ALAMEDA COUNTY MENTAL HEALTH SYSTEM TOO COMPLEX TO NAVIGATE

EXECUTIVE SUMMARY

The mental health system is supposed to provide a safety net for the thousands of homeless and near-homeless residents of Alameda County who struggle with serious mental illnesses. The current approach is missing the mark. Alameda County residents witness daily the inadequacies of our mental health system. The Grand Jury investigated the challenges faced by adult homeless and near-homeless people and their families as they try to navigate the mental health system to obtain care. Those in need of assistance complained that the system is fragmented and unresponsive. The Grand Jury found that the system is complex and difficult to navigate.

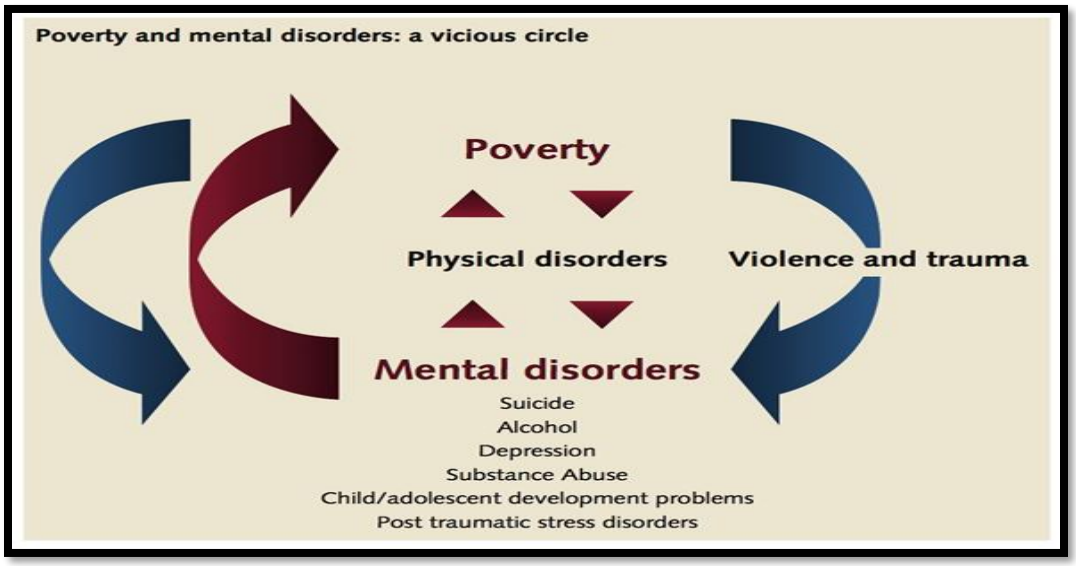
Alameda County's Behavioral Health Care Services department (ACBH) and a dedicated group of agencies and individuals struggle to offer seamless and holistic community care. With a budget of more half a billion dollars annually, ACBH is the center of care for mental health support for low-income residents of Alameda County. Within that budget, California Proposition 63 (Prop. 63), also known as the Mental Health Services Act (MHSA), provides around $100 million annually to augment and enhance community-based care for the mentally ill through ACBH.

More needs to be done. The Grand Jury found that entry to the system needs to be streamlined, communication between ACBH and service providers must be improved, and technology should be updated to improve mental health services and tracking. Most importantly, the Grand Jury is recommending that ACBH conduct a county-wide needs and gaps in services assessment to ensure that funds are directed to services and service providers in the most beneficial and cost-effective way.

BACKGROUND

The Grand Jury investigated the intersection of two of Alameda County's most serious social problems: 1) mental illness, particularly the stabilization and treatment of adults with severe mental illness (SMI, defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities) and 2) homelessness and near-homelessness among adults. Tragically, too many homeless adults with SMI, either on the brink of a mental health crisis or in crisis, populate Alameda County's streets and open spaces. Homelessness among adults is frequently the result of SMI, as well as substance abuse. Those health issues, among other key factors, can lead to poverty, a direct cause of homelessness. And homelessness makes finding, stabilizing, and treating adults with SMI much more difficult. It's a vicious cycle.

