
g. **Adaptability and Resilience:** The landscape of mental health and criminal justice is continually evolving. Training and professional development help staff to adapt to new laws, policies, and practices, ensuring they remain effective and resilient in their roles;
h. **Improved Outcomes for Individuals:** Ultimately, the aim of all training and professional development is to improve the outcomes for justice-involved individuals with mental illness. Through better understanding, effective practices, and compassionate care, staff can play a significant role in supporting the recovery and rehabilitation of these individuals.

Investing in the training and professional development of staff is not only beneficial for the staff themselves but is also a critical component of providing the highest quality care to justice-involved individuals with mental illness.

Recommendation	Partner(s)	Problem that it Solves	Data needed? Budget request? Time to Implement?	Progress/ Outcome, and Racial Equity measures	Notes

DRAFT

10D: ACBH should **enhance the availability and delivery of mental health services for individuals who are currently or previously incarcerated at Santa Rita.** Enforce mandatory and consistent service standards for individuals with diagnoses, both during custody and after release, incorporating triggers for elevated service levels for those with recurrent incarceration instances. Strengthen the collection of diagnosis types and severity, as well as clinical and service data on clients' jail-based services, to ensure appropriate support and connection to housing, psychiatry, medical care, and other supports during reentry.	**Key Partners:** • ACSO **Consult with:** •	• Improved outcomes for individuals	• No Data/ Funding required. Already in process. • BHD has allocated $5.3M over the next two fiscal years to support individuals' need for Medication Assisted Treatment at SRJ (not billable to or covered by Medi-Cal). BHD (ACBH/AFBH) providers will continue to prescribe medications and work in coordination with ASCO contracted provider (Wellpath) to ensure improved quality of care and outcomes.	• Implemented and ongoing. • BHD (ASCO/AFBH) has modified and developed policies to improve care, clinical treatment, and coordination with county/ contracted providers – including those contracted by ASCO (Wellpath).	• Implementation of process and clinical standards highlighted here are already in progress. • Established trainings, Care coordination teams, and increased coordination with SSA also aligned with this recommendation. • Care coordination team(s) have already been established by the BHD Forensic, Diversion, and Re-Entry System of Care via AFBH to enhance care delivery and coordination outside of incarcerated settings as well.

DRAFT

10E: Culturally competent countywide training for first responders in MH crisis services and 5150 assessments: In order to address equity gaps and race-based discrimination in first crisis response, the Taskforce recommends multiple actions specifically for crisis and first responders countywide. 1. **Conduct an evaluation of the current Crisis Intervention Training (CIT) curriculum to identify levels of inclusivity** in regard to racial realities and cultural responsiveness. Based on this analysis, the Task force recommends: ● Any assessment to include a criteria checklist (including a racial equity lens, a concern for decarceration, and success metrics). ● **ACBH to make quarterly reports to the Health Committee** of the Board of Supervisors on the progress (capacity of treatment and training). 2. **Pay Equity throughout the county** ● Align pay to staff and contractors for mobile behavioral health crisis team (CATT and MCT) staff with County compensation structures ● Ensure fair compensation for mobile behavioral health crisis team (CATT and MCT) staff and expand 24/7 city and county crisis response teams to all parts of Alameda County. Several reports indicate that persons who staff the County's crisis response teams are not paid adequately and work in unsustainable conditions.	**Key Partners**: ● BHD (ACBH) Crisis Services System of Care ● BHD (ACBH) Workforce Education, & Training Unit (Health Equity Division) ● County Contracted CBOs ● Healthcare Facilities **Consult with**: ● DHCS ● Crisis Support Services	● Health Equity Driven approach to care, systemwide.	● No additional data or funding required. Evaluation of CIT already completed. Currently operated and managed by the BHD (ACBH) Crisis System of Care, Office of Integrated Services. ● Regarding **"ACBH to make quarterly reports to the Health Committee** of the Board of Supervisors on the progress (capacity of treatment and training)" – subject to BOS approval. ● Regarding "… Pay Equity throughout the county" – BHD (ACBH) is able to incentivize CBO organizations to increase pay through higher contract allocations, however the	● CIT Training Re-tool & System Progress completed and available for use.	● The county is not responsible for the administration of pay schedules within organizations; nor is it able to intervene with personnel matters (including salaries) not directly impacting client or family-member care. ● Incentive payments for innovative recruitment and retention strategies have been implemented in recent fiscal years and will be explored (subject to funding availability and the implementation of Proposition 1) in the future.

DRAFT

			department is unable to establish pay equity as they are individually administered through CBO organizations. CalAIM pay for performance, and changes with payment structure (to Fee for Service) will also require CBOs to implement programs to have an opportunity to draw down increased funds to the organization (and thereby, offer higher pay schedules).		

