Alameda County Behavioral Health Care Services (BHCS)
Report on the AB1421 Planning Process

Prepared by:

Resource Development Associates

October 2014

This page left intentionally blank.

Acknowledgements

RDA would like to acknowledge the organizations and individuals that participated in this planning process. These individuals gave their time, their expertise, and most importantly, their insight, to support this planning effort, and their contributions were pivotal in developing the recommendations that follow. We at RDA extend our sincere thanks for their committed participation.

Alameda County Community AB1421 Planning Committee Members

Radawn Alcorn, Transition Age Youth System of Care, ACBHCS

Khatera Aslami, Office of Consumer Empowerment, ACBHCS

Vanessa Baker, Public Guardian-Conservator, Social Services Agency

Brian Bloom, Public Defender's Office

Bianca Bustos, La Clinica de La Raza

Anthony DeSousa, Sheriff's Department

Candy DeWitt, Family Member

Susan Drager, WestCoast Children's Clinic

Bettye Foster, Family Education and Resource Center

Alane Friedrich, Alameda County Mental Health Board

Steve Grolnic-McClurg, Berkeley Mental Health Department

Mary Hogden, Consumer Relations Team, ACBHCS

Yvonne Jones, Criminal Justice Mental Health Services/Conditional Release Program, ACBHCS

Katrina Killian, Alameda County Network of Mental Health Clients

Stephanie Lewis, North County Crisis Response Program, ACBHCS

Michael Lisman, Adult Community Support Centers, ACBHCS

Jay Mahler, Consumer Leader, ACBHCS

Alicia Morales, Public Guardian/Adult Protective Services, Social Services Agency

Andrea Mueller, Sheriff's Department

Peggy Rahman, National Alliance on Mental Illness, Family Member

Haeyoung Sohn, John George Psychiatric Hospital

Francesca Tenenbaum, Patients' Rights Advocacy Program, Mental Health Association of Alameda County,

Rosa Warder, Office of Family Relations Manager, ACBHCS

Shalon Woods, Bay Area Community Services

In addition, thank you to the following members who stepped in to reflect critical stakeholder voices when other members were unable to do so:

Patricia Fontana Narell, Family Member

Sally Zinman, Consumer

Tenli Yavneh, PsyD, Berkeley Mental Health Department

Support to Planning Process and Data and Program Analysis

The following individuals worked consistently to support, engage and maintain this planning process, for which we extend sincere thanks:

Aaron Chapman, MD, Medical Director, ACBHCS

Tracy Henretty, ACBHCS

Manuel Jimenez, MA, MFT, Director, ACBHCS

Gary Spicer, Director, Business Analytics and Compliance, HCSA

Samantha Stonework-Hand, County Counsel

Toni Tullys, Deputy Director, ACBHCS

Andrea Weddle, County Counsel

Victoria Wu, County Counsel

Board of Supervisors' staff

The RDA Team

Amalia Egri Freedman, Project Director
Roberta Chambers, PsyD
Jane Stallman, MBA, Center for Strategic Facilitation
Diana Sanders, MA
Ryan Wythe
Sarah Garmisa
Ari Nelson, MA
Elena Reyes

Use of Technical Language

The nature of this report requires the use of numerous technical terms and acronyms throughout in order to accurately detail the work and recommendations of the Planning Committee. A Glossary of Terms is included in Appendix 1.

Table of Contents

Contents

This page left intentionally blank.

Executive Summary

In California and across the nation, communities have worked to create a continuum of mental health services to foster recovery and to reduce the impact of mental health issues on communities. This transformation has come hand in hand with an increasing understanding of the importance of consumers' and their family members' experience in directing the course of treatment. At the same time, public systems grapple with how to consistently and effectively engage those who are most severely mentally ill. Unawareness of illness, past and current trauma, and stigma can all contribute to a lack of engagement in treatment; among this number, there are individuals whose resistance to treatment could pose a danger to themselves and others.

A growing concern and frustration with California public mental health systems' ability to engage this segment of the consumer population led to the passage of Assembly Bill 1421 (AB1421), known as "Laura's Law," which authorizes and provides guidelines to implement court-ordered intensive outpatient services (called Assisted Outpatient Treatment, or AOT) for individuals with a recent history of recurrent psychiatric emergency room visits and hospitalizations who are significantly deteriorating and unwilling/unable to engage in voluntary services to support their recovery (AB1421 Service Goals are summarized in Appendix 2). Local implementation of AOT requires a vote by the county board of supervisors to enact the measure.

A coalition of family members in Alameda County brought AB1421 to the Board of Supervisors, requesting that AOT be added to the range of available services. When this issue came before the Board in February 2014, it resulted in a lengthy meeting; those who support AOT see little alternative to effective engagement, while many who oppose the measure express deep concerns with this move toward involuntary services and the potential for mis- or over-use.

At the conclusion of this meeting, the Board adopted nine initiatives designed to engage this target population (see Appendix 2), all of which are based on voluntary engagement, and requested that BHCS initiate a stakeholder planning process to address the tenth recommendation, an AOT pilot project, and return with recommendations. The BOS charge read:

> *"The Board voted to direct staff to convene and use a working group of key stakeholders over a 90-day period to conduct a comprehensive review of the programs that could serve the population that is targeted by AB1421 for the purpose of considering alternatives to AB1421 that are more compassionate options for accomplishing the goals of AB1421 and bring back recommendations."*

In May 2014, BHCS initiated a stakeholder planning process to explore and identify programs and services that together would meet the mental health care needs of the target population, evidenced by a reduction

in unnecessary hospitalizations and an increase in engagement with mental health services. BHCS identified stakeholders based on the stakeholder groups named in the AB1421 legislation, which provides guidance to planning processes, and to reflect unique aspects of the County's geography, population demographics and service mix. The committee included twenty-four members, including consumers, family members, and service providers, as well as representatives from the County's Social Services Agency, Sheriff's Office, and Public Defender.

For the purposes of this planning process, BHCS defined the target population as adults with 4 or more Psychiatric Emergency Services (PES) visits, with at least 2 resulting hospitalizations within a 12-month period. BHCS used data on services for the fiscal year ending June 30, 2012, to identify 205 Alameda residents in this target population. Of this group, 51% were male, and 79% fell between the ages of 25 and 59; 98 were African American and 64 were Caucasian, with 19 identified as Asian-Pacific Islander and 16 as Latino. Planning participants were provided with additional details about this population, which are included in Appendix 5.

BHCS engaged Resource Development Associates (RDA) to design and implement this planning process. RDA used a phased, consensus based facilitation approach designed to create a common foundation of understanding about the current system; the target population, its size, level of engagement, and needs; and participants' hopes and concerns related to AOT. Throughout the process, the RDA team used collaborative planning techniques to develop a set of program and service recommendations to address the needs of the target population.

This process included five planning meetings and two workgroup meetings between April 23 and June 30, 2014. The recommendations were then submitted to BHCS to develop supporting budget and implementation details prior to submission to the Board of Supervisors.

Recommendations

Committee workgroups brought recommendations forward at the fourth planning meeting (June 19, 2014), where there was uniform support for 10 recommendations, encompassing both system- and program-level changes. These recommendations were confirmed at the final planning meeting (June 30, 2014), and are outlined below.

System-level Recommendations

The committee reached consensus on five system-level recommendations.

1. **Administrator for the "AB1421 Population":** This position will provide oversight and coordination for the engagement and service of people with a recent history of recurrent psychiatric emergency room visits and hospitalizations who are significantly deteriorating and

unwilling/unable to engage in voluntary services to support their recovery. This position will use utilization and outcome data to drive individual and systems-level decision making.

2. **Increased Data-Sharing Capacity:** The workgroup recognizes the overlap of people with recurrent psychiatric emergency room visits and hospitalizations and the criminal justice system, and recommends working to increase capacity to share data between Behavioral Health Services, the network of providers and the Sheriff for client care and systems-level evaluation. Recognizing legal impediments to data-sharing must be addressed, this may include a centralized database, data warehouse, or other mechanism to share data.

3. **Staff Development:** The workgroup recognizes the unique challenges in serving the "1421 population" and recommends staff development activities to support the entire system in serving these individuals regardless of point of engagement:
    a. Cognitive Behavioral Therapy for Psychosis
    b. Dialectical Behavioral Therapy
    c. Motivational Interviewing
    d. Seeking Safety
    e. Wellness Recovery Action Planning
    f. Co-Occurring Disorders

4. **Family Engagement:** Family members serve as critical resources to their loved ones when accessing services. The workgroup recommends looking for mechanisms, as permitted under 42 CFR, CMIA and HIPAA, to allow family members to support consumers to make appointments, access services, and participate in their care.

5. **Meaningful Involvement of Peers and Family Members:** The workgroup recommends that the County continue to seek ways to include peer and family support specialists throughout the service system.

Program-level Recommendations

In addition, the committee reached consensus on five program-level recommendations.

6. **Crisis Residential Treatment:** A Crisis Residential Treatment (CRT) program will expand the capacity of the existing system to provide alternatives to hospitalization for this population. The current CRT is located in the Castro Valley/San Leandro area, and the workgroup recommends siting the additional CRT beds in Northern Alameda County. This CRT will also develop the capacity to accept referrals directly from Behavioral Health Services and divert PES utilization, as permissible by Titles IX and XXII and when clinically appropriate. *The CRT will also develop increased co-occurring competency to serve individuals in dual recovery*.

7. **Peer Respite Program:** The Peer Respite program will provide an additional alternative to hospitalization with short-term residential services that consumers can access during times of crisis in order to divert PES visits and hospitalization. Peer Respite is a peer-led model and may or may not include a clinical consultant.

8. **"Rapid Engagement Team" (RET):** The RET is based on the fidelity model of Assertive Community Treatment and is comprised of a multi-disciplinary, mobile staff that includes clinical, peer, and family supports. The RET is designed to engage individuals while they are still in the hospital, sub-acute facility, and/or jail to begin the relationship-building process and enroll them in the RET team. The RET is also designed to "meet people where they're at" and provide field-based, flexible services to support individuals as they move through the stages of recovery.

9. **Co-Occurring Disorders Full Service Partnership (FSP):** This program will provide the full range of FSP services targeted to people with co-occurring disorders to support the dual recovery process. Every member of the team will have competency in working with people with co-occurring disorders, and the team will include a certified substance abuse counselor.

10. **"Bridges" System Navigation Team:** Bridges is a multi-disciplinary team that would provide outreach and engagement services as well as systems navigation support. This program would engage those who are not currently receiving mental health services and maintain relationships with these individuals as they move through the various levels of care. They would serve as a consistent source of support regardless of how and where the person moves within the mental health system.

In addition, one recommendation, the creation of a **24-hour Crisis Stabilization Unit**, was referred to the Crisis Planning effort that BHCS plans to undertake in Fall 2014.

However, the committee was unable to reach consensus on two alternatives, **Community Conservatorship** and **Assisted Outpatient Treatment (AOT)**. These recommendations became the focus of the fifth planning meeting (June 30, 2014).

Approach to Community Conservatorship and AOT

The RDA team modified the facilitation approach for the final planning meeting in order to enable further exploration of the two remaining proposals before the committee adopted its recommendations. There was no expectation that the group would reach consensus on these two programs. Instead, the group engaged in an exercise to determine which, if either, had stronger overall support from stakeholders. Individuals were asked to indicate their level of support using colored cards, with stronger support indicated by green, opposition indicated by red, and concerns or questions indicated by yellow.

The committee found stronger consensus for a conservatorship model based on aspects of San Francisco's CIPP conservatorship and the San Mateo County Conservatorship Program, adapted to Alameda County's unique legal and service environment. With a show of cards and some discussion, the group moved to request that BHCS develop a hybrid model of community conservatorship for implementation in Alameda County. This model should include housing and connection to intensive recovery services, family member involvement, conservatorship in the community, and an examination of recidivism. No stakeholders present indicated opposition (red card) to this adaption.

For AOT, the group indicated 3 green cards, 6 yellow cards, and 4 red cards, and discussed their concerns and questions. While participants expressed an understanding of the inherent challenges in engaging the target population, there was a lack of consensus around the inclusion of AOT. Many participants expressed concern about the involuntary nature of AOT services, and the desire to see the implementation of their recommendations, designed to increase program linkages and consumer and family member involvement in engagement efforts, prior to undertaking an AOT pilot. In addition, participants noted that the upcoming crisis system planning process would provide further opportunities to address system linkages and overall engagement efforts that would include this population. Ultimately, AOT did not receive the level of support indicated for Community Conservatorship, and thus cannot be considered a consensus recommendation.