The Grand Jury focused its investigation more on SMI support, stabilization, and treatment than homelessness, but it's important to acknowledge up front how interrelated the two issues are. The following chart illustrates this relationship, with poverty serving as a proxy for homelessness.



Locating, Stabilizing, and Treating Homeless Adults with Severe Mental Illness in Alameda County

Though homeless individuals with SMI are clearly visible by observation and through witness testimony, the Grand Jury found it difficult to find good data on the scope of the issues of locating, stabilizing, and treating homeless adults with SMI in Alameda County, which is part of the problem in itself. Therefore, the Grand Jury had to rely on broader California data to help illustrate the scope of this issue.

Estimates on the percentage of homeless adults in California who have SMI range from about 30% to over 75%. Many of the homeless with SMI end up cycling in and out of emergency rooms and jails; close to a third of California jail inmates have a documented mental illness. Most researchers agree that the connection between homelessness and SMI is a complicated, two-way relationship. Homelessness can exacerbate an existing mental illness, and individuals with SMI may find themselves homeless, primarily due to lack of income and housing. Rates of contact with the criminal justice system are higher among unhoused SMI, and SMI individuals are more likely to be the victim of a crime. (bbrfoundation.org)

A Brief History of Alameda County's Current Mental Health System

California began to reform its mental health care system starting in the 1950s. But, prior to 1967, Alameda County's mental health system looked very different than it does now. Many more individuals with SMI lived in state hospitals and large facilities, often for long periods of their lives. Then California passed the Lanterman-Petris-Short (LPS) Act. The LPS Act sought to, "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." The Act in effect ended all hospital commitments by the judiciary system, except in the case of criminal sentencing, *e.g.*, convicted sexual offenders, and those who were "gravely disabled", defined as unable to obtain food, clothing, or housing. It did not, however, impede the right of voluntary commitments. It expanded the evaluative power of psychiatrists and created provisions and criteria for psychiatric holds (5150s).

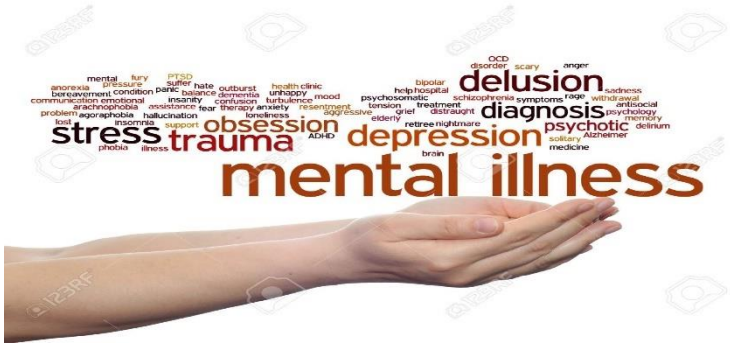
Most mental health services are now delivered within the community by what are known as community-based organizations (CBOs).

Since the passage of the Act, there have been major changes in how mental health support has been provided in California, including Alameda County, and currently few people with SMI are involuntarily institutionalized. Most mental health services are now delivered within the community by what are known as community-based organizations (CBOs).

Also, in 1999, the U.S. Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA). The Court held that public entities must provide community-based services to persons with disabilities when 1) such services are appropriate, 2) the affected persons do not oppose community-based treatment, and 3) community-based services can be reasonably accommodated.

Licensed board and cares, including Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), have long served as important housing options for SMI, disabled, and aging populations by providing safe residences when other housing options are

not possible or appropriate. They offer a room and three meals a day, and basic care and assistance. Licensed board and cares provide alternatives that comply with the requirements of the *Olmstead* decision and cost less than institutional care. However, board and care costs are high compared with federal reimbursement rates, which are low. Because of this, almost one-third of board and cares in California have closed in the last decade in some California counties, adding to the homeless crisis for the poor, aged, and mentally ill. (calmatters.org) Alameda County, like other California counties, has begun to supplement the payments to low-income residents in an effort to maintain this housing option.



