STATE OF RECOVERY | 2019

RECOVERY-ORIENTED SYSTEMS, SERVICES, AND OUTCOMES IN CALIFORNIA’S PUBLIC MENTAL HEALTH SYSTEM
NorCal MHA has changed its name to Cal Voices!

Why the Name Change?
- Our former name – Mental Health America of Northern California – was too long, which made it difficult to say and remember.
- The shortened version of our former name – NorCal MHA – no longer reflected our agency’s scope. We’ve held statewide advocacy and training contracts for over a decade, so we don’t operate exclusively in Northern California anymore. Essentially, we outgrew the "NorCal" in our name and it was time for an update.

Why Cal Voices?
- Cal Voices is short and sweet, making it easy to say and remember, and it doesn't rely on any complicated acronyms.
- Cal Voices is broad enough to encompass all the work we do locally, regionally, and statewide, which includes consumer advocacy, legislative and policy analysis, mental health research, best practices development and promotion, recovery-oriented programming, direct peer support services, education and training, etc.
- Cal Voices is flexible enough to remain relevant to any new activities we may take on in the future.

Will Cal Voices Remain an MHA Affiliate Organization?
- Yes, we will continue our affiliation with MHA National. Other local and regional MHAs have enacted similar name changes while maintaining their MHA affiliation.

When Did the Name Change Take Effect?
- Our name change was approved by the California Secretary of State in October 2019. It’s officially official!

Anything Else?
- Staff will continue to receive all emails sent to their @norcalmha.org email addresses even after we've established their new Cal Voices email accounts.
- Our existing website, norcalmha.org, will redirect visitors to our new Cal Voices website once it's up and running.
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Founded in 1946, Cal Voices is the oldest, continuously-operating consumer advocacy agency in California. Cal Voices is a 501(c)(3) public benefit organization dedicated to improving the lives of residents in the diverse communities of California through advocacy, education, research, and culturally relevant peer support services. In all of its programs, Cal Voices works with individuals and families with mental health challenges to promote wellness and recovery, prevention, and improved access to services and supports.

Cal Voices’ primary imperative is to represent the self-identified needs and priorities of public mental health clients through culturally-relevant and recovery-focused advocacy, outreach, and education. For nearly three decades, we have employed systems advocates to promote change from within local mental health agencies and have advanced individual empowerment and self-advocacy for mental health clients through the direct provision of peer support services rooted in the recovery model of care. Cal Voices strongly advocated for California's Mental Health Services Act (MHSA or Prop. 63), investing hundreds of staff and volunteer hours to promote its passage. In all of our activities, we seek to elevate the voices of clients receiving public mental health services.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is charged with supporting stakeholder advocacy throughout California’s Public Mental Health System (PMHS). To this end, the MHSOAC in March 2017 awarded a three-year contract to Cal Voices to perform statewide advocacy on behalf of public mental health clients. Cal Voices named its MHSOAC-funded client advocacy program ACCESS California (or ACCESS for short).

ACCESS stands for Advancing Client and Community Empowerment through Sustainable Solutions. ACCESS’ mission is to strengthen and expand local and statewide client advocacy through individual and community empowerment. Through ongoing research, data collection and evaluation, legislative and policy analysis, advocacy, education, training, outreach, and engagement activities, ACCESS implements strategies to elevate the voices, identify the needs, and increase genuine public participation of client stakeholders to drive truly transformative change in California's PMHS.
In 2004, the voters of California sent an unequivocal message to public mental health agencies throughout the state: the Public Mental Health System (PMHS) was broken, too many people were falling through the cracks and suffering needlessly, and something drastic needed to be done to reverse course. Upon the Mental Health Services Act’s (MHSA) passage over a decade ago, client/consumer communities across the state rejoiced at the prospect of a truly client-driven mental health system that is responsive to the needs of the people it serves and fully accountable to the public. The MHSA was intended to transform the public mental health system, not only through the generation of new revenue to fund the expansion of services, but also by requiring unprecedented levels of stakeholder input and involvement at all levels of program planning, development, and oversight.

Before the MHSA, many Californians living with a mental illness lacked access to the essential services and community supports necessary to recover and maintain their mental wellness. New and innovative methods of addressing mental health challenges had no reliable funding source to be implemented. The MHSA established a 1% tax on all personal income over $1,000,000 to expand public mental health care. The Act provided an opportunity to design new and adapt old mental health services. System transformation was sought through the expansion of services and an improved continuum and integration of care. Counties are now receiving MHSA funding in an attempt to provide “whatever it takes” treatment for people with serious mental health challenges.

To achieve the level of system transformation envisioned by the Act, the MHSA requires Counties to implement a broadly inclusive Community Program Planning (CPP) process to identify local-level needs, define MHSA funding priorities, and guide the creation, implementation, oversight, and evaluation of MHSA-funded programs, and any changes or updates thereto. As recipients of public mental health services, the MHSA recognizes adult clients are the primary stakeholders in all aspects of system planning and must be included as integral components of client-driven, recovery-oriented systems of care. Through the CPP, Counties must bring together mental health consumers, their family members, representatives of traditionally un-, under-, and inappropriately-served populations, and other local stakeholders to develop a shared vision for MHSA programming and spending based on the unique needs of individual communities and the stated interests of consumers being served in their local mental health systems.

However, without authentic, meaningful stakeholder involvement in all aspects of mental health program planning, implementation, oversight, evaluation, and budgetary decisions, these critical mandates of the MHSA remain impotent and render transformation an unfulfilled promise. Despite the MHSA’s aspirations, the current PMHS is resistant to concepts that would bring about true system transformation, including shared power, collaborative decision-making, participatory budget decisions, and a robust local CPP process with clients and other community stakeholders driving planning efforts and mental health priorities. Unfortunately, there are no mechanisms by which private citizens may enforce the MHSA’s mandates for Counties to engage client stakeholders in ongoing mental health planning and decision-making. Moreover, despite numerous concerns raised by the California Department of Finance (in 20051), the California State Auditor (in 2013 and 20182), mental health policy organizations (California Health Care Foundation in 2013 and 20183), and government
watchdog groups (Little Hoover Commission in 2015 and 2016\(^1\)), state-level oversight agencies (DHCS, MHSOAC, and CBHPC) have either abdicated their MHSA enforcement duties or lack clear authority to act when local mental health agencies fail to adhere to the MHSA’s stakeholder inclusion mandates.

According to a recent study conducted by SAMHSA, 75% of clients in California report that they have not been invited to participate in planning for mental health care in their counties (SAMHSA, 2013). Furthermore, even when clients are actively engaged in MHSA stakeholder processes, their involvement lacks essential knowledge of system navigation, budget allocations, integrated service delivery, and funding streams. Meaningful stakeholder involvement requires an investment in training and education of the populace. Since the inception of the MHSA, counties have had access to 5% of their annual MHSA revenues for investment in their local CPP process. Yet, since the closing of the State Department of Mental Health in 2012, few counties have actually invested this funding into their planning efforts, or provided resources related to training of clients/family members/underserved communities, pertaining to the public mental health system’s inner workings.

Therefore, meaningful client involvement requires organizational change on the part of the public agencies hosting stakeholder groups and meetings, moving transformation from an aspirational concept to a reality. In order for transformative processes to take shape, leadership must value the client voice and provide meaningful opportunities for engagement, candid feedback, recommendations and budget/funding questions. The current lack of investment in planning, training and capacity building related to the MHSA, assumes that mental health clients pursue knowledge about MHSA, county budgets, local planning processes, funding streams, mental health boards and commissions, on one’s own.

**2018 PROGRAM THEME REVISITED**

In the 2018 program year, ACCESS’ annual theme was Advocacy: Meaningful Stakeholder Participation in California’s PMHS. ACCESS began the year with the theory that Counties may not be sufficiently engaging stakeholders in the MHSA’s Community Program Planning Process and other important MHSA-related decision-making. Based on the results of our annual surveys and our extensive interactions with County leadership, PMHS clients, ACCESS Ambassadors, and other advocates throughout the state, our hypothesis bore out.

To test our premise, ACCESS conducted an extensive analysis of the MHSA’s statutory and regulatory provisions governing stakeholder involvement in the PMHS. ACCESS also developed annual data collection tools for clients and Counties to gauge each group’s understanding of the MHSA’s inclusion requirements and measure levels of stakeholder involvement in the CPP across the state. The data collected through these surveys and from feedback at our trainings and workshops demonstrated most California Counties were not upholding the MHSA’s vision for meaningful stakeholder inclusion and involvement in the MHSA planning process.

Stakeholders reported feeling increasingly marginalized and perceive few opportunities to meaningfully participate in important decisions about the PMHS policies and services that directly affect them. Far too many local mental health boards, MHSA steering committees, and other stakeholder advisory bodies in the PMHS function as mere formalities, effectively rubberstamping whatever proposals are brought before them by the agencies they are meant to guide and oversee, without significant discussion or thoughtful deliberation about what they are being asked to approve. This is not necessarily because Counties are averse to meaningful stakeholder involvement. Rather, significant barriers to inclusion exist on the County level that are not adequately addressed through the current system of oversight and accountability.
When PMHS leadership neglects genuine stakeholder inclusion, clients and the agencies representing their interests must either become increasingly confrontational in their advocacy efforts (jeopardizing beneficial relationships and undermining coalition-building efforts) or adopt a “go along to get along” mentality (selling out their constituency for access to the levers of power). Neither approach serves the best interests of clients or increases the effectiveness of public mental health services. Rather than pursuing either of these courses, ACCESS seeks to build constructive relationships with Counties, statewide agencies, and the California legislature, all of which play a significant role in making the MHSA’s vision for meaningful stakeholder involvement a reality, while at the same time faithfully representing clients’ interests.

In its 2018 State of the Community Report, ACCESS identified feasible and cost-friendly solutions to increase client participation throughout the PMHS. Wherever possible, ACCESS offers its own free services to support PMHS leadership in implementing our recommendations.

2018 RECOMMENDATIONS REVISITED

1. **COUNTIES MUST ADEQUATELY INVEST MHSA FUNDING IN THE LOCAL CPP PROCESS AND MORE EFFECTIVELY TRAIN, SUPPORT, AND ENGAGE COMMUNITY STAKEHOLDERS TO EXPAND PARTICIPATION**

The CPP is best viewed as the MHSA’s sixth mandatory component (in addition to CSS, PEI, INN, WET, and CF/TN). Along with the MHSA’s funding guidelines for services-related components, the Act requires Counties to set aside up to 5% of their total annual MHSA funds for the CPP (WIC § 5892(c); 9 CCR § 3300(d)). While the MHSA sets no minimum funding level for the CPP, it nevertheless directs Counties to allocate some portion of their annual MHSA funds to this vital component of the Act. As discussed below however, Counties are not spending anywhere near 5% on the CPP.

Investing in a robust CPP is a requirement of the MHSA, not a mere recommendation. Counties are required to allocate up to 5% of their total annual MHSA funds – the same amount allocated to INN – to the CPP (WIC § 5892(c)). Yet, few Counties have actually invested this funding into their planning efforts, or provided trainings to community stakeholders pertaining to the MHSA and the inner workings of the PMHS.

This is evident from the MHSOAC’s online fiscal transparency tool, which reveals how Counties are spending MHSA funds. Upon review of data collected directly from this tool, it is indisputable that most Counties are spending little to no money on their local CPP. Past analysis compared the MHSA funds Counties have received, interest earned on these funds, the funds available for CPP use (defined as 5% of the County’s annual MHSA budget), and the actual CPP expenditures reported by Counties to the MHSOAC for fiscal years 2013/2014 through 2016/2017. A cursory analysis makes clear that Counties earn more interest on unspent MHSA funds each year than they are spending on the CPP.