Conclusion

Throughout the planning process, participants demonstrated commitment, curiosity, and a deep passion for the health and wellbeing of those served by the mental health system in Alameda County. Participants posed questions about the target population intended to create a better understanding of their needs, including criminal justice involvement, presence of co-occurring disorders and the history of engagement in treatment, that could not be answered within the planning timeframe with existing data (see Appendix 10).

However, participants shared a common view that in order to meet the needs of this target population and others served by the public mental health system in Alameda County, energy should be invested in strengthening the linkages across programs and services, as well as increasing coordination across systems, to include the criminal justice system. At the conclusion of the process, most participants expressed the hope that the recommended programs would create more timely "warm handoffs" to those transitioning from the hospital or acute setting as well as those in treatment. Participants also expressed a belief that the planning process, and the opportunity to work closely with peers with different perspectives and opinions, would strengthen future planning and advocacy efforts in Alameda County.

This work and these relationships can be leveraged as BHCS undertakes an expanded planning process to address its crisis system in the coming months, using the strengths and gaps identified through this process as a starting point towards greater integration across services and providers.

This page left intentionally blank.

Introduction

In California and across the nation, communities have worked to create a continuum of mental health services to foster recovery and to reduce the impact of mental health issues on communities. This transformation has come hand in hand with an increasing understanding of the importance of consumers' and their family members' lived experience in directing the course of treatment. At the same time, public systems grapple with how to most effectively engage those who are most severely mentally ill. Among this number, there are individuals whose resistance to treatment could pose a danger to themselves and others.

A growing concern and frustration with California public mental health systems' ability to engage this segment of consumers led to the passage of Assembly Bill 1421 (AB1421), known as "Laura's Law," which provides guidelines to implement court-ordered intensive outpatient services (or Assisted Outpatient Treatment) for individuals with severe mental illness who refuse voluntary treatment and are at risk for self-harm or grave disability. With the passage of Laura's Law, Assisted Outpatient Treatment (AOT) became a tool that California counties may consider in the design of a service system to reach and engage this hard-to-reach population. However local implementation of AOT requires a vote by the county board of supervisors to enact the measure.

Alameda County Behavioral Health Care Services (BHCS) is the safety net provider for thousands of residents living with mental illness. Its stated mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns. Like many counties across California, Alameda County is grappling with the challenge of how to best serve residents living with severe mental illness who are not engaged in treatment.

A coalition of family members in Alameda County brought AB1421 to the Board of Supervisors, requesting that AOT be added to the range of available services. When this issue came before the Board in February 2014, it resulted in significant public comment, as those who support AOT see little alternative to effective engagement while others are deeply concerned with this move toward non-voluntary commitment and the potential for mis- or over-use in an imperfect system. At the conclusion of this meeting, the BOS adopted nine new or expanded initiatives designed to engage this target population (see Appendix 3), and requested that BHCS initiate a stakeholder planning process to address the tenth, AOT, and return with recommendations. The BOS charge read:

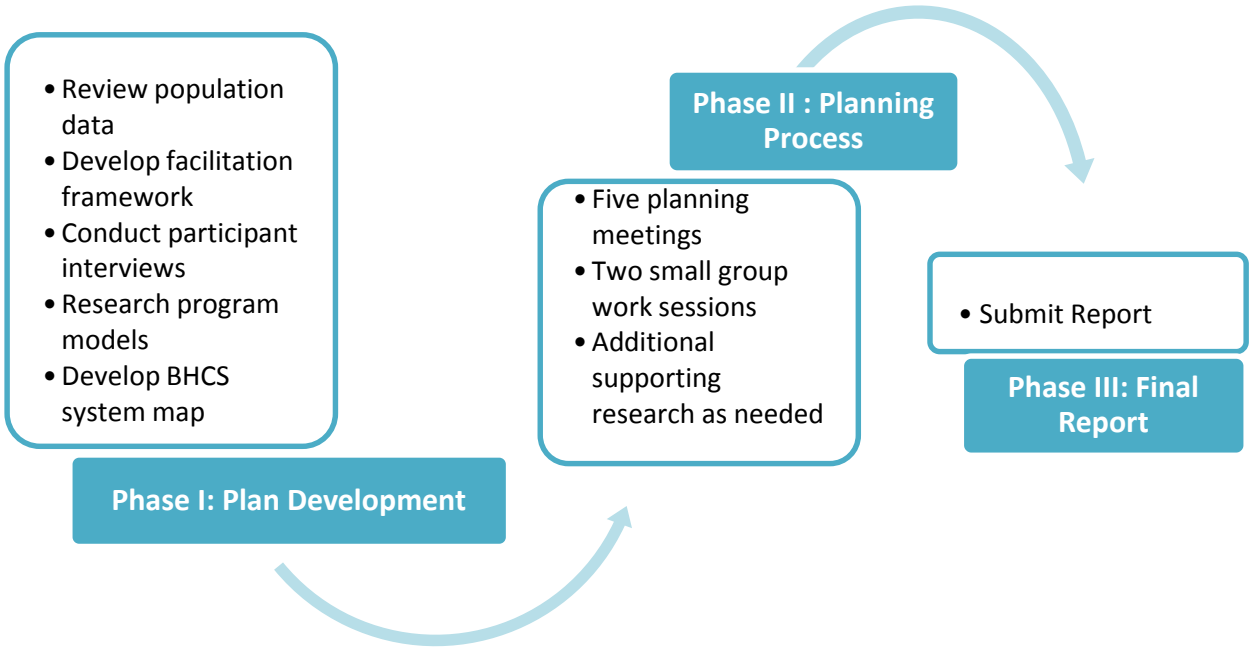
> *"The Board voted to direct staff to convene and use a working group of key stakeholders over a 90-day period to conduct a comprehensive review of the programs that could serve the population that is targeted by AB1421 for the purpose of considering alternatives to AB1421 that are more compassionate options for accomplishing the goals of AB1421 and bring back recommendations."*

In May 2014, BHCS initiated a stakeholder planning process to explore and identify programs and services that together would meet the mental health care needs of the target population, evidenced by a reduction in unnecessary hospitalizations and an increase in engagement with mental health services.

BHCS engaged Resource Development Associates (RDA) to design and implement this process. RDA used a phased, consensus based facilitation approach designed to create a common foundation of understanding about the current system; the target population, its size, level of engagement, and needs; participants hopes and concerns related to AOT; and ultimately, a set of program and service recommendations to address these needs.

This report documents the planning approach, the work of planning process participants, and their recommendations to the Alameda County Board of Supervisors. The scope of the overall process is summarized below in Figure 1: AB1421 Planning Process.

Figure 1: AB1421 Planning Process



Background

California State Assembly Bill (AB) 1421

In 2002, the California State Assembly passed the Assisted Outpatient Treatment Demonstration Project Act (AB1421). AB1421, also known as "Laura's Law," was developed in response to the 2001 Nevada County shooting of a mental health worker by a man who was not participating in psychiatric treatment.

AB1421 provides court-ordered intensive outpatient services for individuals with a recent history of recurrent psychiatric emergency room visits and hospitalizations who are significantly deteriorating and unwilling/unable to engage in voluntary services to support their recovery. AB1421 outlines the target population and eligibility criteria in Welfare and Institutions Code (WIC) Section 5346, and the service goals and requirements of AB1421 programs (see Appendix 2). These programs, known as Assisted Outpatient Treatment (AOT), attempt to address a gap in the continuum of treatment for these individuals.

At this date, while several counties are grappling with whether and how to implement the services defined in AB1421, few have established AB1421-informed programs; Nevada and Yolo Counties remain the only entities in California to fully implement the program, though Los Angeles, San Francisco and Orange Counties have approved future plans. However, groups in opposition threatened to file legal suits against counties planning to implement AOT programs with funding from Proposition 63, which established the Mental Health Services Act fund in 2004. On February 2, 2013, the California State legislature passed Senate Bill 585, which clarified the allowable use of Proposition 63 funds for service costs associated with AB1421/AOT programs.[1]

Alameda County Engagement in AB1421

On March 18, 2013 the Board of Supervisors' Health Committee engaged BHCS to discuss implications of AB1421 in Alameda County. BHCS presented to the Health Committee an overview of the eligibility, implementation, and evaluation criteria set forth by the legislation. At this meeting, the Committee charged BHCS with developing a set of programs and services that would address the mental health needs of the target population identified by AB1421.

BHCS proposed seven recommendations for programs and services 45 days later in May 2013. A public comment period of 45 days subsequently opened, during which BHCS actively engaged stakeholders through community meetings to present their recommendations and gather additional input. After collecting stakeholder feedback, BHCS enhanced the proposed recommendations to a set of 10 (see Appendix 3).

[1] S.B. 585 Chapter 288 Sess. of 2011 (Steinberg, Correa, 2011).

The revised recommendations reflect BHCS's focus on engaging clients and their families that are not engaged in treatment in a manner that aligns with the BHCS values of wellness and recovery. This is manifested in the expansion of opportunities for peer support through the utilization of peer mentors and navigators at each level of service.

On February 5, 2014 the Alameda County Health Care Services Agency Director (in conjunction with BHCS) recommended that the Board of Supervisors approve the proposed AB1421 plan including a pilot AB1421/AOT program. BHCS presented the revised recommendations to the Board of Supervisors in a Board meeting on February 25, 2014. Speakers, including consumers, family members, service providers, and concerned community members, voiced their concerns in over six hours of public comment. The Board of Supervisors ultimately approved nine of the proposed programs, however they deferred a ruling on the tenth, the AB1421 pilot/AOT.

The Board tabled the decision on AOT, directing BHCS to develop and return to them with an improved, more detailed, holistic, compassionate and Alameda County-specific recommendation to meet the needs of the population identified in AB1421.

Planning Process Overview

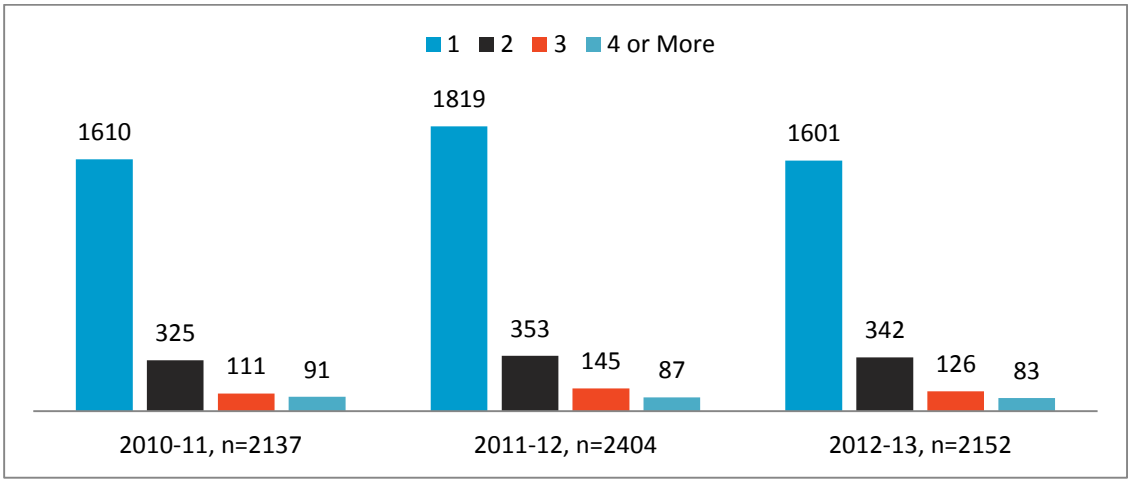
Upon direction from the Board of Supervisors, BHCS took several steps to frame the process, including definition of the target population and selection of participants.

Target Population

AB1421 provides court-ordered intensive outpatient services for individuals with severe mental illness who refuse voluntary treatment yet are also at risk for self-harm or grave disability. AB1421 outlines the target population and eligibility criteria per Welfare and Institutions Code (WIC) Section 5346, and the service goals and requirements of AB1421 programs (see Appendix 2). These programs, known as Assisted Outpatient Treatment (AOT), attempt to address a gap in the continuum of treatment for these individuals.