Alameda County Behavioral Health Care Services (ACBH) – the Center of Mental Health Services in Alameda County

Within Alameda County, responsibility for administering public mental health and substance use services for low-income residents falls primarily on ACBH, housed within Alameda County Health Care Services Agency (ACHCSA). ACBH is responsible for providing mental health services for people with moderate to severe mental health needs as well as for substance use disorders. Alameda County residents are generally eligible for services from ACBH if they have a mental health disability that impairs their daily functioning and are eligible for Medi-Cal.

The level and range of recommended services and the target population are prescribed by California's Bronzan-McCorquodale Mental Health Act, which requires the counties to fund mental health services for people with a serious, persistent mental illness (or children with serious emotional disturbances within specific funding guidelines) instead of the state. Most hospital and less intensive sub-acute stays are funded solely by county funds, while community-based services are typically eligible for federal Medicaid (which is Medi-Cal in California) match dollars. Medi-Cal-mandated services include: psychiatric crisis or emergency treatment, inpatient care, outpatient/day treatment, case management, conservatorship, administration, and evaluation. Medi-Cal consolidation requires ACBH to provide the full range of mental health services to any Alameda County Medi-Cal beneficiary meeting Medi-Cal medical necessity criteria and in need of those services.

The core continuum of care for mental health includes a variety of services with different levels of intensity that should be available and easily accessible to all individuals. ACBH supports "upstream" behavioral health services—it considers the social, economic, and environmental origins of health problems that manifest at the population level, not just the "downstream" symptoms or end effects that manifest at the individual level.
The core continuum of care includes:

- Prevention and wellness services.
- Outpatient services.
- Peer and recovery services delivered in the community.
- Community supports, including flexible services designed to enable individuals to remain in their homes and participate in their communities, such as supportive housing, case management, supported employment, and supported education.
- Residential treatment provided on a short-term basis to divert individuals from or as a step-down from intensive services.
- Crisis services such as call centers, mobile crisis services, and crisis residential services.
- Intensive treatment services that are provided in structured, facility-based settings to individuals who require 24-hour/7-days-per-week care, including inpatient psychiatric treatment and clinically managed inpatient services.

Acute Crisis Care Evaluation for System-wide Service (ACCESS) - the Designated Entry Point for ACBH Services

ACCESS is the system-wide point of contact for information, screening, and referrals for mental health and substance use services and treatment for Alameda County residents. The ACCESS line (800-491-9099) is a state requirement, dating from when county behavioral health departments became carve-out mental health plans in the 1990s. The intent of ACCESS is a one-stop entry point, with "no wrong door," that can provide services using a person-centered approach, reducing, in theory, the number of barriers for accessing services. A centralized team is responsible for linking beneficiaries to appropriate, medically necessary services. ACCESS is a portal telephone service staffed during the day by licensed clinical social workers (LCSWs), who determine eligibility for specialty mental health services after screening for symptomology and program qualifications, including verification of health plan eligibility. Referrals are based on clinical need and provider availability.

ACCESS is the system-wide point of contact for information, screening, and referrals for mental health and substance use services and treatment for Alameda County residents. The ACCESS line is 800-491-9099.

The ACCESS line is not staffed by a live person after 5 p.m. on Mondays through Fridays or on weekends. Although there is a phone line answered by a local mental health provider during hours when ACCESS is not staffed, emergency mental health intervention or referral services for low-income seriously mentally ill individuals are not offered 24-7. There is no crisis referral line or alternative to jail or 5150 holds for immediate care for the seriously mentally ill when ACCESS is closed.

The substance abuse line is not staffed by a live person after 9 p.m. There is no place for law enforcement or others to call for mental health referral support during evening hours, so psychiatric emergency services or jail become the only option for law enforcement by default. To obtain care, the client needs to be on the line unless they are experiencing an active psychotic episode. To be called back, a client must have phone access, which can be problematic for someone homeless. ACBH's website is rich in some information but difficult to navigate. After-hours calls are answered by Crisis Support Services of Alameda County, which offers phone support from non-professional crisis counselors. ACCESS is not a crisis line; **Alameda County's 24-7 crisis line is 800-273-8255.** (crisissupport.org)

Mental Health Services Act (MHSA) - Prop. 63

One key area of funding for ACBH is the MHSA, also known as Prop. 63. Prop. 63, passed in 2004, includes a 1% tax on individual incomes over $1 million. At least 51% of the funds must be spent on community services and support for children and adults with or at risk of developing mental illness.