The average spent by Counties on their local CPP was just $89,152.46 in 2013/2014, $79,494.47 in 2014/2015, $94,008.73 in 2015/2016, and $68,014.93 in 2016/2017. However, this average is not representative of the amounts actually spent by most Counties. In fiscal year 2013/2014, only five of the 59 counties reported spending any funds on planning at all. This trend is true for all years examined: four of 59 for 2014/2015, five of 59 for 2015/2016, and 15 of 59 for 2016/2017. In essence, the mode of total funds spent on CPP was $0 for each of the fiscal years examined.
A recent review of the MHSOAC’s fiscal transparency tool revealed no new information for fiscal year 2017/2018.

2. **DHCS MUST STEP UP ENFORCEMENT OF THE MHSA’S CPP REQUIREMENTS**

DHCS must require Counties to allocate up to 5% of their annual MHSA funding to the CPP as already mandated under the MHSA (WIC § 5892(c); 9 CCR § 3300(d)) and create minimum funding guidelines and standards for CPP funding, as well as fiscal reporting obligations specifically for the CPP.

To accomplish this, DHCS can develop a review process that scrutinizes the quality and quantity of client and stakeholder involvement in the development, planning, implementation, oversight, and evaluation Counties’ mental health plans and MHSA-funded services. DHCS should also ensure Counties thoroughly document their outreach, engagement, and inclusion strategies to ensure client voices are the primary driver of all MHSA programming and funding decisions.

Additionally, DHCS should convene a client leadership panel to develop benchmarks for CPP participation and incorporation of the MHSA’s six General Standards into all MHSA programming. Utilize this leadership panel to provide ongoing guidance and recommendations to Counties regarding the MHSA’s mandates for county staff and community trainings (frequency, subject matter, etc.), meaningful stakeholder inclusion in the CPP, and integration of the General Standards in MHSA programs and services. Create opportunities for multiple client leaders to serve on review committees to evaluate Counties’ MHSA plans and stakeholder outreach and engagement efforts.

To date, we have found no evidence DHCS has implemented these recommendations.

3. **THE MHSOAC MUST STEP UP ENFORCEMENT OF THE MHSA’S CPP REQUIREMENTS AND CREATE MORE OPPORTUNITIES FOR CLIENT INVOLVEMENT IN MHSOAC PLANNING AND DECISION-MAKING ACTIVITIES**

Under the MHSA, the MHSOAC must not only ensure Counties comply with the MHSA’s mandates relating to meaningful stakeholder involvement, client-driven services, and community collaboration, the MHSOAC itself must demonstrate that all of its own pursuits, programs, and operational objectives genuinely reflect the needs and priorities of public mental health clients, their families, and representatives of traditionally un-, under-, and inappropriately-served communities. At a minimum, this means the MHSOAC must incorporate stakeholder voices at all stages of its strategic planning, policymaking and analysis, program development and implementation, oversight, and evaluation activities.

In our 2018 State of the Community Report, ACCESS offered the following recommendations to help the MHSOAC increase client stakeholder participation at the County level and in its internal decision-making processes:

- Require Counties to allocate up to 5% of their total INN plan budgets and other MHSA-funded program budgets to the CPP, as already mandated by law (WIC § 5892(c); 9 CCR § 3300(d)). Create minimum funding guidelines and standards for CPP funding in the County plans that the MHSOAC reviews, approves, and oversees.

- Develop an initial MHSA/INN plan review process that evaluates the quality and quantity of client and stakeholder involvement in the development, planning, implementation, oversight, and evaluation of
 Counties’ proposed MHSA-funded services. Require Counties thoroughly document their outreach, engagement, and inclusion strategies to ensure client voices are the primary driver of all MHSA programming and funding decisions.

- Create a Stakeholder Leadership Committee comprised of representatives from all MHSOAC-funded stakeholder advocacy programs that will:
  - Develop benchmarks and guidelines for meaningful stakeholder involvement in the CPP and incorporation of the General Standards into all MHSA programming on both the state and County levels;
  - Evaluate County plans that come before the MHSOAC for compliance with the MHSA’s requirements for meaningful stakeholder involvement in the CPP and incorporation of the General Standards into all MHSA programs and services;
  - Provide ongoing guidance and recommendations to Counties regarding the MHSA’s mandates for county staff and community trainings (frequency, subject matter, etc.), meaningful stakeholder involvement in the CPP, integration of the General Standards into all MHSA programs and services, and the effectiveness of Counties’ stakeholder outreach and engagement efforts;
  - Provide ongoing guidance and recommendations to the MHSOAC (both Commissioners and staff) regarding the MHSA’s mandates for meaningful stakeholder involvement in the CPP, integration of the General Standards into all MHSA programs and services, and the effectiveness of the MHSOAC’s stakeholder outreach and engagement efforts;
  - Identify additional opportunities for stakeholder participation in the MHSOAC’s activities; and
  - Help the MHSOAC develop and evaluate its legislative objectives and priorities.

- Create at least one non-voting seat on the Commission for a representative of the Stakeholder Leadership Committee who will contribute to deliberations and decision-making by providing feedback and analysis from the stakeholder perspective during public sessions at all MHSOAC meetings.

To date, we have found no evidence the MHSOAC has implemented these recommendations.

4. THE LEGISLATURE MUST CLARIFY THE MHSA’S CPP REQUIREMENTS, STRENGTHEN MHSA ENFORCEMENT, AND CREATE WAYS TO EXPAND CLIENT INVOLVEMENT ON THE STATE AND LOCAL LEVELS

While the MHSA is a wonderful example of aspirational legislation representing the progressive views and preferences of stakeholders in California, updates to the Act have primarily focused on funding provisions, data collection, and reporting requirements. Although such changes are necessary as deficiencies in the initial law have emerged, similar gaps in enforcement of the MHSA’s General Standards and requirements for meaningful stakeholder involvement remain unaddressed. Clients are left to advocate for these issues on the local level when systemic change is truly required.

ACCESS seeks to change this paradigm by working directly with the MHSOAC, DHCS, and the California Legislature to secure minor changes to the MHSA’s statutes and regulations to increase client stakeholder participation on the state and local levels. These legislative and regulatory updates include:
Creating clearer guidelines and enforcement mechanisms around the requirement for Counties to set aside up to 5% of their annual MHSA funding for the Community Program Planning Process (per WIC § 5892(c) and 9 CCR § 3300(d));

- Requiring each County’s MHSA Community Program Planning Process (mandated under 9 CCR § 3300) be comprised of a committee or advisory body that is subject to the Ralph M. Brown Act and comply with all open meeting laws applicable to local government agencies and bodies;
- Requiring each County’s MHSA Community Program Planning Process (mandated under 9 CCR § 3300) be comprised of a committee or advisory body that reflects the ethnic diversity of the client population in the County and is at least 50% clients and family members (the same requirements applied to local mental health boards per WIC § 5604(a));
- Establishing minimum percentages or ratios of peer provider positions (mandated under 9 CCR § 3610(b)) to clinical provider positions in County mental health systems;
- Developing standardized definitions of the peer roles identified in 9 CCR § 3610(b), including the types of personal lived experience required to work with specific populations served in the Public Mental Health System;
- Requiring each County to fund a full-time designated Client Advocate/Liaison position to serve as part of the County’s management team and provide systemwide representation and advocacy for the interests and concerns of public mental health clients in that County;
- Expanding the application of the MHSA’s existing stakeholder inclusion requirements (mirroring the requirements placed on Counties under WIC § 5848(a) and 9 CCR § 3300) to all state-level agencies responsible for implementing and/or overseeing MHSA-funded programs (e.g., DHCS, MHSOAC, OSHPD, etc.); and
- Establishing minimum funding requirements for the state-level agencies identified above to develop and implement their own inclusive stakeholder planning process for implementing and/or overseeing MHSA-funded programs (similar to the County mandates in WIC § 5892(c) and 9 CCR § 3300(d)).

In 2019, ACCESS worked with the California Legislature to clarify the MHSA’s CPP funding requirements and to require Counties to comply with the Ralph M. Brown Act when engaging in the CPP process. The resulting bill, AB 43, was held in suspense and will be taken up again during the next legislative session. To date, the California Legislature has not taken steps to implement any of our other recommendations.

2019 CLIENT ADVOCACY ISSUES AND UPDATES

Throughout history the voices of mental health clients have been minimalized and marginalized. In order for PMHS to be successful, our system must be guided and informed by individuals with a life experience of mental health challenges who have significant roles at all levels of the system and a system that is informed by client driven recovery outcomes. MHSA programs and activities were intended to be transparent and driven by clients representing the diverse communities of California. The MHSA’s requirements for community collaboration and client-driven adult systems of care require the PMHS to give clients an active role in ongoing statewide and local efforts to inform and evaluate mental health services, identify and analyze client and system outcomes, and ensure that the findings are used to inform future funding and system-wide policy decisions.
However, our research and data collection from 2019, including ACCESS’ Annual Stakeholder Inclusion and Feedback Survey (Appendix 1) and Annual Participation Barriers Survey (Appendix 2), indicate that ongoing lack of information-sharing, training, community support, and accountability continue to hinder meaningful stakeholder involvement at both the local and state levels.

2019 ANNUAL STAKEHOLDER INCLUSION AND FEEDBACK SURVEY

ACCESS’ Annual Stakeholder Inclusion and Feedback Survey (Appendix 1) measures respondents’ general knowledge of the MHSA’s Community Collaboration and Community Program Planning (CPP) process requirements, and gauges levels of community inclusion in local- and state-level MHSA policy discussions, program planning, and oversight. ACCESS disseminated this survey between November 30, 2018 – December 31, 2018, and received 271 responses. Respondents represented a wide variety of PMHS stakeholder groups:

- 65% identified as an adult client or consumer
- 46% identified as a family member of an adult client/consumer
- 20% identified as a parent/caregiver
- 3% identified as a transition age youth
- 67% of those identifying as a client/consumer or transition age youth have received services in the PMHS
- 49% have worked in the PMHS
- 29% have served on a state or local PMHS policy-making/oversight body

The Annual Stakeholder Inclusion and Feedback Survey quizzed respondents on their knowledge of the MHSA’s stakeholder inclusion and CPP process mandates, revealing:

- 75% of respondents were unaware Counties’ Annual Updates to their MHSA Three-Year Program and Expenditure Plans must go through the same CPP process as the Three-Year Plans themselves.
- 59% of respondents did not know County MHSA funds cannot be used to pay for programs and services that were not developed through a County’s CPP process.
- 58% of respondents did not know County MHSA funds cannot be used to pay for programs and services that were not included in a County’s MHSA Three-Year Program and Expenditure Plan or Annual Update.
- 56% of respondents were unaware the MHSA requires Counties to spend up to 5% of their total annual MHSA revenues on annual planning costs (the CPP process).
- 54% of respondents did not correctly identify the MHSA’s definition of “Family-Driven” (one of the MHSA’s six General Standards).
- 47% of respondents did not know the MHSA requires Counties to provide trainings to stakeholders, clients, and family members who are participating in the CPP process.
- 28% did not know the MHSA requires Counties to utilize peer support services in some MHSA-funded programs.
- 27% of respondents were unaware the MHSA requires Counties to provide trainings to their own staff who are responsible for establishing and sustaining their local CPP processes.
- 21% of respondents did not correctly identify the MHSA’s definition of “Client Driven” (another of the MHSA’s six General Standards).
- 21% of respondents did not know the MHSA requires Counties to develop their MHSA Three-Year Program and Expenditure Plans in collaboration with mental health clients and other community stakeholders through a local CPP Process.
The Survey also asked respondents to share information about community inclusion and MHSA planning practices within their own Counties:

- Just 53% of respondents reported their County convenes a local CPP process before developing an initial draft of its MHSA Three-Year Program and Expenditure Plan.
- Just 44% of respondents reported all of the programs and services included in their County’s MHSA Three-Year Program and Expenditure Plan and Annual Update are developed and/or approved through their local CPP process.
- Just 37% of respondents reported their County convenes a local CPP process before developing an initial draft of the Annual Update to its MHSA Three-Year Program and Expenditure Plan.
- Just 35% of respondents reported all of their County’s MHSA funding allocations are developed and/or approved through their local CPP process.
- Just 26% of respondents reported their County provides internal trainings to its own staff responsible for coordinating and managing their local CPP process; 15% said their County does NOT provide such trainings, and 59% were unsure whether their County provided these trainings.
- Just 20% of respondents reported their County provides trainings to community stakeholders on the MHSA and CPP process to ensure they have the requisite knowledge to meaningfully participate; 24% said their County does NOT provide such trainings, and 57% were unsure whether their County provided these trainings.