This target population is intended to limit the use of AOT to those with the most intense need, who are experiencing recurrent hospitalizations, are not engaging in recovery services, and are unlikely to survive safely in the community without additional support. For the three-year period ending June 30, 2013, 4,143 adult Alameda County residents had an involuntary hospitalization at John George Psychiatric Hospital. Two-thirds (2/3) of this group had only one involuntary hospitalization. The 1,397 adult Alameda County residents involuntarily hospitalized at John George Psychiatric hospital at least twice during this period would meet one of the eligibility criteria from the legislation be eligible for AOT as described in AB1421.

An analysis of the hospitalizations in this target population is illustrated below.



Over 2,000 Alameda residents are hospitalized every year. In the fiscal year ending June 30, 2013, 2,404 residents were hospitalized, 585 (23%) of whom were hospitalized at least twice (including both voluntary and involuntary admissions).

California counties have the discretion to further define this population in order to determine the number of individuals who might be eligible for services, based on their existing service mix and population size, and other factors. For the purposes of this planning process, BHCS defined the target population as Adults with 4 or more Psychiatric Emergency Services (PES) visits, with at least 2 resulting hospitalizations within a 12-month period.

BHCS used data on services for the fiscal year ending June 30, 2012, to identify 205 Alameda residents in this target population. Of this group, 51% were male, and 79% fell between the ages of 25 and 59; 98 were African American and 64 were Caucasian, with 19 identified as Asian-Pacific Islander and 16 as Latino. Planning participants were provided with additional details about this population, which are provided in Appendix 5.

Planning Participants

AB1421 requires that local mental health departments enact a service planning and delivery process involving groups who would provide, receive, or be affected by AB1421 programs; members of the mental health board, contracted providers, consumers, family members, and other consumer citizen constituency groups are eligible. BHCS identified and selected participants from a range of groups, perspectives, and geographies, as well as BHCS and community providers and those who are peripherally engaged in the mental health system, including the courts and criminal justice. A complete list of participants follows.

AB1421 Defined Group Affiliation	Position and Agency	AOT Workgroup Participant
Alameda County Behavioral Health Services Staff	Director, Behavioral Health Services	Aaron Chapman, MD, Interim Director (through June 2014) Manuel Jimenez, MA, MFT, Director (beginning July 2014)
	Deputy Director, Behavioral Health Services	Toni Tullys, MPA
	Medical Director, Behavioral Health Services	Aaron Chapman, MD
	Clinical Supervisor, North County Crisis Response Program, ACBHCS	Stephanie Lewis
	Director, Adult Community Support Centers, ACBHCS	Michael Lisman
	Clinical Services Manager, Transition Age Youth System	Radawn Alcorn
	Director, Criminal Justice Mental Health Services/Conditional Release Program	Yvonne Jones
City of Berkeley Mental Health Department	Mental Health Manager	Steve Grolnic-McClurg
Alameda County Partner Agencies Staff	Public Guardian-Conservator, Social Services Agency	Vanessa Baker
	Assistant Public Defender, Alameda County	Brian Bloom
	Sergeant, Alameda County Sheriff's Department, Special Victim's Unit	Anthony DeSousa
	Director, Public Guardian/Adult Protective Services, Social Services Agency	Alicia Morales
	Youth and Family Services Manager, Alameda County Sherriff's Department	Andrea Mueller
	Manager, Social Services & Utilization Management, John George Psychiatric Hospital, Alameda Health System	Haeyoung Sohn

AB1421 Defined Group Affiliation	Position and Agency	AOT Workgroup Participant
Mental Health Board	Chair, Alameda County Mental Health Board	Alane Friedrich
Contracted ACBHCS Providers and Partners:	Clinician, La Clinica de la Raza	Bianca Bustos
	Program Director, Transition-Age Youth Services, WestCoast Children's Clinic	Susan Drager
	Director, Patients' Rights Advocacy Program, Mental Health Association	Francesca Tenenbaum
	Interim Program Director, Woodroe Place Crisis Residential Treatment, Bay Area Community Services	Shalon Woods
Consumers:	Consumer Empowerment Manager, Office of Consumer Empowerment, ACBHCS	Khatera Aslami
	Consumer Relations Team, ACBHCS	Mary Hogden
	Executive Director, Alameda County Network of Mental Health Clients	Katrina Killian
	Consumer Leader, ACBHCS	Jay Mahler
Family Members of Consumers:	Candy Dewitt	Family Member
	Family Advocates Manager, Family Education and Resource Center	Bettye Foster
	Board Member, National Alliance on Mental Illness	Peggy Rahman
	Family Relations Manager, Office of Family Empowerment, ACBHCS	Rosa Warder

While BHCS adopted a general policy that substitutes would not be invited in order to protect the forming and learning of the group, four substitutes became necessary, due to events that prevented ongoing engagement from key stakeholders. These categories of participants include consumers, family members and the representatives of the Mental Health Board and the City of Berkeley.

Planning Process Approach

Facilitation Approach

BHCS sought to create a planning process in which service providers, consumers, family members and others could participate as peers, where questions about the system and the challenge of engaging the target population could be addressed neutrally, and the group could collaboratively investigate a range of program models. The department retained Resource Development Associates (RDA) to facilitate this planning process. RDA utilized an iterative and collaborative approach based on the Institute of Cultural Affairs Technology of Participation (ToP) facilitation method in use throughout Alameda County Health Care Services Agency (HCSA); to this end, the RDA team included Jane Stallman of the Center for Strategic Facilitation, a ToP mentor trainer.

The facilitation team developed clear goals and objectives for each meeting, based on the achievements and questions from prior meetings, utilizing activities designed to promote engagement and consideration of key topics, and to move the group towards a set of recommendations. Prior to the first planning meeting, the team conducted an interview with each member of the planning committee. The team used a consistent set of questions in order to yield information about the participants' experience with and in the mental health system and the AB1421 target population, their expectations and any concerns regarding the process, and their perspectives on AOT and other program models the committee might consider.

Once the planning process commenced, the RDA team facilitated meetings and workgroup sessions, prepared materials and background information for committee participants, managed communication with BHCS leadership and planning participants between meetings, and on-boarded substitute and replacement participants throughout the process. In addition, the team established a web-based document archive to facilitate participants' access to materials throughout the process.

Number and Type of Meetings

The planning process consisted of five facilitated planning meetings and two workgroup sessions spanning from April 23 to June 30, 2014. The RDA team supported the formation and facilitation of four committee workgroups. Members of each workgroup were assigned to develop a mix of services for the target population, thinking about ensuring access and engagement to enable appropriate treatment at every juncture. Each workgroup included at least one program provider, one BHCS staff, and all groups included both a consumer and a family member. Forms were provided to the groups at each meeting to help guide the recommendations; forms included prompts regarding system- and program-level recommendations, the nature of the intended benefit to the target population, and specifically, the inclusion of AOT.

The schedule of meetings and objectives are provided below.

Planning Process Meetings		
Session	**Date**	**Objective**
Session 1	April 23, 2014	Understand the task and the need
Session 2	May 7, 2014	Review programs and launch workgroups
Workgroup 1	May 19, 2014	Identify system strengths and gaps; develop initial workgroup recommendations
Session 3	May 28, 2014	Check-in on progress, learnings, and questions
Workgroup 2	June 2, 2014	Review and finalize recommendations
Session 4	June 19, 2014	Review workgroup recommendations; identify planning committee recommendations
Session 5	June 30, 2014	Continue AOT and community conservatorship discussion; confirm committee recommendations

Meeting Ground Rules

The facilitators worked with planning participants to establish ground rules at the first committee meeting in order to enhance the collaborative process and ensure meeting times were used efficiently and respectfully. According to these guidelines, participants agreed to participate and learn through each other, to lead with curiosity and a belief in participants' good intentions, and to show courtesy for other voices – even ones of differing opinions. Participants also agreed to rely on inquiry more than advocacy in order to promote learning regarding others' perspectives and experiences. A full set of ground rules is provided in Appendix 7.

In addition to the ground rules, the facilitation team used a "parking lot" to keep track of concerns and ideas that extended beyond the scope of the planning process. This parking lot was prominently displayed and the concept was re-introduced at each gathering of the planning committee, so that participants were familiar with the approach and at times "self-parked" items that were raised in discussion and thought to deserve future attention. At the conclusion of the planning process, RDA collaborated with BHCS leadership to redirect these questions to the appropriate program or process for further consideration. A list of parking lot items and their disposition is included in Appendix 10.

Meeting Materials: BHCS System Map, Target Population Data and Program Summaries

Throughout the planning process, RDA prepared materials to support the participants' learning and decision-making. During the pre-planning phase, RDA worked with BHCS to conduct an analysis of mental health consumer data to better understand how many people in Alameda County fit the criteria set forth in AB1421, as well as a more detailed analysis of the characteristics of the proposed target population. RDA prepared an analysis for the first planning meeting, and continued to develop this information based on participant questions and the capacity of the BHCS Network Office.

In addition, RDA worked with BHCS staff to develop a system map that illustrates existing crisis programs provided by BHCS and its contract partners (see Appendix 4). During the planning process, this map was expanded to include the nine programs approved by the Board of Supervisors and was used to identify potential gaps that could contribute to the lack of engagement of the members of the target population.

RDA also prepared program model summaries regarding AOT, the three programs that BHCS requested the committee consider (community conservatorship, crisis residential treatment and peer respite), and suggestions from participants (unawareness of illness, Assertive Community Treatment (ACT), trauma-informed care, Prevention and Recovery in Early Psychosis (PREP) and others). BHCS Medical Director Dr. Aaron Chapman, MD, reviewed program summaries and provided significant input to the conceptual understanding of unawareness of illness.

The RDA team received several communications from stakeholders throughout the process, including letters, emails, articles and other materials. The team made the decision that these would not be distributed to committee members or included in project documentation, in keeping with the group's ground rule, "use inquiry more than advocacy".

A complete list of materials distributed to the participants is provided in Appendix 8.

Results of the Planning Process

In Workgroup Meeting 1 (May 19, 2014), after participants had reviewed the target population data, BHCS system map and proposed program summaries, participants began to propose and discuss potential service recommendations for the target population. Over the course of three meetings, the groups solidified their proposals, which were presented to the full planning committee on June 19. Groups presented programs and services for which they reached consensus, and through the larger group process, identified overlapping proposals to form recommendations. The resulting areas of consensus identified through this process are outlined below, and further summarized in Appendix 9.

	Program Recommendations	System Recommendations
Areas of Consensus	• **ACT/FSP/RET** • **Crisis Alternatives, expansion to 24 hour stabilization model, expansion to north Alameda** • **Peer respite model that wrap around the family or peer support**	• **Data oversight** • **Staff development/training** • **Philosophical, cultural shift** • **Enhanced and expanded outreach and engagement**

Near the conclusion of the fourth planning meeting, it became clear that the group would not reach consensus regarding two proposals, AOT and Community Conservatorship. BHCS Deputy Director Toni

Tullys recommended a final planning meeting to focus on these two recommendations, recognizing that while consensus would be unlikely, an expanded discussion would better inform the Board of Supervisors regarding the committee's intentions.

Planning process participants reconvened for Planning Session 5 on June 30 in order to finalize their recommendations. At this final meeting, the planning committee was unable to reach full consensus on either program; the group approved moving forward with development of a hybrid of the Community Conservatorship models implemented in San Francisco and San Mateo Counties, a program that would be aligned to the unique legal and programmatic requirements found in Alameda County.

Key Themes

During the planning process, a set of themes emerged that deserve specific consideration.

Assisted Outpatient Treatment (AOT)

The question of whether to include AOT in Alameda County services remained a contentious issue throughout the planning process. While the original Board charge implied that the participants would not consider AOT, at the first planning meeting both Supervisor Keith Carson and HCSA Director Alex Briscoe urged the committee to give consideration to AOT as an option.

Given the lack of uniformity of opinion, the planning process was designed to explore a range of methods for addressing the needs of the target population. The facilitation team worked to foster this discussion by distributing AB1421 objectives and service information, as well as program model information that included AOT as well as the three programs put forward by BHCS.