Services funded by MHSA must be voluntary. None of the funds are to be used for programs with existing fund allocations, unless it is for a new element or expansion in those existing programs.

Prop. 63 income has increased significantly since its passage. Alameda County received $91 million in fiscal year (FY) 2020-2021, and $97.6 million in FY 2021-2022; MHSA currently provides approximately 25% of the ACBH budget. In addition, there have been significant carryover funds (exclusive of a $14.5 million reserve). Alameda County in recent years has left a significant amount of its MHSA funds unspent; excess funds are at risk of being returned to the state if they remain unspent for over three years. To accomplish its objectives, the MHSA applies a specific portion of its funds to each of six system-building components:

1. Community services and supports (CSS) (45%)
2. Prevention and early intervention (20%)
3. Community program planning and administration (10%)
4. Capital (buildings) and information technology (IT) (10%)
5. Education and training (human resources) (10%)
6. Innovation (5%)

A Community Program Planning Process is required every three years whereby the MHSA meaningfully engages its stakeholder community and creates a three year plan, with annual updates.

A Mental Health Advisory Board (MHAB) is mandated by Prop. 63. Roles of the Alameda County MHAB include education and advocacy, as well as review and evaluation of the county's mental health system. Three-year plans and annual updates are developed by ACBH with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. (ACBH 2020-2023 Highlights)

The Courts, Alameda County, and Alameda County Behavioral Health Care Services

Behavioral Health Court (BHC)

BHC is a collaboration between the Alameda County Superior Court, the District Attorney's Office, the Public Defender's Office, and ACBH. Its mission is to promote public safety and assist SMI persons who commit non-violent crimes by diverting them away from the criminal justice system. Judges, lawyers, and mental health professionals work in partnership with the court's client, aka "partner," to develop a treatment plan for the "partner," who has been charged with a non-violent crime. The program diverts those who qualify for the program out of Santa Rita Jail and into a one to two-year treatment program with an Alameda County-based mental health provider. The "partner" is closely monitored by the court, and upon successful completion of their treatment plan, the "partner's" pending criminal case and associated arrest record are sealed.

A Mental Health Advisory Board (MHAB) is mandated by Prop. 63. Roles of the Alameda County MHAB include education and advocacy, as well as review and evaluation of the county's mental health system.

The MHSA funds many of the treatment providers and the clinical team that staffs the BHC program. The lawyers and judges are funded by their respective departments.

Civil Rights Lawsuit

Alameda County has been the subject of a class action civil rights lawsuit, Babu v. Ahern and a Department of Justice inquiry into mental health conditions and services at Santa Rita jail. The parties agreed that Alameda County has violated the civil rights of people with SMI by failing to provide adequate care and allowing them to go into crises, ending up in the county jail, where violations of their rights occurred.

The Consent Decree from the Babu lawsuit has been approved and will impact how ACBH will provide services. Among its stipulations are that Alameda County provide evidence-based community-based services in the most integrated setting, implement a comprehensive crisis-response system, implement a sufficient number of full service partnership (FSP, a comprehensive and intensive mental health program for adults with severe and persistent mental illness) teams that can provide sufficiently intensive community services to those who need them, implement a sufficient quantity of scattered-site, permanent supported housing slots, implement peer support services, and implement sufficient community-based services, including case management.

As a result of the lawsuit, the Alameda County Board of Supervisors (BOS) has made a public commitment to a shift in priorities: from incarcerating those with mental illness to providing effective, evidence-based mental health treatment options for SMI individuals who are at risk of incarceration. The BOS adopted a "Care First, Jails Last" Resolution in 2021. The "Care First, Jails Last" Resolution includes behavioral health and wrap-around services that reduce the number of people with mental illness, substance use, and co-occurring disorders in Santa Rita Jail. The same resolution states there will be no net cost to the county.

INVESTIGATION

The Grand Jury received a complaint that there was inadequate community-based support for the seriously mentally ill in Alameda County and that services were fragmented and siloed. The complaint also stated that families of people with SMI were unable to find appropriate care for their loved ones.