Of the Annual Stakeholder Inclusion and Feedback Survey respondents who were either employed by a County or state mental health oversight agency, or who have served on a local or state mental health oversight body:

- Just 27% reported their agency provides stakeholder trainings on mental health policy matters.
- Just 21% reported their agency provides stakeholder trainings on MHSA program planning, development, and implementation.
- Just 17% reported their agency provides stakeholder trainings on the general budgeting process and specific MHSA funding provisions/restrictions.
- Just 10% reported their agency provides stakeholder trainings on MHSA program oversight and evaluation.

Respondents also shared the following comments related to the topics addressed in the Annual Stakeholder Inclusion and Feedback Survey:

- This is tax-payer's funding and should adhere to MHSA goals and objectives, not just to line their own pockets (what's in it for me attitude).
- This is something that [My] County has to work on: People who understand budgeting as a whole (There are few places where clients can be trained on budgeting tax-payer funded services.) The county is willing to involve peers and clients, but there is an ongoing challenge to find and educate peers and clients about budgeting. Clients who care about other clients enough to be involved in the process enough to meaningfully improve the tax-payer's funded services system and not just to line their own pockets (what's in it for me attitude).
- Based in my eight (8) years of MHSA experience, I believe there is a serious lack of proper training of enough local (county) peers to create MHSA program oversight and evaluation teams: Training of: a) enough local (county) peers in order to help them become fully qualified to: b) define/help define and then evaluate
outcomes, c) revise/help revise the scopes of work, d) budget allocations, all as part of the MHSA program oversight and evaluation team at the county level.

- For clients to be meaningfully involved in CPP, they have to be trained and mentored. I don't know if [My County] does the training or mentoring.

- Although my county does make some effort towards stakeholder inclusion (surveys, transportation, local advisory committee meetings) it feels perfunctory at best. Even when consumers attend the CPP meetings they usually have no idea of what is going on as the processes, language and terms referenced are over their heads. Attendance at the meetings is weighted heavily on the side of service providers and [County] staff and the power differential can intimidate lay consumers from giving input. Placement of Stakeholder surveys links on the [County] website are not immediately visible and must be scrolled to, to access. CPP and Plan Update documents are usually hundreds of pages long and tedious to read. However it is difficult to give meaningful feedback on the Plan without understanding its content. Finally there is no mechanism to submit a completed stakeholder survey online. The form must be downloaded, completed, scanned and uploaded to a [County] email. This discourages the participation ...

- Although [My] county understands that all materials should be in all threshold languages, they say the have no "procedure" to do this. They are consciously neglecting to follow this guideline, because it is "too difficult to coordinate". I have made public comment on 12/20/18 at the Mental Health Board commission meeting and will continue to follow up with this issue.

**2019 ANNUAL PARTICIPATION BARRIERS SURVEY**

ACCESS disseminates a brief Annual Participation Barriers Survey (Appendix 2) to its network of client stakeholders at the end of each program year, asking respondents to identify whether and to what extent specific barriers prevent them from taking a more active role in their County’s MHSA CPP process and other mental health policy discussions. ACCESS disseminated this survey between August 1, 2019 – September 3, 2019, and received 113 responses. Of the individuals who responded:

- 78% identified as an adult client or consumer
- 3% identified as a transition age youth
- 64% have received services in the PMHS

The Annual Participation Barriers Survey asked respondents to identify the specific barriers that prevented them from participating in their County’s local CPP process. The barriers respondents reported having the biggest impacts on their ability to participate in the local CPP process were:

- 61%: a lack of information/advertising about local meetings
  - 23% of all respondents said this barrier rendered them unable to participate at all in their local CPP
- 53%: personal responsibilities/obligations
- 49%: a lack of understanding of MHSA requirements and standards
- 48%: meeting times
- 47%: meeting locations
- 34%: lack of transportation
Respondents identified additional participation barriers not listed in our survey:

- Once I started working it has become almost impossible to participate in the [County] meetings.
- Lack of ADA disability accommodations like closed captions, CART, ASL interpreters. And lack of Spanish translation services for stakeholders.
- Loss of pay for [missing] work.
- Don't hear about opportunities to get involved.
- The security, or police being present.
- [Lack of] Child care prohibits me from attending.
- Pettiness and other things related to the human condition.
- It's not being advertised enough because I don't know anything about it really.
- When I have to interpret for others who are in attendance, it limits my ability to participate and follow the flow of conversations and decisions.
- [My County] often has incorrect information on their website, they send out invitations for important meetings last minute. I personally think they do not really want client participation.
- For more than 6 months there was no Program Planning Process sessions until after my county got their 3 year plan approved presently.
- Not sure how we can be useful in the process. Plus meetings just take too long, too much bureaucracy.

Finally, respondents offered these expanded comments related to participation barriers they have experienced:

- It is obvious that the MHSA Committee is unaware of their obligations and requirements with the CPPP including the Mental Health Advisory Board, while still under the Grand Jury until completed, with all required action plans. The MHSA Committee understood their requirements after receiving the training from ACCESS California […] with commitment and compassion. With my involvement since November 2018 in attending the local Mental Health Advisory Board, I noticed lack of MHSA Committee meetings (not regularly), Administrator not participating regularly in the Adult Mental Health Advisory Board, setting up a meeting (suicide planning) when no public transit is offered at that particular location in evenings. I notified them of this and have changed location that is accessible by transit for those who take public transportation as a form of transportation in order to participate fully.
- [W]e are 'listened' to in community meetings, but we are not part of the decision making process allocating funds. seems like ‘peers’ should be part of the entire process - not just being asked what we think the county needs are.
- [M]y health and wellbeing is being beaten and im scared sometimes id like to see a domestic course of knowing what to do and how.
- Please train people to listen kindly even to those, who present themselves in poor attire, bad hygiene, and/or combative demeanor. They are equally humans deserving to have their relevant and/or underlying point taken into consideration.
- Though I’m very interested in MHSA planning process I find the meetings and speaking up intimidating particularly with a social anxiety. The few times I have spoken up or participated I feel like my ideas are outside the box or disregarded therefore have minimized my involvement.
- Only certain people, a picked group, are able to be on the main committee. Lack of transparency of the County has been great. The spirit of MHSA funding is not currently honored. (defunding of MHSA peer and
family services, only saved by public outcry with temporary funding and MHSA funding is now scheduled to
do things we understood were not what these funds are for.)

- I would love to participate in these [local planning] programs because I really need them but I don't know
  anything about them where do I find them how do I sign up what do I do where do I go who do I talk to.
  They're just so many questions and no information that we can find ourselves we always have to get with
  the social worker or something to get the social worker doesn't really give us anything of use and 211 needs
  a better site so that we can do research.

- This [ACCESS] project needs to continue to educate and monitor the requirements of MHSA as intended. It
  is the fault of the previous California Department of Mental Health, Department of Health Care Services and
  more importantly from State oversight MHSOAC. Counties need guidance from the State both from the
  Department of Health Care Services and MHSOAC.

- The language of MHSA and the spirit, followed by mushy language makes it seem that [Counties] can do
  whatever they want with MHSA funds and don't have to honor what it was designed for. Peer and Family
  services were proposed to be cut and were not even put on the add back list and trust in the powers that
  be is at an all time low. Many of us are traumatized by the last couple of years funding issues, and they say
  they value peers, but it is not shown in actions. They should find other money for their mandated services,
  not hijack MHSA funds, or is that OK and we should all just shutup and not make waves or we will be targeted
  and lose more??? Health services management does not seem trustworthy or very honest.

These responses demonstrate the PMHS still has a long way to go in ensuring clients and community stakeholders
have authentic opportunities to participate in local and state-level mental health policy planning discussions and
contribute to shaping local mental health systems, services, and outcomes.

SAE_MHSAREv_June2008.pdf
content/uploads/2018/12/MentalHealthCA2018.pdf
4 https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/225/Report225.pdf and
This State of the Community Report reflects ACCESS’ cumulative efforts and outcomes for the second year of its client/consumer stakeholder advocacy contract with the MHSAOC (September 1, 2018 – August 31, 2019). ACCESS California’s primary program activities include:

1. Conducting ongoing **local-level, state-level, and legislative advocacy** to help effect and implement improvements to California’s PMHS;

2. Providing **training and education** to PMHS clients, their family members, and **on-call technical assistance** to PMHS policymakers and leaders of local and statewide public mental health agencies;

3. Performing **outreach and engagement** to mental health clients and other stakeholders throughout California’s PMHS and providing information and messaging on important mental health policy issues;

4. Maintaining a network of **subject matter experts** (PMHS clients and leaders in consumer advocacy, whom we call “ACCESS Ambassadors”) throughout California to provide ongoing guidance on the MHSAOC’s policies and programs, and to conduct local-level advocacy in their home communities; and

5. Drafting an **Annual State of the Community Report**, analyzing topics and trends of importance to clients in California’s PMHS, with a different annual focus/theme each year.

Highlights and outcomes from Activities 1-4 are examined in Part I of this Report. Highlights and outcomes from Activity 5 are discussed in Part II of this Report.
## LOCAL-LEVEL ADVOCACY ACTIVITIES

**(100+) Local Policy Planning Meetings and Discussions**

The primary goals of ACCESS’ local-level advocacy activities are to strengthen and expand consumer advocacy through individual and community empowerment. Over the course of the year, ACCESS Ambassadors, local system advocates, and ACCESS team members participated in over 100 local advocacy activities and events, reaching over 2,640 stakeholders in the following 40 local jurisdictions: Alameda, Alpine, Amador, Butte, El Dorado, Fresno, Imperial, Lassen, Los Angeles, Madera, Marin, Mariposa, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tri-Cities, Trinity, Tulare, Tuolumne, Ventura, Yolo, and Yuba. A sample of the issues and concerns ACCESS Ambassadors addressed at local-level meetings include:

<table>
<thead>
<tr>
<th>MEETING ATTENDED</th>
<th>ISSUE(S) ADDRESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butte County Cultural Relevancy/Humility Committee</td>
<td>How the CPP process is supposed to look like with ongoing meaningful stakeholder engagement</td>
</tr>
<tr>
<td>Los Angeles County Department of Mental Health USCC LGBTQA-I2 subcommittee</td>
<td>Panels for parents who have children that identify as LGBTQA-I2 and the need to provide more support for parents who identify as LGBTQA-I2</td>
</tr>
<tr>
<td>Los Angeles County Mental Health Commission Meeting</td>
<td>Need for additional peer support services at the peer resource center e.g.: such as smoking cessation, WRAP, creative coping groups, peer health educators, etc.</td>
</tr>
<tr>
<td>Monterey County Mental Health Board Meeting</td>
<td>MHSA General Standards, MHSA program components, explained the requirements for a robust CPP</td>
</tr>
<tr>
<td>San Bernardino County Behavioral Health Commission Meeting</td>
<td>Educated and advocated for the discontinuance of the stigmatic identification of mental illness and the inclusion of persons of all levels of functioning as to decrease the exclusion of those appearing to be well suffering in silence</td>
</tr>
<tr>
<td>Santa Clara County Behavioral Health Board Meeting</td>
<td>Expressed appreciation to the County Behavioral Health Director for agreeing to make changes to County’s local MHSA planning process and informed attendees about AB 43</td>
</tr>
<tr>
<td>Stanislaus County Behavioral Health Board</td>
<td>The lack of and continuing reduction of peer run centers in Stanislaus County</td>
</tr>
<tr>
<td>Ventura County Behavioral Health Board Meeting</td>
<td>Recognition, support, and upholding local stakeholder structure including meaningful stakeholder involvement in mental health planning and policy discussions</td>
</tr>
</tbody>
</table>
(75) Local Stakeholder Training and Networking Meetings

Local Stakeholder Training and Networking Meetings are facilitated and attended by ACCESS Ambassadors. Ambassadors’ Regional Leaders conduct formal mental health advocacy trainings and organize quarterly Ambassador networking meetings within their communities to discuss important issues affecting consumers in their Region. These activities support the meaningful participation of clients in local advocacy by:

- Increasing client participation in local mental health planning and program design, service delivery, and evaluation
- Facilitating collaboration and communication between clients and County mental health departments, Boards of Supervisors, providers, and other local entities
- Ensuring effective and necessary improvements in local policy, programming, and services delivery; and
- Increasing community inclusion, transparency, and public accountability within local mental health systems.