In addition, "Report Back" forms that were used to summarize the workgroup's recommendations were designed to specifically address the inclusion of AOT. Groups electing to include AOT among their recommendations were asked to discuss what steps would be taken to guide and limit its use to only the most necessary instances. Those groups that rejected AOT were asked to provide a summary of how the proposed plan would ensure connection to services for those who have been unable to engage in treatment as identified in the AB1421 legislation.

RDA team members circulated at work group meetings to provide support to the process. At the final work group meeting (June 2, 2014), an RDA team member sat with each group to clarify the process, and the question of including AOT was specifically addressed. Planning Meeting 4 (June 19, 2014) was specifically designed to share recommendations from all four groups; as two committees included AOT in their proposal, the program model was brought before the full committee for consideration.

The workgroups that included AOT expressed a belief that this approach would offer an opportunity for family members to support system engagement. Those that did not include AOT among their recommendations focused on creating more robust system linkages to support ongoing engagement.

System Linkages

The BHCS system map proved to be a useful tool in developing a common understanding of the range of services available in Alameda County. Participants agreed from the start that the County offered an impressive array of services, but that the linkages across programs and services were less well established, creating the potential for consumers to fall out of engagement. Some participants noted that the preceding years had offered opportunities to develop and expand programs in line with Mental Health Services Act (MHSA) goals and values, and that the next stage of development should focus on creating support for consumer engagement across programs and services. Such linkages would create more stable engagement opportunities for consumers with severe mental illness.

Three of the four groups included recommendations intended to improve this situation by creating more family member and peer involvement in service delivery, and more support for timely "warm handoffs" across the service system.

Unawareness of Illness

A cohort of family member participants raised concerns about anosognosia[2], a medical term describing an impaired ability to recognize the presence or appreciate the severity of deficits in sensory, perceptual, motor, affective, or cognitive functioning[3]. Seen in patients after stroke, brain injury, and dementia, anosognosia is referred to as a "neurological," "anatomical," or "structural" brain condition. These committee members expressed concern that such an impairment exists for consumers with severe psychosis such as schizophrenia, and limits voluntary engagement, and thus recovery.

RDA, in partnership with Dr. Chapman, conducted a search of peer reviewed articles, relying on those that provided a meta-review of the literature (i.e. articles that used multiple primary studies to draw conclusions), and avoiding information from advocacy organizations unless information was also available from a peer reviewed journal.

The research indicated that while "unawareness of illness" occurs in those with schizophrenia and other mental illnesses that involve psychosis, this may be different from anosognosia, and that the effect on treatment and recovery are variable. Thus planning participants were encouraged to use the phrase "unawareness of illness" when addressing this factor as a barrier to engagement.

[2] Antoine C, Antoine P, Guermonprez P, Frigard B. (2004) Awareness of deficits and anosognosia in AD. Encephale. 30:570-7.

Planning Process Next Steps

The planning process by definition offered an abbreviated timeline to focus on a specific population, one with severe mental illness and a history of limited engagement in treatment services. Many participants noted that the challenges that impact engagement among the consumers in this population are present across the larger crisis system. BHCS communicated the intention to launch a Crisis Planning Process at the conclusion of the AB1421 Planning Process to look at strategies to improve the overall effectiveness of this system, including the integration of programs and services, with an emphasis on the program and service enhancements that emerged from the AB1421 planning process.

Recommendations

At Planning Meeting 4 (June 19, 2014), there was uniform support for ten recommendations, encompassing both system- and program-level changes; this support was confirmed at the final planning meeting (June 30, 2014). These recommendations are outlined below.

System-level Recommendations

The committee reached consensus on five system-level recommendations.

1. **Administrator for the "AB1421 Population":** This position will provide oversight and coordination for the engagement and service of people with a recent history of recurrent psychiatric emergency room visits and hospitalizations who are significantly deteriorating and unwilling/unable to engage in voluntary services to support their recovery. This position will use utilization and outcome data to drive individual and systems-level decision making.
2. **Increased Data-Sharing Capacity:** The workgroup recognizes the overlap of people with recurrent psychiatric emergency room visits and hospitalizations and the criminal justice system, and recommends working to increase capacity to share data between Behavioral Health Services, the network of providers and the Sheriff for client care and systems-level evaluation. Recognizing legal impediments to data-sharing must be addressed, this may include a centralized database, data warehouse, or other mechanism to share data.
3. **Staff Development:** The workgroup recognizes the unique challenges in serving the "1421 population" and recommends staff development activities to support the entire system in serving these individuals regardless of point of engagement:
    a. Cognitive Behavioral Therapy for Psychosis
    b. Dialectical Behavioral Therapy
    c. Motivational Interviewing
    d. Seeking Safety
    e. Wellness Action Recovery Planning

f. Co-Occurring Disorders

4. **Family Engagement:** Family members serve as critical resources to their loved ones when accessing services. The workgroup recommends looking for mechanisms, as permitted under 42 CFR, CMIA and HIPAA, to allow family members to support consumers to make appointments, access services, and participate in their care.

5. **Meaningful Involvement of Peers and Family Members:** The workgroup recommends that the County continue to seek ways to include peer and family support specialists throughout the service system.

Program-level Recommendations

In addition, the committee reached consensus on five program-level recommendations.

1. **Crisis Residential Treatment:** A Crisis Residential Treatment program will expand the capacity of the existing system to provide alternatives to hospitalization for this population. The current CRT is located in the Castro Valley/San Leandro area, and the workgroup recommends siting this expanded CRT in Northern Alameda County. This CRT will also develop the capacity to accept referrals directly from Behavioral Health Services and divert PES utilization, as permissible by Titles IX and XXII and when clinically appropriate. *The CRT will also develop increased co-occurring competency to serve individuals in dual recovery.*

2. **Peer Respite Program:** The Peer Respite program will provide an additional alternative to hospitalization with short-term residential services that consumers can access during times of crisis in order to divert avoidable PES visits and hospitalization. Peer Respite is a peer-led model and may or may not include a clinical consultant.

3. **"Rapid Engagement Team" (RET):** The RET is based on the fidelity model of Assertive Community Treatment and is comprised of a multi-disciplinary, mobile staff that includes clinical, peer, and family supports. The RET is designed to engage individuals while they are still in the hospital, sub-acute facility, and/or jail to begin the relationship-building process and enroll them in the RET team. The RET is also designed to "meet people where they're at" and provide field-based, flexible services to support individuals as they move through the stages of recovery.

4. **Co-Occurring Disorders Full Service Partnership (FSP):** This program will provide the full range of FSP services targeted to people with co-occurring disorders to support the dual recovery process. Every member of the team will have competency in working with people with co-occurring disorders, and the team will include a certified substance abuse counselor.

5. **"Bridges" System Navigation Team:** Bridges is a multi-disciplinary team that would provide outreach and engagement services as well as systems navigation support. This program would engage those who are not currently receiving mental health services and maintain relationships

with these individuals as they move through the various levels of care. They would serve as a consistent source of support regardless of how and where the person moves within the mental health system.

In addition, one recommendation, the creation of a **24-hour Crisis Stabilization Unit**, was referred to the Crisis Planning effort, which BHCS will undertake in Fall 2014.

However, the committee was unable to reach consensus on two alternatives:

1. **Assisted Outpatient Treatment:** This pilot project will provide for court-ordered outpatient treatment to individuals with a recent history of recurrent psychiatric emergency room visits and hospitalizations who are significantly deteriorating and unwilling/unable to engage in voluntary services to support their recovery. Consumers enrolled in AOT via the legislatively defined civil court process will concurrently be enrolled in a Full Service Partnership program with access to the full range of FSP services.
2. **Community Co-Conservatorship Program:** This program is designed as a blend of San Francisco's Community Independence Pilot Project and San Mateo's Community Conservatorship Pilot. This program seeks to identify and engage people who meet LPS criteria while in the hospital or sub-acute facility to offer voluntary conservatorship as a support during community transition. Upon release from the hospital or sub-acute facility, the person conserved will be enrolled in a Full Service Partnership program with access to the full range of FSP services. The consumer will also be offered the opportunity to engage a family or other key support person to serve as co-conservator in partnership with the Conservator's Office.

These recommendations became the focus of the fifth and final planning meeting (June 30, 2014).

Community Conservatorship and AOT

Facilitation Process for Final Planning Meeting

The RDA team modified the facilitation approach for the final planning meeting in order to ensure that the committee explored the two remaining proposals, Community Conservatorship and AOT, before adopting its final recommendations. Given the prior meetings, there was little expectation that the group would reach consensus on these two programs. Instead, after examining community conservatorship models from San Mateo and San Francisco Counties, as well as the unique characteristics and requirements of Alameda County, the group engaged in an exercise to determine which, if either, had stronger overall support from stakeholders. Individuals were asked to indicate their level of support using colored cards, with stronger support indicated by green, opposition indicated by red, and concerns or questions indicated by yellow.

Throughout this planning process, participants expressed an openness to perspectives and information that would help them to more deeply understand the target population and the obstacles to engagement. This continued to be true in the final meeting, where participants expressed that their opinion regarding the potential service options had been changed by what they learned during the process.

Final Recommendations

The following section provides a summary of the discussion related to the final two program options.

Community Conservatorship

For the community conservatorship proposal, the group collectively expressed stronger support for the San Francisco version, with more greens (indicating strong favor), and fewer yellows (indicating concern) and reds (indicating disapproval) than for the San Mateo model.

Stakeholders concerned with the San Francisco model (yellows) cited the following reasons:

- Too many questions about the program to endorse.
- Concerns about a purely voluntary system in which individuals who could benefit from treatment will say no. The population that falls through the cracks of voluntary programs is the population that will not be served by this program.

Those indicating disapproval of the San Francisco model expressed these concerns:

- Lack of understanding of how the model will serve the needs of the population.
- Differences between San Francisco and Alameda Counties, particularly the number of jurisdictions to coordinate.
- The challenges related to providing associated housing for consumers.
- Concerns that the benefits of this program could be realized through LPS.

There were stronger reservations for the San Mateo County model. In addition to the concerns expressed above, the stakeholders identified the following reservations:

- Concerns regarding the capacity and availability of a family member or friend to serve as the conservator independent of the County.
- Concerns that given the requirements in Alameda County, the limits on the role of the non-County conservator would make the program ineffective; the community conservator may not have decision-making power regarding where the conservatee lives and other essential aspects of the conservatee's non-treatment environment.

After identifying stronger consensus for San Francisco's CIPP conservatorship adapted to Alameda County, the group then voted to request that BHCS develop a hybrid model of community conservatorship for

implementation in Alameda County. This model should include housing, family member involvement, conservatorship in the community, and an examination of recidivism. While some consumers expressed concerns regarding the methods by which consumers would be engaged in or released from community conservatorship, no stakeholders present indicated opposition (red card) to this adaption.

Assisted Outpatient Treatment (AOT)

Because of the degree to which AOT had been reviewed in prior meetings, this discussion began with a show of cards to determine overall support for the proposal. The group indicated 3 greens, 6 yellows, and 4 reds. The following concerns, both in favor and in opposition, were expressed by committee members who raised a yellow card:

- The desire to see the impact of the previous BOS-approved and committee-endorsed recommendations prior to implementing AOT.
- The risk of overuse of forced treatment that harkens back to easily committing people because of their behavior, and the conflict of non-voluntary commitment in a recovery oriented system.
- Concerns about the crimes and resulting imprisonment that occur when a segment of severely mentally ill people refuse treatment, versus the eligibility factors that have to be met for commitment.
- The mechanism to enable a family member to help engage the consumer in treatment that is offered by AOT, and which does not currently exist in Alameda County.
- A hesitation to implement AOT without knowing more about the 205 individuals in the target population.
- The perceived leniency of AB1421 guidelines regarding number of hospitalizations for a person who might be nonviolent.
- The potential neurological damage posed by untreated psychosis.

Those in opposition to AOT (red votes) expressed the following concerns:

- That AOT criteria is based on past history and potential for future behavior rather than the current status of endangering themselves or others.
- That the system already offers most of the services outlined in AB1421, and the lack of engagement may be related to the system more than the individual, in which case expanding involuntary treatment is a violation of rights.
- That implementation of AOT represents a significant precedent toward involuntary treatment and that other less coercive methods should be tested prior to implementing AOT.
- The potential negative impacts on long-term voluntary participation in treatment resulting from coercive treatment of young people.
- The disproportional use of AOT on people of color as implemented in New York State.