The Grand Jury interviewed staff and board members of numerous local CBOs that provide a variety of mental health services to low-income Alameda County residents. The Grand Jury also interviewed several staff from ACBH, and members of the MHAB. Grand jurors attended MHAB meetings and met with the Alameda County Sheriff's Office.

Many reports, written materials, and internet resources, were studied including but not limited to:

- MHSA three-year plans and annual updates,
- 2015 Crisis Report from Resource Development Associates for ACBH,
- MHAB annual reports and background materials,
- MHSA requests for proposal (RFPs),
- ACBH contracts,
- Alameda County annual budgets,
- Strategic Implementation Framework, Justice Involved Mental Health Taskforce,
- FY2021-2022 Medi-Cal Specialty Behavioral Health External Quality Review,

- Rapid Examination of Jail Diversion Strategies and Services 2020, Justice Involved Mental Health Taskforce, and
- Unrecognized and Underutilized Potential: BHC of Alameda County, Urban Strategies Council.

Additional Alameda County reports and background materials, foundations' and cities' mental health reports, and data available from the state were among other materials reviewed.

The Grand Jury acknowledges that the field of mental health services and support is undergoing changes from new state CalAIM requirements and as a result of the Babu case. The Grand Jury also wishes to acknowledge the committed and knowledgeable staff from local non-profits and government it found during the investigation. But the Grand Jury also found common areas of concern from a variety of sources that gave support to the initial complaint that the system of support for SMI people is not functioning well. The Grand Jury focused on areas of improvement over which ACBH has some control and that address the initial complaint.

Community Needs Assessments and Strategic Plans

The MHSA, which represents approximately 25% of total funding to ACBH, mandates the collection of outcome data for the programs it funds, primarily CSS and FSPs. That data includes:

- 7-day and 30-day hospital recidivism
- 7-day and 30-day follow-up care for hospital discharge
- 7-day and 30-day crisis stabilization unit recidivism
- 7-day and 30-day follow-up care for crisis stabilization discharge
- Housing status at admission and discharge
- Primary care utilization
- Reduction in incarceration days

However, there is not a recent broad-based, Alameda County mental health needs/gaps assessment that explores where in the county there are service needs, equity disparities, successful interventions, and that reviews current best practices and gaps in service availability, both inside MHSA and outside MHSA. One witness described funding choices by ACBH as "shooting in the dark." The Grand Jury understands that a large-scale community needs assessment and strategic plan has not been completed since 2015, which was a crisis planning report completed by consultants *Resource Development Associates* for ACBH.

The Grand Jury reviewed many sources of information in addition to the annual MHSA reports, such as the External Quality Review, Alameda County Office of Homeless Care and

Coordination data and plans, various city agencies' reports and plans, Emergency Medical Services statistics, the Rapid Examination of Jail Diversion Strategies and Services Report, MHSA Integration Evaluation 2020-2021, and Santa Rita Jail data.

To summarize, Alameda County does not currently know if it is currently meeting the needs of its residents struggling with SMI.

Absence of Data

The lack of quality data integration and analysis was a concern for almost all witnesses, who came to this issue from a variety of perspectives. The Grand Jury agrees with this concern. The Grand Jury's investigation of many aspects of service needs and delivery was impeded by the unavailability of useful and coordinated data. There is no available data that reviews local CBO performance (outside data noted earlier in this report required by MHSA), or that compares success rates by agency, intervention, and diagnosis. There is no data documenting whether callers to ACCESS receive appropriate, or any, care. There is no integration of data from different organizations that follows a single individual and their outcomes. There is no data that explores reasons for failed outcomes for clients. Because waiting lists for services are not kept by all agencies, the actual need for individual interventions is unknown.

The Grand Jury's investigation of many aspects of service needs and delivery was impeded by the unavailability of useful coordinated data.

As an example, Assisted Outpatient Treatment (AOT) is a well-regarded MHSA program. It has a total of 30 slots in Alameda County and is chronically at capacity. Witnesses suggested that demand-based AOT capacity might be closer to 160 slots. It is unclear why this program has a cap of 30 while other MHSA-funded programs remain below capacity. Isn't AOT a "best practice" that should be rewarded, replicated, and expanded? Better data could help drive the decision.