In 2019, ACCESS Ambassadors conducted/attended 75 local training and networking meetings throughout the state of California. Ambassadors report their local stakeholder training and networking meetings have created opportunities to hear community feedback on key issues within the PMHS, become more familiar and educated on their rights and advocacy opportunities, and have allowed Ambassadors to troubleshoot with each other and learn effective support tools in their community engagement.

(6) Regional Stakeholder Focus Groups

Regional Stakeholder Focus Groups give ACCESS first-hand knowledge and feedback from people with current or previous experience receiving services from their PMHS, allowing ACCESS a meaningful look at the genuine experiences of mental health clients that other data collection methods are unable to fully capture. Focus Group participants engage in intimate, inclusive conversations identifying the barriers they or their community members, family/friends, etc., have experienced, what things are working well in the PMHS, what aspects of the PMHS could be improved, and possible solutions for stakeholders to mitigate challenges and/or enhance service and experiences within the PMHS. Participants include PMHS clients, peer support workers, mental health advocates, family members, community stakeholders, ACCESS Ambassadors, local level providers and leadership, and the general public. All persons invested in California’s PMHS are invited to attend to increase and diversify our sources of feedback and to promote stakeholder networking opportunities across Regions and Counties. Focus Groups produce meaningful discoveries that help to drive ACCESS’ statewide stakeholder advocacy efforts.

In 2019, ACCESS held the following six Stakeholder Focus Groups, which were attended by a total of 138 individuals:

- Bay Area Region (Solano County): January 15, 2019
- Superior Region (Butte County): February 19, 2019
- Southern Region (San Bernardino County): March 6, 2019
- Los Angeles Region (Service Area 5): March 20, 2019
- Los Angeles Region (Service Area 8): May 22, 2019
- Central Region (Sacramento County): June 17, 2019
Stakeholder Focus Group participants consistently identified several challenges they face within the PMHS (see Appendix 3). The concerns cited most frequently were:

- Access to mental health care is at times difficult due to gatekeeping and system navigation barriers
- Barriers to stakeholder meeting attendance (e.g., transportation difficulties, inconsistent meeting times and locations, etc.)
- Lack of awareness/advertisement of stakeholder meeting time and locations
- Lack of affordable housing options for clients
- Lack of living wages for peers
- Ongoing mental health stigma

Participants also offered ideas on how the PMHS can improve the experiences of clients and other stakeholders:

- Enhanced transparency and accountability for local and statewide mental health agencies
- Increased inclusion of community stakeholders in mental health policy planning discussions
- Elevation of peers
- Comprehensive stakeholder engagement strategies
- Better stigma reduction efforts

(8) Regional Leadership Roundtables

ACCESS’ Regional Leadership Roundtables have proven to be an extremely valuable component of our program. Regional Leadership Roundtables provide ACCESS with an opportunity to connect with key policy makers, including local County and provider leadership and designated client/consumer liaisons. Members of local mental health boards and MHSA steering committees also participate in these discussions. Leadership Roundtables help ACCESS acquire a deeper understanding of local- and state-level challenges facing public mental health agencies and service providers, provide networking opportunities to forge lasting working relationships with County and statewide agency partners, and help generate new ideas about how to effectively address the most pressing issues related to client care, access to services, and improved system outcomes.

In 2019, ACCESS held the following eight Leadership Roundtables, which were attended by a total of 142 individuals:

- Bay Area Region (Solano County): January 14, 2019
- Superior Region (Butte County): February 21, 2019
- Southern Region (San Bernardino County): March 8, 2019
- Bay Area Region (Alameda County): March 16, 2019
- Los Angeles Region (Service Area 4): March 22, 2019
- Los Angeles Region (Service Area 4): May 24, 2019
- Southern Region (Orange County): June 21, 2019
- Bay Area Region (Santa Cruz County): July 24, 2019

ACCESS partnered with the MHSOAC’s Client and Family Leadership Committee (CFLC) to host this Roundtable at the CFLC’s July 2019 meeting in Sacramento County; the meeting location was later
changed after ACCESS committed to hosting its Roundtable at this event, so we could not hold a Leadership Roundtable in the Central Region this program year.

Through the Leadership Roundtable process many Counties identified that they are not opposed to a meaningful stakeholder process (see Appendix 3). Instead, they noted two major barriers:

- They don’t know how to go about it; or
- They lack the time and/or capacity to support an ongoing CPP. (For example, in some of the smaller Counties the Mental Health Director wears multiple hats i.e. Director, MHSA Coordinator, Ethnic Service Manager etc.)

Additionally, when we began the discussion around the collection of meaningful recovery outcomes, there was quite a bit of concern around the idea that more documentation, more data-collection, more training (all of which a Recovery Outcome Tool will entail) will take away crucial time from the individual client care. It became evident that, again, it is not that County/community leadership is not opposed to create a more recovery data driven system, but something else will have to give or this will leave little time for direct care and create more staff burnout.

STAT-E-LEVEL ADVOCACY ACTIVITIES

ACCESS’ state-level advocacy activities strengthen and expand consumer advocacy through individual and community empowerment, and are designed to:

- Inform participants of their rights as mental health clients/consumers, families, advocates, and members of underserved communities
- Treat clients as necessary and valued participants in state-level policy discussions
- Respect their unique needs and empower them to participate in state-level policy discussions
- Keep them informed about important statewide mental health policy issues that affect them, their families, and/or their communities
- Identify opportunities, strategies, and access points for state-level advocacy
- Include key facts, findings, recommendations, and talking points to help them effectively participate in state-level public advocacy
- Connect them to statewide networks of like-minded individuals with whom they can collaborate to effect positive change on the state level

ACCESS staff, Ambassadors, ACCESS-affiliated local system advocates participated in more than 50 state-level, in-person, advocacy events, including but not limited to: MHSOAC meetings, MHSOAC Stakeholder Feedback on Draft INN Incubator Plan meetings, MHSOAC PEI Subcommittee meetings, MHSOAC Immigrant and Refugee Listening Sessions, MHSOAC CFLC/CLCC meetings, and a DHCS Fiscal Regulations Hearing. A sample of the issues and concerns addressed at these meetings included:
MEETING ATTENDED | ISSUE(S) ADDRESSED
--- | ---
DHCS MHSA Fiscal Regulations Hearing | ▪ Inclusive and authentic consumer involvement in the development of the MHSA fiscal regulations
▪ Proper interpretation of applicable statutory provisions governing MHSA fiscal allocations and prudent reserve limitations at the local level

MHSOAC Commission Meetings | ▪ The need for Peer Employees to be treated as equal members of the team
▪ Collection and measurement of meaningful recovery outcomes for MHSOAC-approved INN plans
▪ Increased client/consumer involvement in the development of INN plans
▪ Increased peer staffing in INN plans
▪ Client-driven services in INN plans
▪ County and state agency adherence to the MHSA’s General Standards and CPP process requirements

MHSOAC Client and Family Leadership Committee (CFLC) meetings | ▪ Culturally competent data collection
▪ Challenges and barriers in Counties’ implementation of the MHSA CPP process

MHSOAC PEI Subcommittee Meetings | ▪ Difficulties for the deaf and hearing-impaired individuals to participate in the CPP

State Capitol/Advocacy Day | ▪ Mental health-related criminal justice reform

LEGISLATIVE ADVOCACY AND PUBLIC POLICY ACTIVITIES

ACCESS’ legislative and public policy team monitors legislation and public policy issues that have the potential to impact clients and consumers within the PMHS, with a focus on client/consumer driven services, recovery-oriented services and policies that support and empower peers and consumer operated services. We offer meaningful input to strengthen legislation and policies that further these principles, and oppose policies and legislation that are detrimental to them. These activities have the following goals:

▪ Support the voice and meaningful participation of clients/consumers in local mental health advocacy activities;
▪ Ensure effective and necessary improvements in local policy, programming and services delivery, and increase community inclusion; and
▪ Increase community inclusion, transparency, and public accountability within local mental health systems

Our legislative and policy efforts have proven to be integral to effectuating system-wide change, while simultaneously educating and empowering our constituency. Advocates who are frustrated with the system will eagerly support legislation which attempts to remedy some of the issues.

(10) Legislative Advocacy Letters
ACCESS tracks federal and state legislation impacting clients/consumers and services in California’s PMHS, and submitted 10 legislative advocacy letters to lawmakers and committees in support of or opposition to legislation.
These activities not only support the interests of our constituency at the legislature, but they also enhance the existing network of clients and consumers at the local level.

(8) In-Person Legislative Meetings
ACCESS held eight in-person meetings with legislators to discuss support and opposition to various bills. These meetings also allow ACCESS an opportunity to educate lawmakers about ACCESS’ themes of meaningful stakeholder participation, recovery-oriented services, and peer support.

(4) Quarterly Legislative Policy Updates
ACCESS tracks all mental health legislation that will impact clients and consumers in the PMHS, develops positions on legislation and posts this information on our website as a policy update. Legislation is tracked as it is amended, and as it progresses throughout the session. ACCESS submits support or oppose letters to significant legislation, along with suggested language to strengthen legislation when appropriate.

(4) Position Statements
This year, ACCESS completed four position statements. In response to Peer Certification Legislation, ACCESS drafted a position statement on peer certification based upon Cal Voices’ extensive experience providing peer support training and statewide technical support to agencies who employ peers. ACCESS also created position papers on Enforcement of Local Community Planning Processes, Digital Phenotyping, and the distinction between Wellness Applications and Digital Therapeutics.

Our position paper on community planning processes was especially effective as an advocacy tool when presented to state legislators. Lawmakers interested in pursuing efforts related to unspent MHSA funds were surprised by the information gathered by ACCESS which shows that most Counties in California report spending no money on their CPP. This information resulted in ACCESS and Cal Voices sponsoring AB 43 (Gloria), which was ultimately held in Senate Appropriations.

(3) Legislative Hearings
ACCESS attended three legislative hearings to voice support/opposition for bills and offered opportunities for Ambassadors and the public to attend these events.
ACCESS promotes the expansion of meaningful recovery concepts, consumer-operated services, consumer cultural humility, and a PMHS that is truly client-driven. To accomplish this, ACCESS actively trains, educates, and engages with both clients and mental health leaders throughout California to help them recognize, participate in, and expand stakeholder advocacy opportunities on the state level and within their own local mental health systems. We are informing both stakeholders and PMHS leadership about the MHSA’s statutory and regulatory mandates as they relate to recovery-oriented systems and services, community collaboration, the MHSA’s CPP process, client-driven services, and effective outreach and engagement to clients with severe mental health challenges and to traditionally unserved, underserved, and inappropriately-served populations.

To achieve ACCESS’ primary goal of strengthening and expanding client advocacy through individual and community empowerment, policy makers, providers, and communities need educational resources and support that will help them effectively engage and include clients at all levels throughout the PMHS, encourage clients to advocate for their own mental health needs, and create systems, services, and outcomes that are truly client-driven and recovery oriented. Thus, our training activities are focused on teaching policy makers, providers, and communities how to successfully collaborate and share power with clients and other community stakeholders.

Highlights and outcomes from ACCESS’ training, education, and technical assistance activities are discussed in greater detail below.