While participants expressed an understanding of the inherent challenges in engaging the target population, there was a lack of consensus around the inclusion of AOT centering on two chief concerns:

the involuntary nature of AOT services; and the desire to see the implementation of their recommendations – designed to increase program linkages and consumer and family member involvement in engagement effort – prior to undertaking an AOT pilot. In addition, participants noted that the upcoming crisis system planning process would provide further opportunities to address system linkages and overall engagement efforts that would include this population. Ultimately, AOT did not receive the level of support indicated for the Community Conservatorship model, and thus cannot be considered a consensus recommendation.

Conclusion

Throughout the planning process, participants demonstrated commitment, curiosity, and a deep passion for the health and wellbeing of those served by the mental health system in Alameda County. Participants posed questions about the target population intended to create a better understanding of their needs, including criminal justice involvement, presence of co-occurring diagnoses and the history of engagement in treatment, that could not be answered within the planning timeframe with existing data (see Appendix 10).

However, participants shared a common view that in order to meet the needs of this target population and others served by the public mental health system in Alameda County, energy should be invested in strengthening the linkages across programs and services, as well as increasing coordination across systems, to include the criminal justice system.

At the conclusion of the process, most participants expressed the hope that the recommended programs would create more "warm handoffs" to those exiting hospitalization and to those in treatment. Participants also expressed a belief that the planning process, and the opportunity to work closely with peers with different perspectives and opinions, would strengthen future planning and advocacy efforts.

This work and these relationships can be leveraged as BHCS undertakes an expanded planning process to address its crisis system in the coming months, using the strengths and gaps identified through this process as a starting point towards enhanced integration across services and providers.

Appendices

1. Glossary of Terms
2. AB1421 Service Goals, Components and Target Population
3. BHCS Service Goals (Sep. 2013) and BHCS Service Recommendations (Feb. 2014)
4. Mental Health Adult System of Care Map
5. Target Population Demographics
6. Planning Meeting Agendas
7. Meeting Ground Rules
8. List of Handouts
9. AB1421 Planning Process Meeting #4 Recommendations by Workgroup
10. Parking Lot Items

Appendix 1: Glossary of Terms

	Acronym	Meaning	Definition
Crisis and Hospital Services	PES	Psychiatric Emergency Services	A Psychiatric Emergency Services (PES) unit is designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance abuse crisis, and strive to stabilize consumers on site and avoid psychiatric hospitalization whenever possible. A PES provides emergency/urgent walk-in and police-initiated evaluation and crisis phone service 24 hours a day, 7 days a week.
	IPU	Inpatient Unit	An inpatient unit, also called acute inpatient psychiatric unit, provides 24 hour mental health services to individuals with acute psychiatric conditions. Acute inpatient services are short-term and targeted towards individuals who are often high-utilizers of PES or other community resources. Services provided in these settings are tailored to the individual's needs and may include but are not limited to: medication evaluation and management; psycho-educational groups; group and individual counseling; family interventions; and substance use.
	CSU	Crisis Stabilization Unit	Crisis Stabilization Unit services are provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in the residential service settings. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is 23 hours. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services.
	PHF	Psychiatric Health Facility	A psychiatric health facility is defined to mean a health facility that provides 24-hour inpatient care for patients with severe mental health needs whose physical health needs can be met in an affiliated hospital or in outpatient settings. Services include, but are not limited to: psychiatry; clinical psychology; psychiatric nursing; social work; rehabilitation; and medication evaluation and management.
Residential Services	MHRC	Mental Health Rehabilitation Center	Mental health rehabilitation center means a 24–hour program which provides intensive support and rehabilitation services designed to assist adults with mental disorders who would otherwise have been placed in a state hospital or another mental health facility to develop the

	Acronym	Meaning	Definition
			skills to become self–sufficient and capable of increasing levels of independent functioning.
	CRT	Crisis Residential Treatment	An alternative to hospitalization, CRTs provide intensive mental health and behavioral supports to resolve the consumer's current crisis and develop skills to reduce the likelihood of future crisis events. CRT's use a short stay model, generally 5-14 days, through which consumers have access to integrated professional staff, medication evaluation and management, individual and group therapy, and life skills support.
	ART/TR	Adult Residential Treatment / Transitional Residential	ART/TR represents a wide a variety of transitional living programs designed to meet the needs of multiple populations who do not required locked or institutional settings for treatment. Lengths of stay range from three to eighteen months and focus on assisting individuals in addressing any issues that lead to their enrollment in the program and develop a strategy for returning to a more independent setting.
Outpatient Services	ACT	Assertive Community Treatment	Assertive Community Treatment is an evidence-based team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. Among the services ACT teams provide are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual's ability to live successfully in the community. ACT services are available 24 hours per day, 365 days per year.
	ICM	Intensive Case Management	Intensive Case Management (ICM) is a community based package of care, aiming to provide long term care for severely mentally ill people who do not require immediate admission. Intensive case management is differentiated from other forms of case management through factors such as a smaller caseload, team management, outreach emphasis, a decreased brokerage role, and an assertive approach to maintaining contact with clients.

Appendix 2: AB1421 Service Goals, Components and Target Population

Board of Supervisors Minutes
Tuesday, February 25, 2014

"As to recommendation 10, the Board voted to direct staff to convene and use a working group of key stakeholders over a 90-day period to conduct a comprehensive review of the programs that could serve the population that is targeted by AB1421 for the purpose of considering alternatives to AB1421 that are more compassionate options for accomplishing the goals of AB1421 and bring back recommendations."

AB1421 Service Goals
Welfare and Institutions Code Section 5348

The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive services, to the extent feasible, that are designed to enable recipients to:

- Live in the most independent, least restrictive housing feasible in the local community;
- Engage in the highest level of work or productive activity appropriate to their abilities and experience;
- Create and maintain a support system consisting of friends, family, and participation in community activities;
- Access an appropriate level of academic education or vocational training;
- Obtain an adequate income;
- Self-manage their illnesses and exert as much control as possible over both the day- to-day and long-term decisions that affect their lives;
- Access necessary physical health care and maintain the best possible physical health;
- Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system;
- Reduce or eliminate the distress caused by the symptoms of mental illness;
- Have freedom from dangerous addictive substances.

AB1421 Service Requirements
Welfare and Institutions Code Section 5348

Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member and a personal service coordinator.

- Outreach and engagement services;
- Coordination and access to medications, psychiatric and psychological services, and substance abuse services;

- Supportive housing or other housing assistance;
- Veterans' services;
- Family support and consultation services;
- Parenting support and consultation services;
- Peer support or self-help group support, where appropriate;
- Age, gender, and culturally appropriate services.

AB1421 eligibility criteria are defined by the WIC Section 5346:

- The person is 18 years of age or older, is suffering from a mental illness, and there has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
- The person has a history of lack of compliance with treatment for his or her mental illness in that at least one of the following is true:
  - At least 2 hospitalizations within the last 36 months
  - One or more acts of serious and violent behavior toward himself, herself or another, or threats, attempts to cause serious physical harm to him, herself or another in the last 48 months.
- The person has been offered an opportunity to participate in a treatment plan and does not engage in treatment.
- The person's condition is substantially deteriorating.
- The person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to him, herself or others, as defined in Section 5150.
- It is likely that the person will benefit from assisted outpatient treatment.

Appendix 3: BHCS Service Goals (Sep. 2013) and Recommendations (Feb. 2014)

Summary of Goals of Ten Revised AB1421 Recommendations, BHCS

September 2013

Goals of Revised AB1421 Recommendations
• Implement new outreach and engagement initiatives targeted to meet the needs of youth, adult consumers and family members.
• Identify and deploy strategies to engage clients/consumers who are not compliant or engaged in services with treatment and support designed to continue to engage them until they have an ongoing source of care.
• Address the special needs of families for support, information and assistance.
• Offer individual peer support for clients/consumers who are in the hospital or transitioning among different levels of care and into the community.
• Expand intensive case management for clients/consumers as soon as they are discharged from the emergency room, acute hospital or sub-acute facilities to help them transition back into the community and to better support therapeutic gains made after acute episodes.
• Expand intensive case management services for clients/consumers who are incarcerated and experiencing initial or early episodes of mental illness.
• Consider referral to the AB1421/AOT pilot only after clients/consumers have been unable to engage in services through the new outreach and engagement strategies, with individual peer support and participation in an intensive case management program.

Revised AB1421 Recommendations proposed by BHCS

Updated February 20, 2014

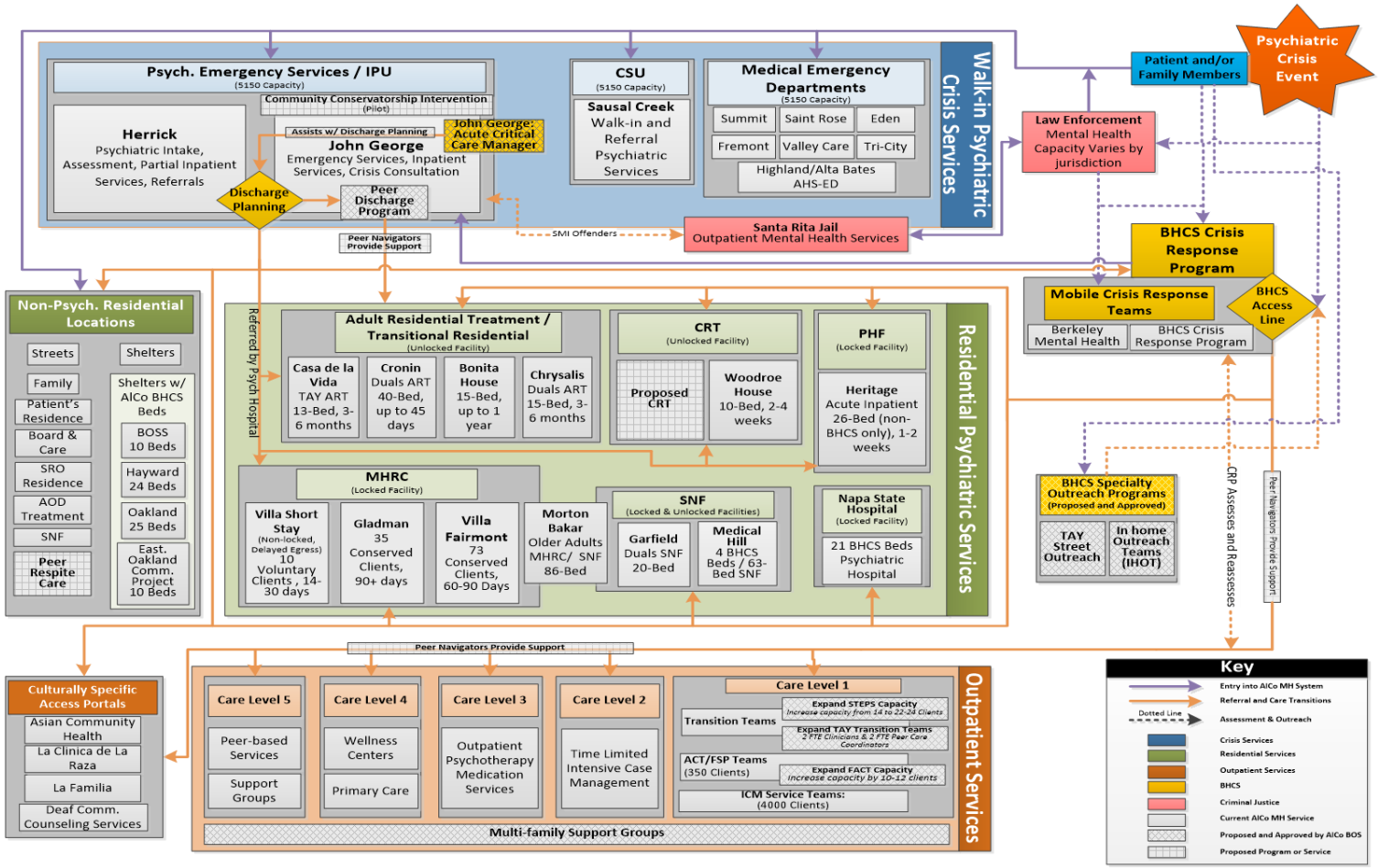
Program Name	Type of Program	Funding	Implementation Timeline
1. **Pilot San Diego County's** *In Home Outreach Team* **(IHOT) to provide home or community-based support and education to clients/consumers, family members and caregivers.**	Outreach and Engagement with Youth, Consumers and Families	$275,000 (two teams) - $400,000 (three teams) This pilot would be funded through a BHCS MHSA Innovations Grant.	6 months
2. **Pilot a** *Street Youth Outreach Team* **to meet and engage young people "where they're at" in the community and help link them to services and treatment.**	Outreach and Engagement with Youth, Consumers and Families	$300,000 Update: In January 2014, BHCS received a state MHSA OAC Crisis Triage grant which will cover the costs of this program for 3 years.	6 months