It is unclear if there is equity in funding and services for AOT or other ACBH services. More information than just the race and gender of recipients is needed. The Grand Jury could not find data that compared services by geographic location. Nor could the Grand Jury find data that showed rates of funding or services compared with rates of disease for various population groups. There are many competing needs for mental health funding support. Better data and better data transparency would greatly clarify those needs for service providers and the community at large.

ACCESS: A Misnomer?

The Grand Jury found that ACCESS as a single point of entry to mental health help can be useful at certain hours, but those hours are limited. The phone number is only staffed by ACBH from 8:30 a.m. to 5 p.m. Monday through Friday; after-hours and weekend calls get referred to Alameda County Crisis Support Services, where nonprofessionals provide telephone support, with a call back from ACBH the next day. This makes ACCESS useless during immediate crises at night, when police report the majority of their need for help, or on weekends. While ACCESS may not have been intended as a crisis line, there is currently no county-wide alternative to jail or 5150s (involuntary holds in a psychiatric institution for up to 72 hours) when psychiatric events require an immediate response. Some cities are trying to create their own models for crisis response, such as the new Mobile Assistance Community Responders of Oakland (MACRO) pilot program.

Also, witnesses explained that the police do not have time to stay on the phone with a client and help complete a referral form—a form that requires clinical information. In addition, since ACCESS is a phone service, calls back the following day require access to a phone at the time of the call. And there is no follow-up with people who interact with this service, beyond the initial callback. Also, although loved ones and friends may call for information, the client must be on the call and participate willingly to initiate a service referral. Also of note, the new state budget includes proposed Medi-Cal eligibility for crisis intervention services and those services will be required to be provided 24-7.

ACCESS can be valuable as an information and assistance service, as it is staffed with LCSWs. But outreach is extremely limited, even to police and mental health providers. Witnesses from ACBH were not aware of any instances of any recent outreach efforts for either professionals or consumers. Of the approximately 2,300 calls that come into ACCESS monthly, fewer than 50 calls come from crisis management teams and law enforcement combined. And only about 10% of calls come from family members. Someone must know enough about the Alameda County mental health system, or be able to type the correct key words into a web search engine, to get to the ACBH or MHSA websites to find the ACCESS phone number.

Nonprofit programs describe a disconnect between ACCESS data and their true capacity. For example, witnesses noted that ACCESS often refers clients to their programs when the programs are already at capacity. Programs sometimes call ACCESS to ask about program availability for their clients but do not get accurate information. There is no current technology linking real time program capacity with ACCESS, although the Grand Jury was told there is a list updated daily to reflect service capacity.

Behavioral Health Court—Underutilized Resource?

Witnesses universally spoke highly of BHC. While a state statutory requirement (SB215) requires diversion opportunity for low-level mental health offenders, each county makes its own standards. However, no data is available to the public regarding the success or failures of BHC. For example, graduation rates are available for Collaborative Courts, but there's no public data for BHC graduation rates. The only publicly available data is that for the CBOs funded by FSPs through ACBH. Additional data was unavailable to corroborate witnesses' perception that BHC is a major asset to Alameda County. However, limited data from 2015-2016 indicates that BHC improves public safety, improves psychiatric outcomes for the participant, and lowers public costs. San Francisco BHC, which has similar rigorous criteria for enrollment, provides public data that indicates BHC reduces incarceration and violent behavior. The Grand Jury could find no available data that assesses why people drop out of BHC or don't follow through. There is also no available data that looks at whether the program provides racial and geographic equity.

ACHB needs to provide more flexibility in service delivery rules to ensure treatment and delivery of services work together to support client needs.

Alameda County allows 30 people in BHC at one time and a maximum of 100 people. There is only one BHC site in Alameda County—in Oakland. Witnesses stated that there are waiting lists for referral to BHC. By comparison, San Francisco has a BHC cap of 300 people annually for a population less than half of Alameda County's. Witnesses stated that expansion of BHC necessitates expansion of ACBH staff involvement, but more importantly, there is insufficient community-based treatment infrastructure.