**TRAINING ACTIVITIES**

(1) Ambassador Boot Camp

ACCESS’ annual Ambassador Boot Camp provides consumer advocates throughout California with the basic tools necessary to perform their duties as local-level mental health subject matter experts. The Boot Camp incorporates training modules on a number of advocacy-related subjects, including:

- Understanding the Ambassador Role
- Mental Health Policy Issues and Updates
- MHSA 101
- Local Advocacy 101
- Fundamentals of Public Speaking
- Statewide Advocacy 101
- Operationalizing Local and Statewide Advocacy
- Gathering and Reporting Ambassador Outcomes

These trainings give Ambassadors a consistent framework for representing the MHSA’s higher ideals and core values and for promoting and protecting the rights of others. Ambassadors learn to evaluate MHSA Innovation plans, craft effective public statements, navigate local mental health decision-making bodies and state level
mental health political processes, and other vitally important skills essential to the successful achievement of mental health advocacy outcomes.

In addition to these educational activities, the Boot Camp provides Ambassadors with informational materials to support their local advocacy and networking efforts, along with flyers and fact sheets for community distribution. Ambassadors also meet and bond with fellow advocates to develop local, Regional, and statewide networks of support to strengthen community engagement and client advocacy in California.

For the 2018-2019 program year, ACCESS held its annual Ambassador Boot Camp in Sacramento from November 5 – November 7, 2018. The three-day Boot Camp hosted 34 Ambassadors from all five MHSA Regions, as well as several local advocates from other Cal Voices programs.

The 34 Ambassadors in attendance completed a post-Boot Camp evaluation (see Appendix 4), providing ACCESS with useful feedback on which aspects of the Boot Camp they liked best and least, sharing what they learned and how it impacted them, and offering suggestions on ways to improve the training in future years:

- 94% agreed the Boot Camp met their needs and expectations
- 97% were satisfied with the Boot Camp training materials
- 97% were satisfied with the Boot Camp training delivery
- 100% were satisfied with the ACCESS program staff who led the Boot Camp
- 96% agreed the Boot Camp expanded their knowledge and understanding of the MHSA’s General Standards and CPP process requirements
- 97% agreed the Boot Camp increased their advocacy skills and confidence as a public speaker

(9) Regional Leadership Trainings

Many mental health leaders have never received a meaningful overview of the MHSA and other applicable mental health laws that apply to their work, the role of committees and bodies in the PMHS, stakeholder inclusion and accountability, fiscal transparency, or open meeting laws prior to assuming the responsibilities of their positions. Without a deep understanding of the goals and values of the MHSA and the principles upon which public mental health services are founded, they cannot be truly effective in their roles.

The Leadership Training was developed for local- and state-level PMHS decision makers and policy influencers, including local mental health directors, MHSA coordinators, unit/division managers, county supervisors, members of local boards and commissions, MHSA steering committee members, state agency directors, executive leaders, senior managers, and members of the California legislature. This training educates participants about their responsibilities under the MHSA, and teaches them how to effectively implement the MHSA’s six General Standards and Community Program Planning (CPP) process requirements. This training provides agency leaders and other key decision-makers in California’s PMHS a better understanding of their roles and how to effectuate the transformative change and community participation envisioned under the MHSA. PMHS Leadership Training attendees learn the following MHSA fundamentals:

- How the MHSA works: its grassroots origins and transformative intent, the MHSA’s six General Standards, and its requirements for meaningful stakeholder inclusion at all levels.
- How to support program planning and development and expand client stakeholder participation in the MHSA’s CPP process.
In 2019, ACCESS conducted a total of **nine** Leadership Trainings in all five MHSA Regions, with a combined attendance of 142 people representing the following 34 California Counties/jurisdictions: Alpine, Butte, Los Angeles, Napa, Orange, Riverside, San Bernardino, San Diego, Yolo, Alameda, Contra Costa, El Dorado, Imperial, Kern, Lake, Lassen, Marin, Mono, Nevada, Placer, Plumas, San Francisco, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Stanislaus, Sutter, Tehama, Tri-City, Tulare, Tuolumne, Ventura.

ACCESS received 117 post-training evaluations from 2019 Leadership Training participants (see Appendix 5). These evaluations and the additional feedback provided by attendees help ACCESS monitor the effectiveness of our learning materials and training approaches:

- 98% of respondents agreed the trainers appeared well organized and prepared
- 97% of respondents agreed that trainers demonstrated a clear understanding of the workshop content
- 98% of respondents agreed the trainers were responsive to participants
- 97% of respondents agreed the training content was relevant to their work
- 95% of respondents agreed they would recommend the Leadership Training to their co-workers

(Write-In Comments) **Strengths of the training, including the instructors:**

- Good general overview of MHSA
- Engaging participation from different counties
- Well educated on MHSA
- Passionate for work was appreciated
- Totally great information; not widely known by MH boards
- Advanced clarity about MHSA funding and process
- Clear, articulate, knowledgeable of subject
- Excellent review and reminder of MHSA - its purpose and funding
- Very responsive, good overview of MHSA general principles, funding, components, etc.
- Covers a lot of great information, especially MHSA background for those who may not know
- Took a really complex topic and have boiled it down to very easy to understand and comprehensive but not overloaded with information

Our Leadership Trainings have resulted in meaningful change in several Counties. Two Counties – one in the Bay Area Region and one in the Superior Region – did not know how to start an MHSA steering committee until their employees attended our trainings. Both Counties are currently implementing local MHSA Steering Committees that will use ACCESS for technical assistance and training beginning in fiscal year 2019-2020.

**6) Regional Community Empowerment Workshops**

ACCESS’ Community Empowerment Workshop educates clients, peers, advocates, and community stakeholders on key provisions of the MHSA, including its requirements pertaining to the CPP process and meaningful stakeholder involvement in mental health systems development, oversight, and evaluation. This Workshop also teaches attendees how to craft impactful policy statements to deliver at public meetings. ACCESS then accompanies participants to a local Mental Health Board/Commission meeting or MHSA planning meeting, where
they are supported in delivering their public statements and given a real-world opportunity to advocate for services and policies that positively impact clients in their community. Community Empowerment Workshop are taught:

- Applicable federal and state mental health laws
- How the MHSA works: its grassroots origins and transformative intent, the MHSA’s six General Standards, and its requirements for meaningful stakeholder inclusion at all levels of program planning and development
- How to participate in the MHSA’s CPP process
- Essential advocacy tips and guidelines on crafting effective public statements
- Basic public speaking skills and how to effectively advocate at open meetings
- How much of their personal story to share based on setting, audience, time constraints, etc.

In 2019, ACCESS conducted six Community Empowerment Workshops in every MHSA Region of the state, with a total attendance of 140 people representing the following 21 California Counties: Butte, Contra Costa, Los Angeles, Sacramento, San Bernardino, Solano, Alameda, El Dorado, Fresno, Glenn, Lassen, Monterey, Orange, Placer, Plumas, Riverside, Santa Clara, Stanislaus, Tehama, Ventura, Yolo.

ACCESS received 121 post-training evaluations from 2019 Community Empowerment Workshop participants (see Appendix 6). These evaluations and the additional feedback provided by attendees help ACCESS monitor the effectiveness of our learning materials and training approaches:

- 99% of respondents agreed the trainers appeared well organized and prepared
- 99% of respondents agreed that trainers demonstrated a clear understanding of the workshop content
- 100% of respondents agreed the trainers were responsive to participants
- 94% of respondents agreed the training content was relevant to their work
- 97% of respondents agreed they would recommend the Community Empowerment Workshop to their colleagues/co-workers

(Write-In Comments) Strengths of the training, including the instructors:

- Educational/Inspiring
- Strong advocates; very good venue and presenters.
- Excellent presence!
- They were informed, knew their material, excellent style in presentation
- Personable trainers, demonstrated respect for stakeholders. The final small group activity was a very strong component
- Made me feel calm & relaxed & able to learn
- Reinforced our passion!
- Training was concise, didn't seem like 7 hours at all! Lively, engaging, great job!
- Instructors were very educated and passionate about the topic. Small group was perfect.
- Well versed on MHSA policy and the required components of MHSA
- Engaging, energetic, very knowledgeable! Thank you!
- Clear and concise! Valid information regarding MHSA funds, county responsibilities & consumer/stakeholder participation and responsibility for action.
- Knowledgeable, great flow, good use of videos, activities, and handouts
They facilitated the training with knowledge and professionalism and listened to the participants and gave good feedback and answered questions. Well-paced.

- Detailed w/excellent communication skills, reps modeled passion and advocacy
- Great at incorporating examples to make things more understandable

EDUCATION ACTIVITIES

2019 Annual Advocacy Conference: Return to Recovery

Each year, ACCESS hosts a statewide consumer advocacy conference to disseminate findings from our annual data collection efforts, share highlights from our annual State of the Community Report, and discuss topics related to our annual theme.

This program year, ACCESS held its second annual conference – Return to Recovery – on August 23, 2019, at the California Endowment in downtown Los Angeles. Over 190 individuals attended this event for clients, community stakeholders, County and state mental health agency employees, and PMHS leadership and key mental health decision-makers. Conference attendees hailed from the following California Counties: Alameda, Butte, El Dorado, Fresno, Kern, Los Angeles, Marin, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Stanislaus, Tri-Cities, Tulare, and Ventura.

As ACCESS’ annual theme this year was Recovery-Oriented Systems, Services, and Outcomes in California’s PMHS, conference content focused on recovery-related themes and topics impacting the overall PMHS. Highlights from this conference include:

- ACCESS’ Statewide Advocacy Liaison, Tiffany Carter, fired up the already enthusiastic crowd with a performance of her original spoken word poetry
- Andrea L. Crook, NCPS, ACCESS’ Director of Advocacy, along with Dr. Jonathan E. Sherin, M.D., Ph.D., Director of Los Angeles County’s Department of Mental Health, delivered the conference’s welcome and opening remarks.
- Tiffany Carter and the 2019 ACCESS Ambassadors shared their stories of advocacy, individual and community empowerment, and successful outcomes for this program year.
- Dr. Sherin and Mimi Martinez McKay, M.A., M.L.I.S., provided a thorough presentation on Your DMH, a new project Los Angeles County has undertaken to strengthen the County’s local MHSA CPP process and produce community-driven stakeholder priorities that will guide the County in its development of its forthcoming Mental Health Action Plan.
- Dr. Elyn Saks, J.D., Ph.D., delivered an inspiring talk entitled: “The Center Cannot Hold: My Schizophrenia with Thoughts About Recovery,” in which she shared her personal story of recovery and hope. Dr. Saks is a distinguished Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law.
- Dawniell A. Zavala, Esq., ACCESS’ Program Director and Cal Voices’ Associate Director and General Counsel delivered an update to the audience regarding the outcomes of ACCESS’ annual data collection activities, primarily our Annual Client and Leadership Survey, which measured the extent to which recovery concepts are applied in the PMHS and meaningful recovery outcomes are driving mental health planning decisions on the state and local levels.
Dr. Mark Ragins, M.D., the conference’s keynote presenter, is the former Medical Director at the MHA-LA Village in Long Beach and co-developer of the Milestones of Recovery Scale (MORS), an award-winning model of recovery based mental health care. Dr. Ragins’ talk, “Recovery-Based Outcomes and Accountability: Possibilities and Pitfalls,” provided meaningful insights on recovery-oriented systems of care, services, and outcomes in the PMHS, as well as the importance of and struggles around the collection, measurement, evaluation, and utilization of recovery outcomes data.

The conference created unique opportunities for clients and other community stakeholders to participate in statewide policy discussions and collaborate with local and state policy makers, organizational leaders, providers, and the general public to address important issues impacting mental health services in local communities and affecting clients throughout California.