Program Name	Type of Program	Funding	Implementation Timeline
3. **Offer** *Multifamily Groups* **to support family members of youth who are not engaged or participating in their treatment.**	Outreach and Engagement with Youth, Consumers and Families	Training is in the range of $1200/person, which includes 12 months of monthly phone supervision. For a three person team, the training cost would be approximately $3600. Training expenses would be covered by the BHCS Training Budget.	3 months or less, depending on trainer availability.
4. **Implement the** *Mentors on Discharge Program* **to support clients/consumers following their discharge from John George Psychiatric Pavilion and possibly other local psychiatric hospitals. Funded by a BHCS MHSA Innovations Grant, this program demonstrated a 67% decrease in hospital recidivism rates for clients/consumers that had a peer mentor upon their discharge.**	Utilize Peer Navigators to Provide Peer Support to Clients/Consumers Receiving Services	$187,500 This program would be supported by MHSA funding.	This is a new program which will be contracted out to a community-based provider through the BHCS Request for Proposal (RFP) process. The RFP process takes approximately six months from posting the RFP to the execution of the contract.
5. **Develop and pilot a** *Peer Navigators Program* **to offer individual peer support to clients/consumers during care transitions and to provide linkages to primary and behavioral health care services and community resources.**	Utilize Peer Navigators to Provide Peer Support to Clients/Consumers Receiving Services	$200,000 This pilot would be funded by a BHCS MHSA Innovations Grant.	6 months
6. **Hire an *Acute Care Clinical Manager* to work with staff at John George Psychiatric Pavilion and to identify BHCS services and community resources for clients/consumers in the**	Expand Hospital-Based Resources and Intensive Case Management Services	This BHCS position was vacant and funded.	Position filled in October 2014.

Program Name	Type of Program	Funding	Implementation Timeline
Psychiatric Emergency Room or in the hospital.			
7. **Expand *Intensive Case Management Services for Transition Age Youth* who are difficult to engage, require assistance with maintaining their activities of daily living and would benefit from these services.**	Expand Hospital-Based Resources and Intensive Case Management Services	$350,000 The expansion would be supported by MHSA funding. Update: In January 2014, BHCS received a state MHSA OAC Crisis Triage grant which will cover the costs of this program for 3 years.	This is a new program which will be contracted out to a community-based provider through the BHCS Request for Proposal (RFP) process. The RFP process takes approximately six months from posting the RFP to the execution of the contract.
8. **Expand capacity of the *STEPS Adult Intensive Case Management Program* to address a broader target population that includes clients/consumers experiencing early episodes of mental illness in the hospital.**	Expand Hospital-Based Resources and Intensive Case Management Services	$250,000 The expansion would be supported by MHSA funding.	BHCS would seek to provide and implement services with an existing provider, as soon as possible, through a contract augmentation.
9. **Expand capacity of the *Forensic Assertive Community Treatment (FACT) Team* to address a broader target population that includes clients/consumers experiencing early episodes of mental illness while incarcerated.**	Expand Hospital-Based Resources and Intensive Case Management Services	$350,000 The expansion would be supported by MHSA funding	BHCS would seek to provide and implement services with an existing provider, as soon as possible, through a contract augmentation.
10. **Develop an *AB1421 Pilot* that reflects BHCS values of wellness and recovery, consumer choice and peer support and expands eligibility criteria to include**	Pilot an AB1421/Assisted Outpatient Treatment Program	$225,000 (total) for the pilot $125,000 for services would be supported by MHSA funding $100,000 for court costs, per the Court's request, which	If approved by the Board of Supervisors, BHCS will convene a Planning Work Group to develop

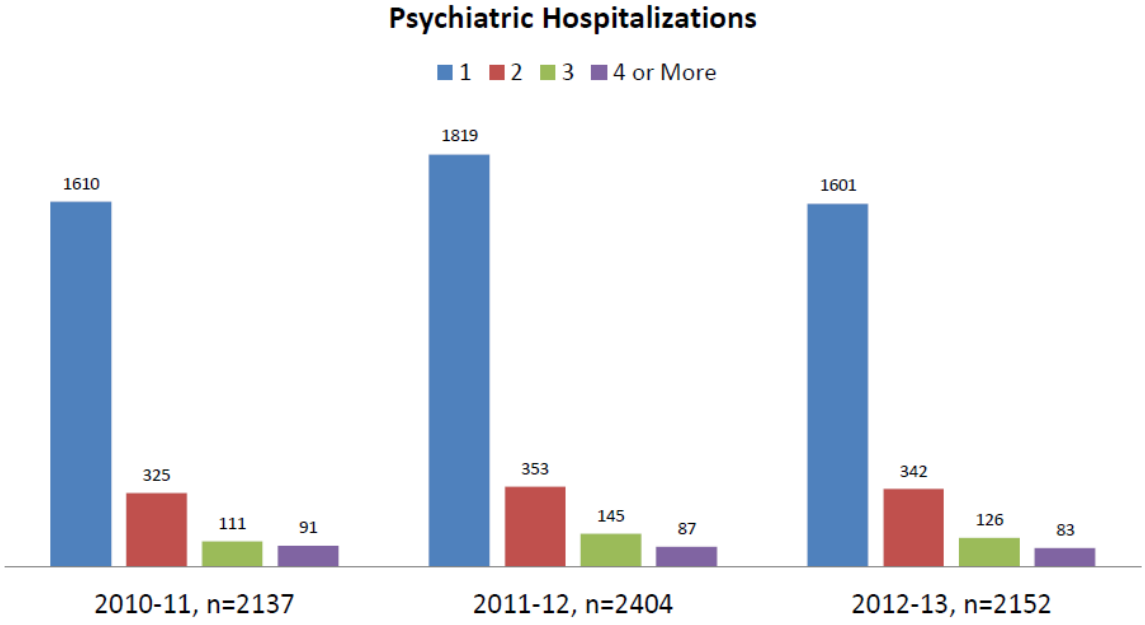
Program Name	Type of Program	Funding	Implementation Timeline
client/consumer participation in: a) outreach or engagement programs and/or b) a peer mentor and c) participation in intensive case management prior to consideration for the pilot.		would be supported by County General Funds, as MHSA cannot be used for involuntary services and these costs do not meet realignment requirements.	eligibility criteria, program design and processes and to identify outcome measures and an evaluation plan.

Appendix 4: Alameda County Mental Health Adult System of Care Map

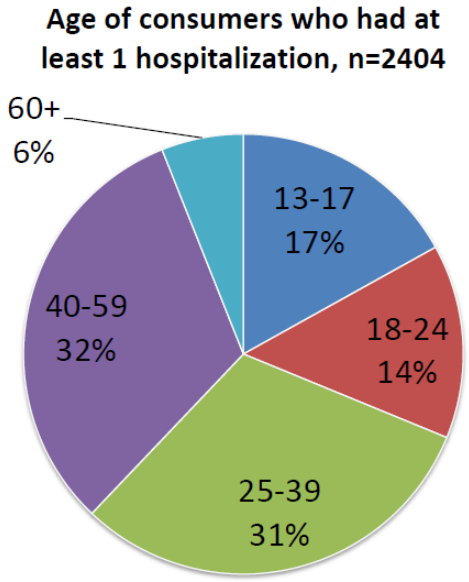


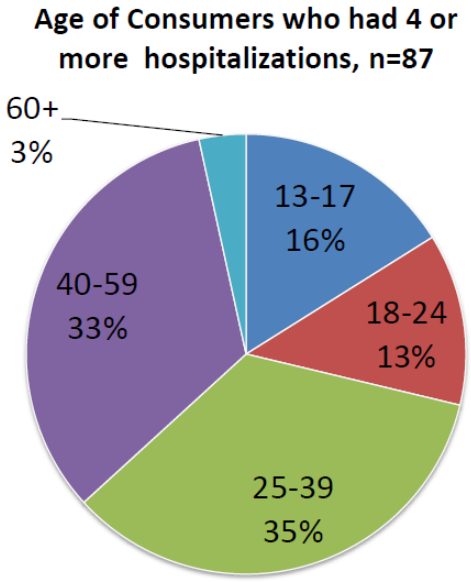
Appendix 5: Target Population Demographics

How many clients are hospitalized each year?
How many hospitalizations did consumers have?

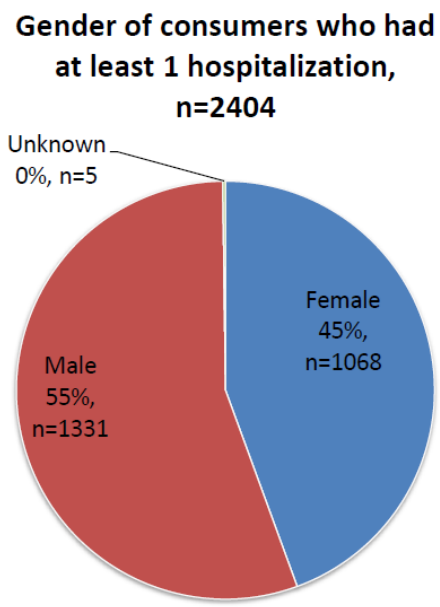


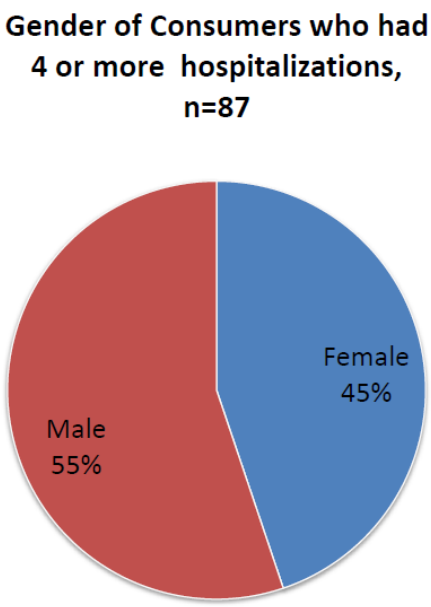
How old were consumers who experienced a psychiatric hospitalization?



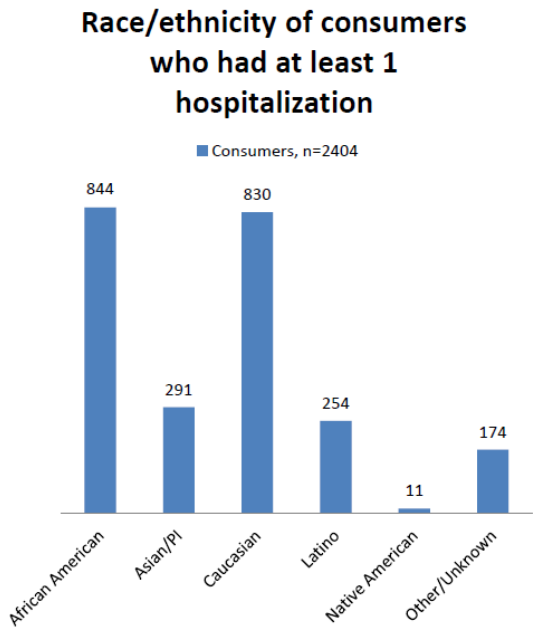


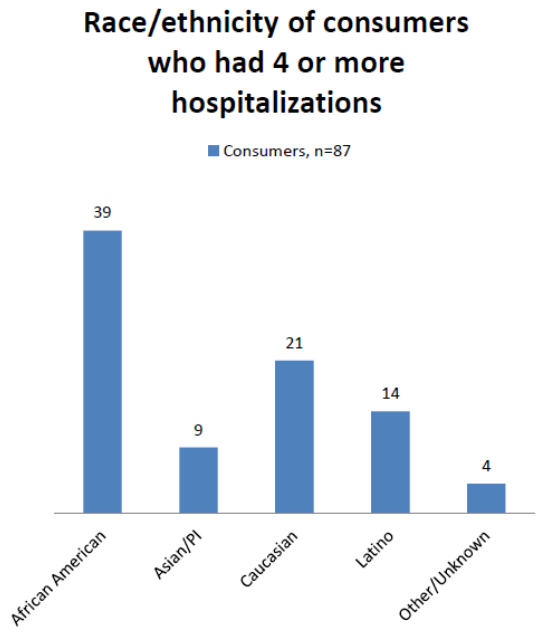
What gender are consumers who experienced a psychiatric hospitalization?