Mental Health Services Act (MHSA)—Good Funding Source, Limited Guidance

ACBH provides information to MHSA CBO stakeholders on a regular basis, but does not extend those stakeholders structured opportunities to offer feedback or participate in a bidirectional communication process with ACBH. Witnesses from local CBOs expressed frustration with some aspects of the MHSA funding and contracting processes, particularly how funding choices are made and the limitations within the contracts, calling them inflexible and the process as opaque compared with other counties. A Grand Jury review of MHSA contracts confirmed that they are exacting in their expectations and that the timeline for new RFPs and contracts is not on a disclosed schedule.

ACBH needs to provide more flexibility in service delivery rules to ensure treatment and delivery of services work together to support client needs. Contracts are currently fee-for-service, where separate services are paid for individually, instead of performance-based, which set targets for measurable performance requirements and quality standards in

developing statements of work. Witnesses also complained that their FSP contracts are capped, and they are not allowed to over-serve. Reimbursement for these contracts is from MHSA and Medi-Cal funding, so additional services are at no cost to the county. County staff noted that agencies can make a request for additional funds if over-service is anticipated.

The Grand Jury also learned that not all MHSA funds are spent down annually. In FY 2021-2022, MHSA had $64 million in unspent funds from prior years, and anticipated carryover funds of almost $26 million, excluding the prudent reserve.

Equity of MHSA funding should be made more transparent. MHSA plans highlight groups that are undeserved by the system, but the Grand Jury is not aware of any systematized racial or geographic equity lens regarding funding allocations for services.

MHSA paperwork is a problem—FSP CBO contracts include substantial paperwork. One provider told the Grand Jury it no longer accepts funding for FSPs because the paperwork took 60% of staff time. Another provider called the paperwork "overwhelming." Some of the paperwork is unavoidable due to state and Medicaid requirements, but providers state that the paperwork can be significantly streamlined.

Medical record access is challenging—providers discussed their challenges in providing integrated care without adequate access to medical records. None of the providers who met with the Grand Jury have full interoperability of medical records with other FSP providers, which would allow timely and secure access, integration, and use of electronic health data so that it can be used to optimize health outcomes for individuals and populations. Some service providers are connected to some parts of the overall support system but not others. This contributes to the sense of fragmentation of the system felt by clients and their families. ACBH acknowledged this challenge.

Mental Health Advisory Board (MHAB)—Well-Meaning Watchdog with Limited Bite

MHAB meetings are open to the public and written materials are posted on its website. Part of the MHAB's charge is to advise the BOS on mental health issues. The BOS has a representative at MHAB meetings and ACBH attends the meetings regularly. The MHAB has written thoughtful letters to the BOS over the last several years about relevant issues, such as the Santa Rita Jail issues and the need for more transparent data, but the BOS has not responded to those letters nor invited members to present at a BOS meeting. Thoughtful communication deserves a response. And there are MHAB vacancies to be filled. There are 16 available positions on the MHAB, all appointed by the BOS, and only 10 are currently filled. MHAB members can enrich mental health service delivery and provide outside expertise and perspective.

CONCLUSION

Through its investigation, the Grand Jury found and verified that Alameda County's mental health system is very complex and challenging to navigate, particularly for the SMI individuals and their families and friends for whom it should be primarily designed to serve. Based on its findings and through its recommendations, the Grand Jury seeks to help simplify this complex system for those trying to use it, and to help facilitate needed improvements for those attempting to maintain and manage it.

The Grand Jury wants to make clear that the problems it identified through its investigation lie largely with the system itself, not the people working within it. Despite questionable allocations of resources and the high personal and financial costs and stresses of working in the San Francisco Bay Area, the Grand Jury found dedicated groups of individuals committed to serving Alameda County's mental health needs. The following findings and recommendations are focused on helping these noble mental health service providers and the people they serve.

FINDINGS

Finding 1:

A county-wide needs/gaps assessment (broader than what the Mental Health Services Act mandates) has not been completed since 2015. A current strategic plan for Alameda County Behavioral Health is missing.