ACCESS collected post-conference evaluations from 125 attendees (see Appendix 7) to gauge the efficacy of our conference content, materials, presenters, and to assess the overall participant experience:

- 100% of respondents felt the conference fulfilled their primary reason for attending
- 96% of respondents were satisfied with the conference topics
- 95% of respondents were satisfied with the conference speakers

**Write-in comments regarding Dr. Elyn Saks’ presentation:**

- Elyn's book helped me so much when I was experiencing psychosis in and out for years. Hearing her speak was so inspiring and emotional.
- Was my first time to see and hear Dr. Elyn Saks it was great. A great story teller of own recovery, uplifting
- Thank you for sharing your experience and journey. Very powerful and uplifting and will help me in working with consumers.
- Thank you for turning your mess into a message and your testinto a testimony.
- I attended today to hear her speak. Her story is a huge inspiration to many.

**Write-in comments regarding Dr. Mark Ragins’ presentation:**

- The presenter always a pleasure from first meeting at LA MHA. Authentic peer driven great power point very precise and helpful.
- Very accessible personality
- Nice balance in how/why program outcomes are important
- Inspiring, excellent, extraordinary
- Very informative and engaging
- Very engaging. As good as videos if not funnier
- Loved his down to earth way
- I enjoyed his candid ability to hold the audience.
- I always love hearing Dr. Mark Ragins
- Wonderful and comical presenter with the working knowledge
- Very informative, funny and honest
- Thank you for dedicating your life to this subject. Is a model that strengthens providers and consumers
Informative, great, direction, love learning about history for future recovery based cultures and values

Most useful info I will take back to my community and loved your use of humor.

Although subject matter is abstract it is very necessary

Explained issues around recovery very well and explained more better than I've heard anyone explain in such a short span of time

Deep material but being a nuts and bolts guy while having a heart. I loved it

Good topic. He clarified the meaning of recovery for me

(10) Advocacy, Leadership, and Learning Series Webinars

Quarterly Advocacy webinars provide mental health policy updates from a client perspective, present legislative and policy analysis in an accessible manner, discuss opportunities for stakeholders to get involved with local- and state-level advocacy activities, and offer practical tips and resources to effectively participate in the MHSA Community Program Planning process. Stakeholders give feedback on important policy issues and help the ACCESS program focus its state-level advocacy activities. ACCESS’ Advocacy webinars also offer vital support and collaborative coaching for ACCESS Ambassadors.

Quarterly Leadership webinars offer a collaborative forum for County and state PMHS leaders including County-designated client advocates/liaisons in California to discuss local and statewide mental health policy issues, local-level trends and concerns, best practices and success stories, and the needs of clients throughout the state. Legislative and policy analysis will be provided, and participants will identify opportunities for local- and state-level public advocacy. County leadership and other policy makers will receive practical tips and resources to help facilitate stakeholder participation in the MHSA Community Program Planning process.

Quarterly Learning Series webinars for clients, policy makers, organizational leaders, providers, advocates, and community stakeholders provide a forum for individuals working in the PMHS and those receiving services to discuss their experiences, tips, challenges, and best practices related to services delivery, stakeholder inclusion and engagement, effective advocacy and systems change, recovery-oriented practices, peer employment and other important topics, with opportunities to share ideas and get questions answered in a friendly, supportive, and nonjudgmental environment.

ACCESS conducted the following webinars this program year:

- **(9/28/18) Recovery 101: Fundamental Principles of Recovery.** This webinar educated individuals who are not familiar with recovery concepts by teaching the differences between the medical model and the recovery model of care, why these distinctions are significant, and the major dimensions that contribute to a life in recovery. Participants had an opportunity to reflect on how recovery concepts are integrated into the public mental health system, services, and outcomes.

- **(11/27/19) ACCESS Ambassador Advocacy Webinar.** This webinar offered a refresher on the topics addressed during the ACCESS Ambassador Boot-Camp, including a review of the findings in ACCESS’ 2018 State of the Community Report, key principles of the MHSA, local and state advocacy opportunities, tips for effective public speaking, and the roles and responsibilities of an ACCESS Ambassador.

- **(11/29/18) Moving Forward Together.** ACCESS detailed the unique findings from our 2018 State of the Community Report and took a more in-depth look into the mental health needs of public mental health clients
and explored how these needs differ on the local and state level. The webinar concluded with tangible recommendations to both the state and local leaders.

- **(12/19/18) Recovery 101: Ten Guiding Principles of Recovery.** This webinar educated individuals who are not familiar with recovery concepts by reviewing the recovery model of care and the major dimensions that contribute to a life in recovery. Additionally, this webinar taught individuals the ten guiding principles of recovery in depth. Participants had an opportunity to reflect on how recovery concepts are integrated into the public mental health system, services, and outcomes.

- **(2/12/19) Shared Power and Collaborative Decision-Making Part I.** ACCESS introduced the process that supports multiple stakeholders with the development of a vision and long-term ambition, and with the translation of that vision and ambition into a specific approach and activities.

- **(2/12/19) ACCESS Ambassador Advocacy Webinar.** Clarity on the ACCESS Ambassador role both in the community and within their Regional team, what advocacy means as an Ambassador, ACCESS’ role with Ambassadors, and an overview of the National Certified Peer Specialist program.

- **(3/29/19) Shared Power and Collaborative Decision-Making Part II.** Participants learned the definitions and benefits of shared power and collaborative decision-making, and were provided with practical tips on how to foster collaborative decision-making when engaging in community planning.

- **(5/14/19) Shared Power and Collaborative Decision-Making Part III.** ACCESS explored the various approaches local and state leaders may take to better ensure the CPP is upheld through a meaningful process that values transparency, a shared vision and goals.

- **(5/20/19) ACCESS Ambassador Advocacy Webinar.** ACCESS conducted a discussion around challenges encountered when advocating, questions to reflect on as an advocate, finding solutions to challenges encountered, how to nurture self-momentum, how to nurture stakeholder momentum, and focus on the Ambassador impact.

- **(8/16/19) Stakeholder Advocacy in 2019: Opportunities and Challenges.** A discussion of the challenges faced by advocates, solutions to manage or overcome those challenges, and successes advocates have experienced.

(6) E-Learning Modules

Because ACCESS delivers a limited number of in-person trainings each year, ACCESS develops e-learning modules from each of its core in-person trainings and other educational content, all of which are available for free online at www.accesscalifornia.org. This year, ACCESS created the following six e-Learning modules:

- **Shared Power and Collaborative Decision Making:** Collaborative Decision-Making is a process that supports groups of stakeholders with the development of a vision and with the translation of that vision and into a specific approach and activities. Despite stakeholder partnership being a requirement of the MHSA, collaborative decision-making is frequently missing from community planning in general. Because of this, most definitions of collaborative decision-making are rooted in clinical practice. ACCESS developed an E-Learning Module to illustrate the importance of Client-Driven services and policy implemented with MHSA funds as functions of shared power and collaborative decision making in the Public Mental Health System.

- **MHSA Basic Training:** This E-Learning Module provides basic training on the MHSA for those community stakeholders and leadership members who are unable to attend our in-depth trainings. We highlight the statutory requirements and best practices of the MHSA as a means of system transformation of the Public
Mental Health System. The statutory language is very empowering for those who are steeped in it and educates stakeholders and agency leadership about how mental health services are developed in their Counties.

- **Recovery 101:** Educates community stakeholders and County leadership about the values and principles of the Recovery Model as an alternative to more broadly practiced Medical Model systems. When a community member learns to promote personal quality of life changes to ensure stable and sustained periods of recovery as opposed to simple medical compliance, more informed choices can be made about how to reach personal goals.

- **Recovery Orientation:** This e-Learning module promotes the vision of Dr. Mark Ragins, and others, who view mental health services within a more holistic approach. Recovery-oriented systems of care are person-centered, recovery-oriented, and community based.

- **Recovery Planning:** Recovery planning is defined as the development of an individualized strategy for achieving or maintaining recovery that is created, implemented, monitored, and revised by the person receiving services. Client-driven adult mental health services is a promise and goal of the MHSA because a self-directed life gives an individual purpose and empowers them toward independence.

- **California’s PMHS:** An introduction to the landscape of funding, oversight and responsibilities within the PMHS, and how clients and consumers can access services. The PMHS functions because of the funding cooperation between federal, state, and local agencies to ensure that local clients/consumers have access to local culturally complementary services that are best suited to their needs.

**TECHNICAL ASSISTANCE ACTIVITIES**

ACCESS provides individualized Technical Assistance (TA) local- and state-level PMHS leaders, policy makers, providers, agencies, and community organizations. Our TA efforts have increased awareness of the MHSA’s stakeholder inclusion and CPP process requirements, and have expanded entities’ understanding of effective methods to engage clients and communities, support consumer employment reduce mental health stigma and discrimination, increase inclusiveness in systems and communities.

In the 2018-2019 program year, ACCESS’ TA has also helped leaders and agencies within the PMHS to accurately assess the recovery orientation of their systems and agencies, enhance recovery-based and client-driven adult mental health services, and implement methods to collect and utilize meaningful recovery outcomes data to improve the quality of services and client experiences in the PMHS. Our TA activities have supported the implementation of transformative change in the PMHS and have increased client participation in local planning and policy discussions. This year, ACCESS provided TA, guidance, feedback, and support to the following entities:

<table>
<thead>
<tr>
<th>ENTITY/ORGANIZATION</th>
<th>SUPPORT PROVIDED</th>
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<tbody>
<tr>
<td>Butte County</td>
<td>▪ Coached County on implementation of ACCESS’ Stakeholder Bill of Rights on the County level. Butte County now has the Stakeholder Bill of Rights on their website.</td>
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<tr>
<td>CalMHSA</td>
<td>▪ Offered feedback and guidance on Counties’ Tech Suites Innovation projects, digital phenotyping, passive data collection, and client privacy issues.</td>
</tr>
<tr>
<td>ENTITY/ORGANIZATION</td>
<td>SUPPORT PROVIDED</td>
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<tr>
<td>CIBHS</td>
<td>▪ Gave suggestions and advice on how to strengthen its relationship with CALBHB/C and leverage connections to improve engagement.</td>
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<tr>
<td>El Dorado County Mental Health Board</td>
<td>▪ Supported County’s understanding and implementation of the MHSA’s six General Standards and the MHSA CPP process.</td>
</tr>
<tr>
<td>Lake County</td>
<td>▪ Supported County’s understanding and implementation of the MHSA’s six General Standards, the MHSA CPP process, and ACCESS’ Stakeholder Bill of Rights.</td>
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<tr>
<td>Los Angeles County</td>
<td>▪ Provided ongoing guidance and feedback related to the County’s implementation of the County’s new Your DMH initiative (a strategic plan to ensure broad and meaningful stakeholder processes are in place to drive local mental health priorities).</td>
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<tr>
<td>Orange County Board of Supervisors</td>
<td>▪ Educated supervisors on how to utilize and best leverage their available MHSA funding to invest in a robust and ongoing local CPP process.</td>
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<tr>
<td>San Mateo County</td>
<td>▪ Guided County’s efforts to better collaborate with local stakeholders and offer them advocacy training and supports.</td>
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<tr>
<td>San Mateo Office of Consumer and Family Affairs Behavioral Health and Recovery Services</td>
<td>▪ Supported consumer leadership with enhancing County’s knowledge and implementation of the MHSA’s stakeholder collaboration and CPP process requirements</td>
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<tr>
<td>Santa Cruz County Behavioral Health Board and County Behavioral Health Leadership</td>
<td>▪ Supported County’s understanding and implementation of the MHSA CPP process; attended and provided support at the County’s very first meeting of its MHSA Steering Committee.</td>
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<tr>
<td>Soroptimist International of the Americas</td>
<td>▪ Assisted in the coordination of their annual Stop-Stigma event in Butte County; conducted outreach and recruited a speaker from their community for the event; provided attendees with educational materials.</td>
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<tr>
<td>Tuolumne County Peer Support Staff</td>
<td>▪ Supported staff with the County grievance process to contest the County’s proposed elimination of peer positions.</td>
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<tr>
<td>UC Berkeley</td>
<td>▪ Offered guidance on shared decision making and the mental health recovery model.</td>
</tr>
<tr>
<td>UCLA’s Community Advisory Group</td>
<td>▪ Gave feedback and guidance regarding data sets and measures of the MHSA’s seven outcomes: Suicide, Incarceration, Homelessness, Unemployment, Prolonged Suffering, Removal from Home, and School Failure.</td>
</tr>
</tbody>
</table>
Because ACCESS’ primary goal is to strengthen and expand consumer advocacy through individual and community empowerment, local clients/ consumers, family members, and members of underserved populations were provided outreach, engagement, and communication strategies that:

- Inform them of their rights as clients, families, and members of underserved communities
- Treat them as necessary and valued participants in the local stakeholder process
- Respect their unique needs and empower them to take individual action in their communities
- Keep them informed about important MH policy issues affecting them
- Identify opportunities, strategies, and access points for local-level advocacy
- Include key facts, findings, recommendations, and talking points to help them craft effective public statements
- Connect them to grassroots and statewide networks of like-minded individuals in their communities with whom they may collaborate to effect positive change

ACCESS’ outreach and engagement activities focus on engaging the voices of historically underserved communities in the PMHS. Highlights and outcomes from ACCESS’ community outreach, engagement, and communications activities are discussed in greater detail below.