11. Family Supports

Context:

Family support plays a crucial and multifaceted role in the lives of justice-involved individuals with mental illness. The importance of this support can be understood through several key perspectives:

a. **Emotional and Psychological Stability**: Family support provides a crucial emotional anchor for individuals facing the double challenge of mental illness and legal issues. The knowledge that one has a supportive network can significantly mitigate feelings of isolation, stress, and anxiety, which are common in such situations. Families can offer a sense of belonging and unconditional support, which is vital for emotional and psychological stability;

DRAFT

b. **Advocacy and Navigation:** Navigating the justice system, along with mental health services can be overwhelmingly complex. Family members can advocate for their loved ones, ensuring they receive fair treatment and appropriate care. They can help navigate legal processes, communicate with attorneys, and ensure their relative's rights are protected. Additionally, they can assist in coordinating mental health care and advocating for services that meet the individual's specific needs;
c. **Continuity of Care:** Individuals with mental illness often require ongoing treatment and support. Families can play a significant role in maintaining continuity of care, especially when transitions occur between the justice system and community-based care. They can help manage medications, appointments, and treatments, ensuring their loved one adheres to care plans that contribute to their recovery and well-being;
d. **Reintegration Support:** Reintegrating into society after involvement with the justice system can be a daunting process for individuals with mental illness. Families can provide crucial support during this transition, offering a stable environment and assisting with practical aspects such as finding employment, continuing education, and rebuilding social connections. Their support can significantly impact the individual's ability to reintegrate successfully and reduce the likelihood of recidivism;
e. **Reduced Stigma:** Families can play a vital role in challenging the stigma associated with mental illness and involvement in the justice system. By openly supporting their loved ones, they can contribute to changing societal attitudes and fostering a more understanding and compassionate community environment;
f. **Resource Access:** Families often become the primary researchers and connectors to resources for their loved ones. They can help identify and access various supports available, including legal assistance, mental health services, financial aid, and community-based support groups. This role is especially critical when individuals might be overwhelmed or unable to seek out resources themselves;
g. **Monitoring and Early Intervention:** Family members, being closely connected to the individual, are often in a position to recognize early signs of mental health distress or relapse. This proximity allows for early intervention, preventing crises, and ensuring timely access to treatment and support.

In summary, family support is indispensable for justice-involved individuals with mental illness. It provides emotional sustenance, practical assistance, and advocacy. It enhances the likelihood of better outcomes across various legal, health, and social domains, contributing to a more compassionate and effective approach to mental illness within the justice system. Particularly for many family members without access to a private psychiatrist, the informational void is vast. Particularly in the prodromal phase of an illness, when families are mystified by behavioral changes, early diagnosis, and care can lead to far better outcomes than others face after periodic episodes of psychosis. What we learn from psychiatrists is that each psychotic episode can mean further insult to the brain and deterioration of competencies. By connecting people with timely and appropriate advice and services, it's anticipated that the number of SMI/SUD unhoused, 5150s, and incarcerations, including the high rate of recycling admissions and incarcerations, will be reduced. It should be noted that it is not uncommon for individuals to lose family member housing as the mental illness or substance use behavior deteriorates.

Recommendation	Partner(s)	Problem that it Solves	Data needed? Budget request? Time to Implement?	Progress/ Outcome, and Racial Equity measures	Notes

DRAFT

11A: Assign a case manager or family navigator to any patient/family experiencing an early illness episode. This applies to anyone with Severe Mental Illness or Co-occurring Disorder (designated number 3 or 4 level of care in the jail) and/or exiting hospital on a psychiatric hold.	**Key Partners**: • CBO Providers • BHD (ACBH) Systems of Care • BHD (ACBH) Health Equity Division **Consult with**: • BHD (ACBH) Systems of Care • California Institute for Behavioral Health Solutions (CIBHS) • Individual Consultant	• Improved quality of care for client and family members.	• No additional funding required. Programs providing services to individuals with severe mental illness or co-occurring disorders are already providing services through case managers and care coordinators. • Individuals referred by the Health Plan (Alameda Alliance) are also receiving automatic case management services upon intake, through nursing staff to support any health-related need or referral to other health providers.	• BHD (ACBH) Health Equity Officer currently partnering with CIBHS, CalMHSA, and an outside Consultant to initiate systemwide changes to improve the active participation of the Office of Family empowerment (and Peer Support Services) to expand and retool the County's current capacity for this support. The Assessment and Integrated Plan (Workforce & Health Equity) is expected to be completed during the 3rd quarter of Fiscal Year 2025-2026.	• BHD (ACBH) has already increased staffing to its office of Family Empowerment. The increased staffing and new leadership will offer the county an opportunity to pivot towards the full implementation of MediCal Billing through Peer services. • BHD's (ACBH) Workforce, Education, & Training Unit is also being transferred to the department's Health Equity Division to better improve the department's expansion of peer specialist designated positions able to bill Medi-Cal. Existing county positions (Mental Health Specialists) will be enhanced by the addition of a professional position/designation