What race/ethnicity were consumers who experienced a psychiatric hospitalization?

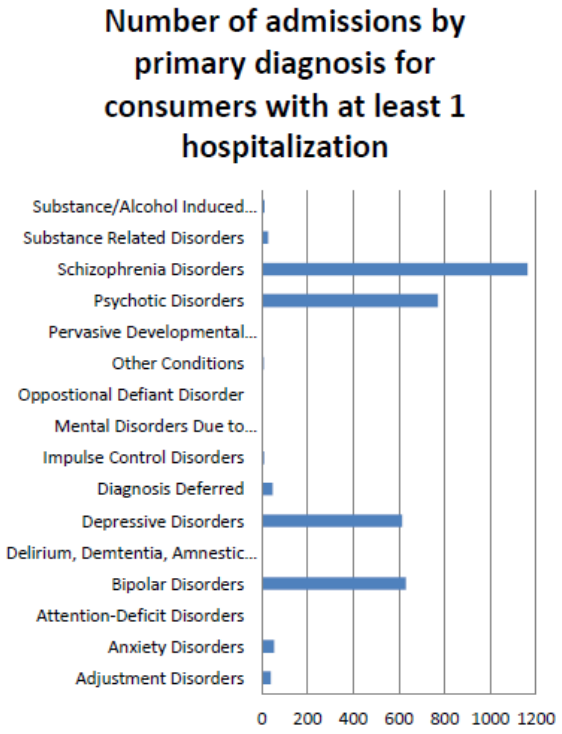


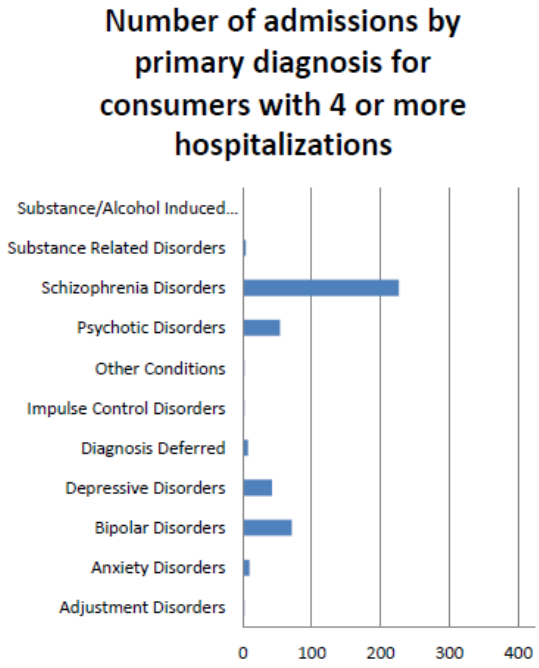


What was the city of residence for consumers who experienced a psychiatric hospitalization?

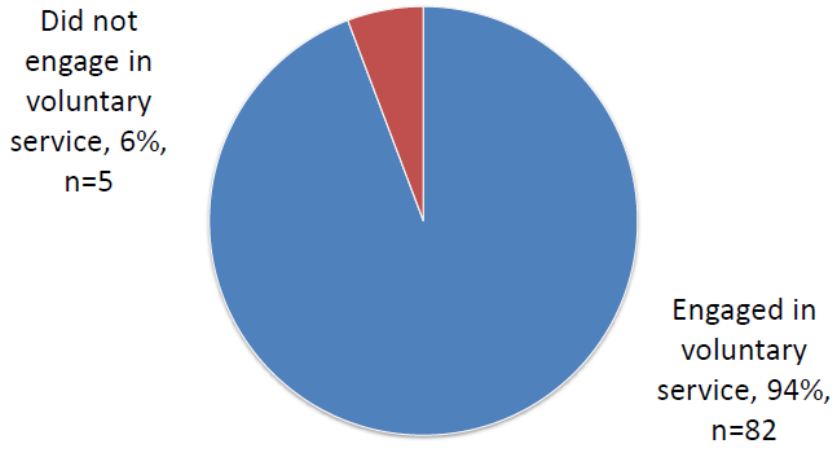
City of residence for consumers who had 4 or more hospitalizations			City of residence for consumers who had 4 or more hospitalizations		
ALAMEDA	64	3%	ALAMEDA	1	1%
ALBANY	7	0%	BERKELEY	12	14%
BERKELEY	155	6%	CASTRO VALLEY	2	2%
CASTRO VALLEY	42	2%	EMERYVILLE	1	1%
SUBLIN	35	1%	FREMONT	4	5%
EMERYVILLE	18	1%	HAYWARD	7	8%
FREMONT	125	5%	NEWARK	1	1%
HAYWARD	338	14%	OAKLAND	44	51%
LIVERMORE	59	2%	SAN LEANDRO	7	8%
NEWARK	28	1%	UNION CITY	1	1%
OAKLAND	848	35%	UNKNOWN	1	1%
PIEDMONT	3	0%	Out of County	6	7%
PLEASANTON	33	1%	**Total**	**87**	**100%**
SAN LEANDRO	288	12%			
SAN LORENZO	19	1%			
SUNOL	1	0%			
UNION CITY	59	2%			
UNKNOWN	7	0%			
Out of County	274	11%			
Total	**2404**	**100%**			

What was the primary diagnosis at admission for consumers who experienced a psychiatric hospitalization?



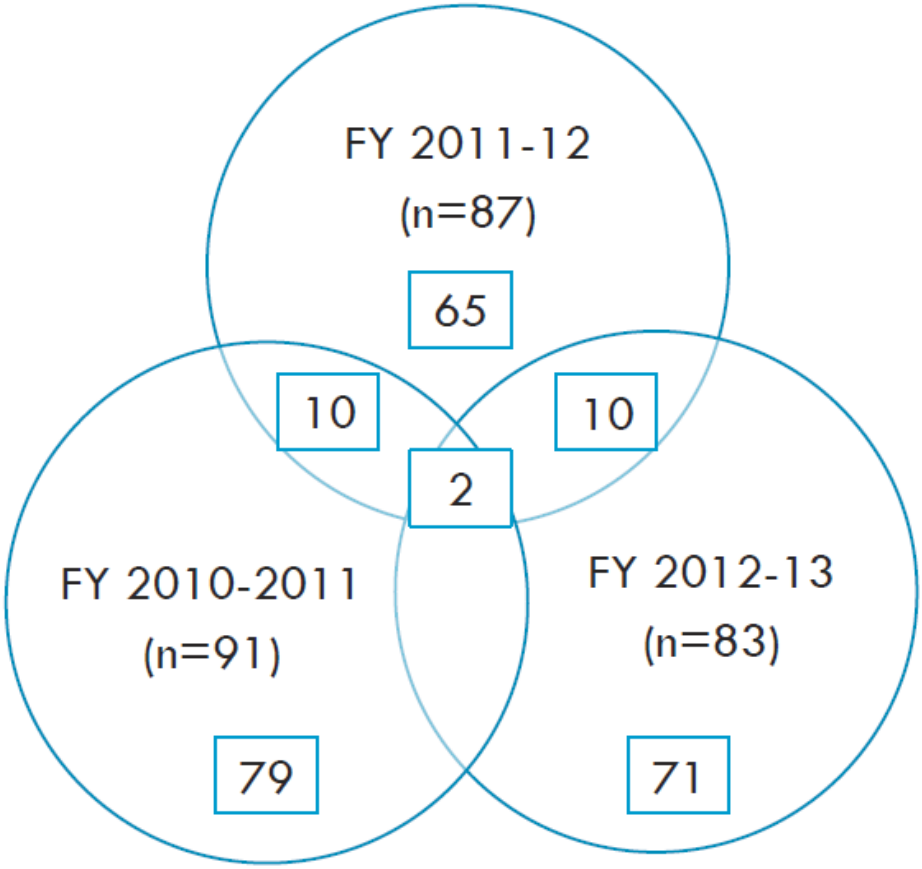


How many of the clients with 4+ hospitalizations within FY 2011-12 participated in a voluntary service* within that same year or within six months prior to or after the fiscal year?



*Voluntary services exclude locked facilities, hospitals, jail, juvenile justice center and hospital-based crisis.

Of consumers with 4+ hospitalizations in FY 2011-12, how many had 4+ hospitalizations in the previous or following year? How many had 4+ hospitalizations in all three years?



Appendix 6: Planning Meeting Agendas

AB1421 Planning Process Meeting #1

April 23, 2014, 12:00pm - 3:00pm

TIME	TOPIC	PRESENTER
11:30	***Assemble, Lunch and Materials Review***	
12 pm	**I. Meeting Convening** • Background • Role of Planning Committee	Alex Briscoe, Director, HCSA
12:15	**II. Participant Introductions** • The Facilitation Team • Participant Introductions	Amalia Egri Freedman, RDA Jane Stallman, Center for Strategic Facilitation
1:00	**III. Facilitation Process Overview** • Working Norms • Process Overview • Questions & Answers	Jane Stallman
1:20	***B R E A K (10 minutes)***	
1:30	**IV. Board of Supervisors Charge**	Honorable Keith Carson, President, Board of Supervisors
1:45	**V. Report Out on Participant Interviews**	Amalia Egri Freedman
2:00	**VI. Building the Foundation** • AB1421 Overview • Target Population • HCSA/BHCS System map	Roberta Chambers, PsyD, RDA Aaron Chapman, MD, Interim Director, BHCS
2:50	**VII. Recap & Close** • Meeting Recap • Work Group Tasks • Adjourn	Amalia Egri Freedman

AB1421 Planning Process Meeting #2

May 7, 2014, 9:00am - 12:00pm

TIME	TOPIC	PRESENTER
8:45	***Assemble, Materials Review***	
9 AM	**I. Meeting Convening** • Review Progress and Agenda	Amalia Egri Freedman, RDA
9:05	**II. Confirming the Target Population** • Defining the Target Population • Questions & Answers	Toni Tullys, Deputy Director, BHCS Roberta Chambers, PsyD, RDA
9:20	**III. BHCS System Overview** • System Map & Proposed Expansion • Questions & Answers • Strength & Gaps Group Exercise	Roberta Chambers, PsyD Jane Stallman, Center for Strategic Facilitation
10:35	***B R E A K***	
10:45	**IV. Overview of Alternative Models**	Roberta Chambers, PsyD
11:15	**V. Launch Workgroups** • Workgroup Charge • Initial Meeting	Jane Stallman
11:55	**VII. Recap & Close** • Meeting Recap • Next Steps • Adjourn	Amalia Egri Freedman

AB1421 Planning Committee Work Group Session

May 19, 2014, 12:00pm – 3:00pm

Alameda County Training Center

TIME	TOPIC	PRESENTER
11:45	***Arrive, Lunch, Be seated in work teams***	
Noon	**I. Meeting Convening** • Introduction & Check in Question • Review Progress	Amalia Egri Freedman, RDA Jane Stallman, Center for Strategic Facilitation
12:15	**II. Updates** • Program Information Distributed (Q & A) • Pertinent Issues Affecting our Work	Roberta Chambers, PsyD, RDA
12:30	**III. Work Team Overview** • Convergence • Review Charter • Review Templates	Jane Stallman
12:45	**IV. Work Team Meetings** • Team Discussions	All
2:45	**IV. Check-Out** • Question: How was this? • Next Steps • Next Meeting: Planning Meeting #3 *May 28th, 2014, Noon to 3pm* • Adjourn	Amalia Egri Freedman