COMMUNITY OUTREACH AND ENGAGEMENT ACTIVITIES

(10) Regional Community Outreach Events

Throughout the year ACCESS conducted ongoing outreach activities aimed at identifying the needs of underserved populations and elevating these voices in both the local and statewide stakeholder processes. These activities included public trainings and speaking engagements, outreach and engagement at community festivals and health fairs, as well as attending events and meetings where PMHS clients were in attendance.

This program year, ACCESS representatives and team members attended regional outreach events in the following regions and counties: Los Angeles Region (Service Areas Four and Five); Southern Region (San Diego and Orange Counties); Bay Area Region (San Francisco and Santa Cruz Counties); Superior Region (Butte County); and Central Region (Sacramento, Amador, and Placer Counties).

COMMUNICATIONS ACTIVITIES

ACCESS Website Redesign

Early in 2019, after consultation with stakeholders, ACCESS redesigned our website with the goal of making our materials and information more accessible for end users. With more intuitive headings and overall website design, the key pieces of the ACCESS California program have been highlighted in prioritized searches.
Our website has proven to be a valuable tool to educate our audience, provide positive messaging around mental health, and engage clients and consumers in mental health advocacy. Our website includes our upcoming trainings, position papers, and a wide variety of advocacy resources. Our website traffic has consistently increased since we began tracking visits this year.

**Online Local and State Advocacy Directories**

ACCESS maintains an online local advocacy directory identifying advocacy access points in each of the 59 local mental health agencies in California. The directory identifies:

- State mental health agencies and their contact information
- Regional ACCESS Ambassadors
- County behavioral health department contact information
- County public mental health meetings
- County MHSA resources

Our online advocacy directories have helped stakeholders find advocacy opportunities, vital information about public mental health agencies, and become more engaged in local- and state-level advocacy throughout California.

**Quarterly Newsletters, Monthly Email Blasts, and Social Media Posts**

ACCESS regularly provides updates on mental health news stories, events, and notices for our program via email blasts, quarterly newsletters and social media posts. These updates increase awareness of local services, promote wellness and recovery, and provide information on community events, health fairs, and networking opportunities. A standard average for Constant Contact clickthrough rates is approximately 7%, and our average range is between 10-15% of over 1,600 subscribers. Our increasing community of subscribers is very active and interested to learn more about the MHSA and other Public Mental Health System trainings and news.

**Advocacy Helpline and Stakeholder Ombudsman Service**

ACCESS has created a dedicated phone line and email account to continuously provide support to the general public and local clients/consumers who need help advocating for their needs on a grassroots level within their communities. Last year ACCESS responded to over 100 telephone calls and emails from every Region in California to our Advocacy Helpline. Common themes of contacts to the Advocacy Helpline included:

- Guidance on local advocacy for effective County programs that were being discontinued
- Guidance on local advocacy for creation of new programs or services
- The challenges associated with working as a peer within a County
- The lack of peer positions and career ladders within Counties

ACCESS is able to conduct research on issues, assist advocates with development of talking points, and provide informational handouts for distribution by stakeholders. While we are generally not informed about local advocacy successes, the increases in contacts to our program has demonstrated the value that this service provides for local stakeholders and advocates.
To ensure the MHSOAC receives guidance, input, and subject matter expertise from PMHS clients and other individuals with lived experience from diverse communities, ACCESS partners with consumers across the state who not only provide unique perspectives to inform the MHSOAC’s work, but also perform wider advocacy-related activities on both on the local and state levels. Ambassadors are a vital component of the ACCESS program and are crucial to the success of our overall training, outreach, engagement, and advocacy strategies. All ACCESS staff, ACCESS Ambassadors, and collaborative partners are well-versed in the recovery model, community inclusiveness and stakeholder engagement principles, and peer employment issues as they relate to services, processes, and practices within the PMHS.

ACCESS maintains a network of up to thirty ACCESS Ambassadors each program year, with at least two Ambassadors from each of the five MHSA Regions.

WHAT DO ACCESS AMBASSADORS DO?

ACCESS Ambassadors possess invaluable lived experience as current or former PMHS clients and act as our go-to resource within their County and Region on issues related to local mental health advocacy, client empowerment, education, community engagement, stakeholder needs and concerns, and mental health policy and planning activities. Ambassadors also link the wider ACCESS program with local leaders, providers, and stakeholder groups to further our program’s advocacy efforts. ACCESS Ambassadors:

- Create and engage in ongoing opportunities to arm community stakeholders with important mental health policy information
- Assist community stakeholders in expressing their concerns, needs, and wants in appropriate, meaningful settings
- Identify local client advocacy needs and community-wide trends related to mental health policy
- Act as the client experts in their Counties and Regions, sharing relevant information with ACCESS and their community regarding local mental health planning processes and advocacy opportunities
- Represent the needs and wants of their local communities at public meetings, based upon their collaboration with local clients and other stakeholders
- Support stakeholders in advocating for themselves at public meetings where important decisions are made
- Promote awareness of the MHSA’s General Standards and requirements for meaningful stakeholder involvement in the CPP process

In addition, Ambassadors perform all of the following activities each year:

- Attend an annual ACCESS Ambassador Boot Camp
- Participate in quarterly ACCESS Ambassador advocacy and networking webinars
- Train and engage with local stakeholders on important mental health topics affecting their communities
- Provide support and technical assistance to local individuals and stakeholder advocacy networks

2019 ACTIVITIES AND ACCOMPLISHMENTS: ACCESS AMBASSADORS
Disseminate ACCESS outreach materials attendees at local mental health meetings and other events

Support and network with other ACCESS Ambassadors and local community stakeholders

Recruit additional ACCESS Ambassadors, as needed

Conduct local-level advocacy activities by attending local mental health meetings and giving public comments about mental health-related issues of local or statewide importance

Facilitate local stakeholder advocacy meetings to discuss issues of local and statewide importance

Conduct state-level advocacy activities by attending statewide policy meetings and providing public comment on mental health-related issues of local or statewide importance

Attend ACCESS’ annual stakeholder advocacy conference

Ambassadors’ success in impacting, collaborating with, educating, and advocating for stakeholders in their Regions has supported the key concepts of recovery, resiliency and wellness. In program year 2018-2019, Ambassadors have remained steadfast in their dedication to relationship building, networking, policy promotion and awareness, mental health advocacy, and community engagement, both locally and statewide.

WHO ARE THE 2019 ACCESS AMBASSADORS?

For the 2018-2019 program year, Ambassadors came from all five MHSA Regions, representing the following California Counties: Alameda, Butte, El Dorado, Fresno, Lassen, Los Angeles, Modoc, Monterey, Placer, Sacramento, San Bernardino, San Mateo, Santa Clara, Santa Cruz, Stanislaus, and Ventura.

2019 SUPERIOR REGION AMBASSADORS

Andrea Wagner (Regional Leader): Butte County
Andrea Wagner has worked in Butte County Behavioral Health since 2015, believes strongly in what the MHSA provides for California consumers, and has been a huge advocate for the peer empowerment movement in her County.

Billy “Guillermo” Diaz: Modoc County
Billy Diaz engaged massive effort in Modoc County to assure that the Department of Health received valuable feedback respective to the impact of peer-run organizations and their ability to provide MHSA funded services.

John Brooner: Lassen County
John Brooner has been the vice chair for a peer run organization in Lassen County supporting the empowerment of local mental health consumers and providing essential services needed for whole-person wellness.

2019 CENTRAL REGION AMBASSADORS

John Aguirre (Regional Leader): Stanislaus County
John Aguirre has served in California’s mental health field for over a decade in roles supporting children’s mental health, LGBTQ reduction of disparities, coordination of training and County support with the National Alliance of Mental Illness of California, to service on Stanislaus’ Suicide Advisory Committee.
Clarene White: Fresno County
Clarene White has supported consumers in Fresno County by being a provider of mental health counseling and rehabilitative services, is a certified rehabilitation counselor, a certified Wellness Recovery Action Plan facilitator, among other skills.

Bill Floyd: Stanislaus County
Bill Floyd is an active mental health advocate of Stanislaus County who regularly attends Behavioral Health Board meetings, ensuring that peer roles are elevated, peer services are valued and expanded, that the community has efficient reviewal processes, among other vital focuses.

Sheri Courville: Placer County
Sheri Courville has been an active member of her Placer County community by participating with the County’s mental health department, Placer County’s Alcohol and Drug board, consumer council, and speakers’ bureau.

Laura Valdez: El Dorado County
Laura Valdez has been an advocate for consumers in El Dorado County with the goal of supporting more peers with understanding the fundamentals of what mental and behavioral health can offer and their rights as stakeholders.

Kat Wantz: Sacramento County
Kat Wantz has extensive advocacy experience in the Central Region from her work with the Sacramento County Stop Stigma campaign, to the NAMI California, and engagement with MHSA steering committee meetings, and MHSOAC meetings.

2019 BAY AREA REGION AMBASSADORS

Michael Lim (Regional Leader): San Mateo County
Michael Lim believes in meaningful peer support in San Mateo County and brings with him to the table a variety of experience including but not limited to being a Youth Mental Health First Aid Instructor and a graduate of the Health Ambassador Program of the San Mateo County Health System.

Lorraine Zeller: Santa Clara County
Lorraine Zeller is passionate about peer-run, peer-driven services and elevating and empowering the peer movement in her County and statewide. Lorraine facilitates a group in her County called “Transforming the System”, whose participants receive training on advocacy and engagement in the mental health system, and put their training to action by attending various Board and Commission meetings ensuring the consumer voice is at the table.

Pamela Weston: Monterey County
Pamela Weston is an advocate to the core and embarked upon her Ambassador role in order to support nurturing stakeholder involvement at local and statewide policy and budget meetings, to support peer and family support advocacy and community civic engagement.
**Pamela Miles: Alameda County**
Pamela Miles became an ACCESS Ambassador in order to advocate for quality mental and physical healthcare and social concerns that affect the wellness and recovery of the clients/consumers with mental health challenges and physical disabilities.

**Richard Gallo: Santa Cruz County**
Richard Gallo has brought an array of experience to the table as a subject matter expert and consistently advocates for the inclusion of consumers and family members at the table where decisions are being made about impactful services along with the call for elevated peer support roles throughout the County.

**2019 LOS ANGELES REGION AMBASSADORS**

**Pam Inaba (Regional Leader): Los Angeles County, Service Area 6: South**
Pam Inaba is a long-time advocate for the people of Los Angeles County, values the Mental Health motto “nothing about us without us”, and has an array of meaningful experience with a multitude of consumer run agencies, community members, and service area/County leadership which have served as a benefit to her ability to advocate for the people of LA.

**Tiffany Duvernay (Regional Leader): Los Angeles County, Service Area 6: South**
Tiffany Duvernay exudes her passion for mental health advocacy by actively engaging in a variety of local level meetings, being the voice for those that have not found their voice yet, supporting stakeholders engaging in meaningful expressions of their truths within policy focused public forums, all driven by her belief in justice and equality.