DRAFT

					of Peer Specialists as defined by DHCS and recent legislation (SB803). NOTE: Alameda County (BHD/ACBH) was the first county statewide to opt in to SB803.
11B: Involve families starting with the first mental health (MH) crisis (for example, at John George or Santa Rita) by doing the following: a. Assigning a caseworker or advocate to the family; b. Requesting a broad HIPAA Release of Information from the client as early as possible; c. Recruiting family advocates for crisis and outreach teams; d. Recruiting family advocates and giving them peer certification training; e. Having an office for family advocates (*for example Bev Bergman's office at John George*); f. Providing a culturally informed advice line for families and clients; g. Endeavoring to assign a psychiatrist and therapist to follow a client throughout their experience with the system and with medications.	**Key Partners**: • BHD (ACBH) Health Equity Division • BHD (ACBH) Crisis and Adult/Older Adult Systems of Care; Forensic, Diversion, and Re-Entry System of Care • Alameda Health System • BHD (ACBH) WET Unit • ASCO **Consult with**: • County Counsel • MHAAC	• Systemwide Care coordination; • Reduces recidivism across locked settings; and • Increases quality and care outcomes, overall wellness.	• No data required. • Additional funding may be required should additional county system increase its need for Family Advocates beyond the planned expansion of MHAAC services.	• BHD (ACBH) Health Equity Officer currently partnering with CIBHS, CalMHSA, and an outside Consultant to initiate systemwide changes to improve the active participation of the Office of Family empowerment (and Peer Support Services) to expand and retool the County's current capacity for this support. The Assessment and Integrated Plan (Workforce & Health Equity) is expected to be completed during the 3rd	• All BHD (ACBH) funded programs serving individuals with severe mental illness currently provide psychiatric medications should those be clinically indicated. Additional analysis of whether this recommendation requires system enhancements to provider/county operations is warranted as "endeavoring to assign a psychiatrist (and therapist) to follow a client throughout their experience with the system and with medications has

				quarter of Fiscal Year 2025-2026.	already been implemented and is a required component of the county's services to those with severe mental illness. Similarly to above, clients receiving the most intensive care are consistently assigned care managers who may provide therapy (therapist) should that be indicated; or clients with less severe symptomology are assigned individual therapists across the community should that be warranted instead. • All services are individually tailored to client need, legal requirements, programming, and must adhere to regulatory requirements/ ethnical standards for levels of care.

DRAFT

11C: Implement an Advice Line, broadly available (hours to be determined) and modeled after the Kaiser Advice Nurse line, and available to family caregivers, concerned family members, friends and consumers of psychiatric and substance abuse services. Success of service will depend on well-organized public introduction of its availability. • **Site of Service**: Recommend ACBH Psychiatry Department, under Chief Medical Officer, Aaron Chapman, MD, and Department's Deputy Director, Angela Coombs, MD, an African American psychiatrist with a specialty in first episode psychosis. The ACBH Psychiatry Department also houses Mobile Crisis Services. • **Rationale**: The Department of Psychiatry is arguably the best equipped to train and oversee an Advice Line staff, which will require a range of competencies in signs and symptoms of serious mental illness, psychiatric medications and the range of its side effects, equity issues including tendencies to over-medicate African American men and the complex service system. • **Expected Impact**: This service should be particularly helpful in supporting a wide range of families and consumers who invariably face challenging circumstances and decisions in supporting family	**Key Partners**: • CalMHSA • CBO Providers • **Consult with**: • BHD (ACBH) Office of Health Equity	• Improve timely access, support, and the initiation of treatment	• TBD.	• Timeliness standards across the system are currently being monitored both by BHD (ACBH) and the DHCS. Ongoing review will ensure that outcomes are sustained and improved should any operational changes be made in this area (pursuant to MH Plan and SUD Plan requirements).	• Warm Lines in general require multidisciplinary coordination, including those who may coordinate urgent consults/care with MD providers. As such, BHD (ACBH) will work to support systemwide coordination of psychiatric care via the Office of Integrated Services (Chief Medical Officer/ Medical Director's office) and not exclusively require that psychiatry/pharmacy services be the primary support to any potential warm-line services offered.

DRAFT

members or themselves in search of recovery.					

DRAFT