AB1421 Planning Process Meeting #3

May 28, 2014, 12:00pm – 3:00pm
Alameda County Training Center

TIME	TOPIC	PRESENTER
11:30	***Early Arrival /Team Presentation Preparation*** • Write Systems-Level Change on each half sheet • Write Programs/Direct Service Delivery on each half sheet	Jane Stallman, Center for Strategic Facilitation Diana Sanders, RDA
11:45	***Participants arrive; Lunch***	
Noon	**I. Convene Meeting**	Amalia Egri Freedman, RDA Jane Stallman
12:15	**II. Introduction to Manuel Jimenez, BHCS Director**	Toni Tullys, Deputy Director, BHCS Manuel Jimenez, Director, BHCS
12:30	**III. Materials Review** • Response to questions regarding new materials	Roberta Chambers, PsyD, RDA
12:45	**IV. Work Teams Presentations** • Review Objectives • Outline Proposal • Clarification Questions • List significant Questions for Follow Up	Jane Stallman & Diana Sanders
1:55	***B R E A K***	
2:05	**IV. Observations / Discussion**	Jane Stallman & Diana Sanders
2:50	**V. Check-Out** • Review work session experience • Next Meeting: *Work Group Meeting #2* *Monday, January 2, 2014* *1 – 4 PM* *Gail Steele Room, BHCS Offices* *2000 Embarcadero, Oakland, CA*	
3 PM	*Adjourn*	

AB1421 Planning Process Meeting #4

June 19, 2014, 9:00am - 12:00pm

BHCS Offices, 2000 Embarcadero Cove, Gail Steele Room

TIME	TOPIC	PRESENTER
8:30	***Team presentation preparation***	Jane Stallman, Center for Strategic Facilitation Diana Sanders, RDA
8:45	***Participants arrive, coffee, be seated***	
9:00	***I. Convene Meeting*** • Introductions • Process Recap • BOS Charge and AB1421 Goals	Amalia Egri Freedman, RDA
9:10	***II. Review Supplemental Data***	Roberta Chambers, PsyD, RDA
9:25	***III. Teams Report Out & Committee Determines Recommendations*** • Team Report Out • Identify Areas of Agreement ***Short Stretch Break*** • Discuss Remaining Recommendations • Finalize Recommendations	Jane Stallman, Center for Strategic Facilitation Roberta Chambers, PsyD, RDA
11:45	***IV. Check-Out*** • Work session outcomes • "Parking Lot" • Next Steps	Amalia Egri Freedman, RDA Toni Tullys, BHCS
Noon	*Adjourn*	

AB1421 Planning Process Meeting #5

June 30, 2014, 1:00pm – 3:00pm

BHCS Offices, 2000 Embarcadero Cove, Gail Steele Room

TIME	TOPIC	PRESENTER
12:45	***Participants arrive and be seated***	
1:00	***I. Convene Meeting*** • Introductions • Meeting Purpose & Objectives • Committee Ground Rules • Recommendations to Date	Amalia Egri Freedman, RDA
1:10	***II. AOT and Conservatorship Review and Discussion*** • Review Program Elements • Discuss Service Objectives • Determine Program Recommendation	Alameda County Staff Jane Stallman, Center for Strategic Facilitation Roberta Chambers, PsyD, RDA
2:05	***III. Confirm Committee Recommendations*** • Finalize Recommendations	Jane Stallman Roberta Chambers, PsyD
2:40	***IV. Check-Out*** • Review "Parking Lot" • Next Steps • Check Out Exercise	Amalia Egri Freedman Toni Tullys, BHCS
3 PM	*Adjourn*	

Appendix 7: Meeting Ground Rules

Working Together Effectively

Meeting Norms for the Alameda County AB1421 Planning Process

To build our ability to work together we…

- **Agree to participate**. This is complex work. If we had an easy solution it would already be implemented. Each of us has something important to contribute.
- **Learn from others' questions and comments.** No one has the perfect answer. By putting together various insights and wisdom, we'll be able to come up with solutions that invite support.
- **Focus on interests, not positions** – It is difficult to agree on positions, easier to generate solutions that take into account all the interests identified.
- **Try to see the whole picture** – not just the part that concerns you the most.
- **Be open to the possibility** that with our combined intelligence, experience and commitment, we will find ways to address the challenges in front of us.

To show respect and courtesy, we agree to…

- Have **one person speak** at a time.
- **Focus on one process**, one content at a time – stay on the agenda.
- **Express disagreement with ideas, not people.**
- **Keep your comments short** – if you take up a lot of time, others won't have any time to share their experience, ideas and insights.
- **Be on time.** Arrive on time and be back on time from breaks.
- **Use the parking lot** for questions that are not on the agenda or will not serve the greater good of the meeting, but should ultimately be addressed.
- **Turn off electronics** or at minimum put on vibrate (step out if you need to take a call).
- **Practice "Step Up, Step Back"** in order to make room for participation by all.

To promote understanding, we agree to…

- **Assume good intentions** – really hearing one another as genuine participants in solving a challenging problem.
- **Use inquiry more than advocacy**. Inquiry allows us to understand more deeply.
- **Ask for clarification vs. assuming** what another person means or intends to say.
- **Uncover underlying assumptions** – your own as well as others'.

Based on working norms developed by Jane Stallman, Center for Strategic Facilitation

Appendix 8: List of Handouts

1. Planning Process Overview
2. AB1421 Planning Meeting – Feedback Form
3. Alameda County Mental Health Adult System of Care – Map – v1 (05/07)
4. Alameda County Mental Health Adult System of Care – Map – v2 (05/04)
5. AB1421 Planning Process – Revised Meeting Schedule
6. Crisis Residential Treatment (CRT) Program
7. Peer Respite Model
8. Community Independence Pilot Project (Community Conservatorship)
9. Target Population Data Update
10. Alameda County Mental Health Adult System of Care – Map – v3 (05/19)
11. Supplemental Program Model Research – Case Management Models
12. Work Group Session #1 – Guide To Proposal Forms
13. Template – Preliminary Ideas for Program/Service Mix – For Discussion in Planning Meeting #3
14. Template – Proposal Cover Sheet – Complete in Work Group Session #1 for Discussion in Planning Meeting #4
15. Planning Process Overview – v02
16. Target Population Demographics Data Update
17. Assisted Outpatient Treatment (v3) – Overview
18. Supplemental Data for the AB1421 Target Population
19. Draft Recommendations

Appendix 9: Planning Meeting #4 Recommendations by Workgroup

The following draft recommendations emerged from each workgroup prior to the final planning meetings.

Green Team

Proposed Service(s): Rapid Engagement Team (RET)

Key Themes: The RET will follow the consumer through the process, using a validated tool to determine the level of intensity required. The team will include peer support, family support, licensed clinician(s), vocational education, housing, and AOD. Will engage within three days of inpatient placement.

Yellow Team

Proposed Service(s):

- Community Conservatorship with Co-Conservator Model
- Peer Respite
- Crisis Resolution (North Alameda County)
- ACT/FSP for ADD
- Addition of a program administrator to oversee the AB1421 population

Key Themes: Community Conservatorship with additional of co-conservator advocate. Addressing the person who does not engage, recommend access to housing, substance abuse services, appropriate case management, and an administrator that can oversee target population – specifically tracking the 205 on behalf of BHCS. Also, peer respite, which would offer short-term peer residential crisis services, with measured outcomes. When someone accesses peer respite, they would have access to a peer or family mentor.

Blue Team

Proposed Service(s):

- Expansion of crisis services
- Ability for families to more meaningfully participate
- Systems navigator
- Analysis of data
- Centralized database

Key Themes: System navigators that are responsive to client and family members, can go out into the field and get the consumer to crisis residential, with access to AOD and eligibility services. We are creating a bridge to the system by having a resource specialist as a member of the team. The system is worried about crisis, but this is an opportunity for practical engagement, which is a priority for the consumer.

Red Team

Proposed Service(s):

- Expanded conservatorship to include community conservatorship
- Expanded Criminal Justice Mental Health services
- 24-hour Crisis Stabilization Unit
- Expanding co-occurring disorder treatment and care
- Expanding FSPs

Key Themes: Offering 24-hour crisis stabilization services, with peer respite, detox and transportation, outreach, and warm handoffs. This team is including AOT – with three in favor and one not, the proposal will emphasize use of all volunteer programs before resorting to AOT. If voluntary programs work, then there is no need for AOT.

Appendix 10: AB1421 Planning Process – "Parking Lot" Issues

The following questions or issues were raised during the AB1421 Planning Process, and will be addressed through the following efforts.

No.	Item Description	Process or program addressing this issue	Other Notes
1.	Degree to which citizenship status plays a role in access to treatment among the target population	Alameda County provides access to treatment through the Health Program of Alameda County, also known as HealthPAC. HealthPAC provides affordable health care to uninsured people living in Alameda County. HealthPAC is not insurance and does not provide everything that insurance does. Citizenship is not a requirement of the program. In order to be eligible for HealthPAC an individual must be an Alameda County resident and be between 0 and 200 percent of the Federal Poverty Level, not be eligible for Medi-Cal, and not be enrolled in private insurance. Services are provided through one of the 9 community-based clinics that are part of the network or through Alameda Health System. In order to enroll, people make an eligibility appointment at one of the	To find out more about HealthPAC, please go to http://achealthcare.org/health-insurance-info/low-income-coverage-options/healthpac/

No.	Item Description	Process or program addressing this issue	Other Notes
		clinics or at Health Care Services Agency and bring in identification, proof of residency, and proof of income.	
2.	Written vs. verbal consent as a barrier to engagement	The BHCS Quality Assurance practice is to obtain an adult client's (or their legal representative's) written consent for outpatient mental health services on the first face-to-face visit. If the client is experiencing a psychiatric emergency (at risk for imminent hospitalization), crisis services may be provided without written consent. Once the client's psychiatric emergency is addressed, their provider will require the client to sign the written Consent for Services form so that outpatient treatment services may continue. In addition, written informed consent is required for each medication prescribed by a medical provider (CCR, Title 9, Chapter 4, Section 851).	
3.	Program design that includes family referral (for adult clients)	BHCS recognizes that caregivers' ability to provide support to clients is enhanced when they have pertinent information. In addition, the capability of BHCS service providers to effectively	Additional information on the BHCS Confidentiality Guidelines can be found in the BHCS "Response to the AB 1421 Stakeholder Workgroup

No.	Item Description	Process or program addressing this issue	Other Notes
		treat clients can be increased by information received from family caregivers. BHCS supports a collaborative model of practice, which promotes the voluntary sharing of information among clients, BHCS and contract agency staff, and caregivers to the greatest extent feasible in order to facilitate the rehabilitative/recovery process for clients. California and federal laws and statutes require adult consumers to provide written consent to share information with their family members/caregivers. In an effort to promote a more open exchange of information among clients, their caregivers and providers, BHCS has developed a set of Confidentiality Guidelines that protect the statutory rights of clients to privacy and focus on the importance of support systems and open dialogue between clients and their caregivers, keeping in mind the client's privacy rights.	Recommendations" implementation document.

No.	Item Description	Process or program addressing this issue	Other Notes
4.	Availability of a BHCS service directory	BHCS plans to update the online Network of Care directory in FY 2014/2015.	
5.	Racial disparity in engagement in services	As a system, BHCS is committed to improving disparities in engagement and access to behavioral health services, increasing community penetration rates for services, and improving overall health outcomes in underserved and inappropriately served communities. This is an ongoing and long term effort. BHCS recognizes that understanding a community's cultural needs, beliefs and practices, working with cultural brokers and supporting community-defined strategies will improve access to care and help to reduce health disparities. Through MHSA Prevention and Early Intervention funding, BHCS supports five underserved cultural communities to conduct outreach, engagement and education and to provide mental health consultation and early intervention programs in culturally appropriate ways.	

No.	Item Description	Process or program addressing this issue	Other Notes
		In 2010, BHCS commissioned an African American Utilization Study Report, due to the high rates of largely involuntary hospital and jail services for this inappropriately served population. Based on the Study's recommendations and using the MHSA Innovations Grants process, BHCS funded 14 grantees to develop culturally appropriate approaches to provider training, collaboration with the faith community and outreach and engagement. BHCS Leadership will finalize decisions on grant funding and next steps in November/December 2014.	
6.	Are the 70% within the target population who have a co-occurring diagnosis receiving or being referred to treatment?	The BHCS System of Care Directors, Critical Care Manager for John George Psychiatric Pavilion, and Alcohol and Drug Administrator, will work as an operational team to coordinate service delivery among the target population.	