**Emily Wu Truong: Los Angeles County, Service Area 3: San Gabriel**
Emily Wu Truong possesses strong belief in culturally competent services and access to mental health services ensuring that communities of color are able to overcome the barriers that keep generations of diverse populations from seeking mental health services.

**Hector Ramirez: Los Angeles County, Service Area 2: San Fernando**
Hector Ramirez is an active advocate in San Fernando County and became an Ambassador in order to continue efforts to support people, families, and communities towards improving policy decisions which directly impact mental health consumers.

**Amparo Ostojic: Los Angeles County, Service Area 4: Metro**
Amparo Ostojic is a motivated mental health advocate who really embodies being the advocacy boots on the ground for consumers and their family members who are a part of the underserved communities and who lack proper access to mental health services.

**Bianca Gallegos: Los Angeles County, Service Area 6: South**
Bianca Gallegos possess fever for breaking down the stigma and discrimination associated with mental health and focuses efforts on addressing policy level issues which have created challenges with mental health services for consumers.
Alicia Crews Rhoden: Los Angeles County, Service Area 6: South
Alicia Crews Rhoden is driven by supporting local community members and underserved and diverse populations with becoming empowered to find their voice as mental health advocates and consumers.

Thomas Smith: Los Angeles County, Service Area 6: South
Thomas Smith has consistently been a passionate advocate for adults living with trauma, impacted by economic disadvantages, and those disenfranchised by former incarceration, assisting them with accessing services and becoming empowered to independently and collaboratively advocate for policy and systemic changes in mental health.

Jolissa Hebard: Los Angeles County, Service Area 8: South Bay
Jolissa Hebard has been a mental health advocate for Los Angeles County supporting the expansion of educating stakeholders, promoting advocacy, and aiding in the efforts to end mental health stigma.

Johana Lozano: Los Angeles County, Service Area 7: East
Johana Lozano’s motivation as an Ambassador has been to empower and mobilize consumers and stakeholders who often have no voice in DMH, raise awareness on mental health, and the need for quality behavioral treatment.

2019 SOUTHERN REGION AMBASSADORS

Vickie Mack (Regional Leader): San Bernardino County
Vickie Mack has deep roots in San Bernardino and exudes humility with her ability to support, acknowledge and value stakeholder engagement while ensuring that the various, diverse voices and experiences are meaningful and belong at the table where decisions are being made about their loves.

Pete Lafollette: Ventura County
Pete Lafollette has been a strong advocate both within Ventura County and on a state-wide level, ensuring that mental health stakeholders are aware of opportunities to be present in the room and at the table for decisions being made that impact the consumers of California.

WHAT HAVE THE 2019 ACCESS AMBASSADORS ACCOMPLISHED?

This program year, Ambassadors, provided training, education, resources, technical assistance and advocacy in over 40 of California’s Counties. Ambassadors in every Region are reporting meaningful changes within their Counties due to their advocacy efforts. Highlights of Ambassadors’ efforts in each of the five MHSA Regions are detailed below.

SUPERIOR REGION OUTCOMES AND ACCOMPLISHMENTS

Superior Region Ambassadors advocated with their Butte County’s Behavioral Health Advisory Board and with the County’s Behavioral Health Director, resulting in monumental changes in the County’s system of care and local mental health planning process. Upon advocating for changing and enhancing peer support employment, for community participation in MHSA community planning and projects, and for the peer voice in general, change is slowly happening. Superior Region Ambassadors had success with establishing an MHSA steering committee where there was not one before, peer support is undergoing an expansion and overhaul within the County...
system, and peer stakeholders now feel empowered and are participating in proposing new innovations that will impact hundreds of people. The Superior Region now has an ongoing group of stakeholders that meets regularly and is advocating for new projects.

CENTRAL REGION OUTCOMES AND ACCOMPLISHMENTS

Central Regional Ambassadors have been successfully engaged with PMHS leadership on transforming local systems to be more inclusive and supportive of peers in the planning process at all levels. Ambassadors have also participated in collaborative and educational engagements with the DHCS, and have worked to ensure stakeholders have an appropriate allotment of time to submit their public comments regarding matters of public health and mental health. DHCS has responded favorably in ensuring this opportunity for the public is upheld.

BAY AREA REGION OUTCOMES AND ACCOMPLISHMENTS

Bay Area Region Ambassadors have supported meaningful collaborations with their local mental health boards to support more transparency with stakeholders and increased opportunities for stakeholder engagement. In addition, Bay Area Ambassadors have established and nurtured trusting relationships with County leadership and have collaborated with them to ensure proven recovery-oriented practices within the PMHS are being captured and recorded. In Santa Clara County, our Ambassadors have also created a network of County leaders and community-based organizations that utilize and/or seek the Ambassador knowledge of key MHSA principles and requirements. Bay Area Ambassadors are meeting with their local PEI and Cultural Relevancy committees, resulting in the implementation of the MHSA’s General Standards into their Counties’ MHSA Three-Year Plans.

LOS ANGELES REGION OUTCOMES AND ACCOMPLISHMENTS

Los Angeles Ambassadors have established trustworthy relationships with the Los Angeles County Department of Mental Health leadership, resulting in a strengthening of the local MHSA CPP process, called “Your DMH.” Additionally, Los Angeles Region Ambassadors have engaged in innovative collaborations to create MHSA programs to support adults leaving the criminal justice system. The Los Angeles County Client Coalition has significantly expanded due to Ambassadors’ relentless networking activities. The Coalition recognizes ACCESS as a supportive resource.

SOUTHERN REGION OUTCOMES AND ACCOMPLISHMENTS

Southern Region Ambassadors served as an essential resource, enlightening ACCESS with information regarding key events and mental health-related data. Southern Region Ambassadors supported ACCESS’ mission to empower California stakeholders by disseminating policy information and expanding opportunities to advocate.

AMBASSADOR INSIGHTS AND FEEDBACK

To ensure the training, educational materials, support, coaching, and assistance we provide to Ambassadors is adequately meeting their needs, ACCESS creates several opportunities throughout the program year for Ambassadors to evaluate our activities and provide us with useful feedback on our program’s strengths and areas for growth. These evaluations are discussed below.
AMBASSADOR BOOT CAMP EVALUATION

The 34 Ambassadors in attendance completed a post-Boot Camp evaluation (Appendix 4), providing ACCESS with useful feedback on which aspects of the Boot Camp they liked best and least, sharing what they learned and how it impacted them, and offering suggestions on ways to improve the training in future years:

- 94% agreed the Boot Camp met their needs and expectations
- 97% were satisfied with the Boot Camp training materials
- 97% were satisfied with the Boot Camp training delivery
- 100% were satisfied with the ACCESS program staff who led the Boot Camp
- 96% agreed the Boot Camp expanded their knowledge and understanding of the MHSA's General Standards and CPP process requirements
- 97% agreed the Boot Camp increased their advocacy skills and confidence as a public speaker

What are some things you learned at the Boot Camp that you did not know before?

- The degree that others in their regions are prepared and already participating in advocacy. Very smart and engaged stakeholders showing leadership qualities.
- How easy it is to access information about the decision makers in my community. And the power of solid, concise and statistical presentations to garner MHSA funding.
- More details on what MHSA does, what the MHSA General Standards are, what proposition 63 is, I didn’t know almost anything before.
- A legal framework for involvement of parents or consumers as pertaining to the MHSOAC
- The majority of the context of MHSA. The issues there are with getting funds out and into programs that can help.
- I got a better overall understanding of the organizational chart for MHSA. Where to comment and get stakeholders needs and desires met.
- I learned exactly what elements are needed or the questions that are asked of each county in proposing projects for MHSA funding. This is so helpful!
- That the MHSA planning process *shall* (law!) be client-driven. That family-driven does not mean families of adults with mental health conditions. That counties are required to spend money on training stakeholders about the CPP process.

What will you do differently as a result of what you learned at the Boot Camp?

- I will make sure that I will advocate for myself and fellow mental health clients and make sure that mental health remains client and family driven.
- I will make sure that I bring the MHSA standards with me to all meetings so I can see if the use the Department of mental health is meeting the 6 guidelines they are supposed to. I will encourage my community, especially the Spanish speaker to advocate for their rights.
- Bring materials to all meetings, etc. to better spread the word. Use every opportunity to inform and connect.
- I feel more prepared and confident to attend and speak at local legislature meetings and community committee meetings.
- I will broaden where I do my advocacy. Place effort in best places where dialogue is most.
- Encourage and empower others to develop a voice of their own as well as work on my 2 minute speak.
- Help others to become informed and involved in the community planning process. Especially when it comes to stakeholders priorities.
- I am going to organize, in collaboration with my county MHSA coordinator, many stakeholder meetings to set a fresh list of priorities and to write some client-generated proposals to the board.
- I will actually make public statements at BH Board, BOS and possibly other meetings using the tools we have been given to prepare statements and also using my fellow ambassadors and staff for feedback in preparing and practicing statements. I will offer to train clients and peer providers to make public statements, especially as I become more confident in my own abilities (even though I have the tools).
- I will provide more information to my community about the MHSA General Standards and seek to get more stakeholder involvement in the CPP.
- [P]rovide others with an understanding of how much value their voices have in making change happen.

What did you like best about the Ambassador Boot Camp?

- I liked all of the mental health information a lot. I have a lot of knowledge of mental health and now I have a lot more information.
- The power of networking and the wealth of knowledge/experiences around the room.
- That I got to meet everyone that is leading the team, I really appreciated who welcoming and knowledgeable the staff is.
- The facilitators took the time to answer questions. Making the experience about quality not quantity.
- Even though this is serious and weighted material the staff kept the presentation fun and engaging.
- Valuable lessons. Things I can put into practice for the community that result in the best outcomes.
- The acceptance and feeling of equality displayed by all the Access Staff.
- All of it. To know we are doing things across the state and that we are being able to create data that can be measured and help create oversight.
- I liked meeting the other Ambassadors and seeing that we all had similar struggles but we had similar optimism too and a drive to make a difference in mental health care.
- The people! Both staff and ambassadors. :-)
- I knowledge presented and obtained was exceptional. I really enjoyed meeting the Staff and the other Ambassadors including dining together.
- What I like best about the Ambassador Boot Camp was how it was facilitated and the printed material provide to me to use as reference.

COMMUNITY EMPOWERMENT WORKSHOP EVALUATION

Several (13) Ambassadors assisted ACCESS in completing our Regional Community Empowerment Workshops. Those who attended were asked to evaluate and provide feedback on this activity (Appendix 4). Ambassadors who completed the evaluation said the Community Empowerment Workshop:

- 100%: Explained to participants how the public mental health system works (in general) “very well”
- 100%: Helped participants achieve a better understanding of the MHSA's requirements for community program planning and stakeholder collaboration “very well”
100%: Encouraged participants to get involved in local mental health planning and policy issues “very well”
100%: Prepared participants to give an effective public statement at a local mental health meeting “very well” (92%) or “well” (8%)

What did you like best about the Community Empowerment Workshop?
- I loved seeing how people lit up knowing they had the legal backing to participate in the MHSA funding process.
- I liked the exercises because the participants in both groups worked well together by brainstorming and then selecting action plans that would have been effective. I appreciated being able to practice cooperative brainstorming.
- Getting to see familiar faces, brushing up on advocacy info and skills, it was close to home.
- The flow of the presentation and the training room was great. People always leave feeling so empowered with this new information.
- I liked best how this workshop went into greater detail with explaining how the public mental health system works. It also went in deeper to what I learned at boot camp on the MHSA’s requirements for community program planning and stakeholder collaboration.

OVERALL PROGRAM EVALUATION AND ANNUAL REFLECTIONS
Ambassadors completed an Annual Reflection Assignment at the end of the 2018-2019 program year, offering further insights on the successes and challenges they have experienced this year (Appendix 4). Of the 22 Ambassadors who completed the Annual Reflection Assignment:
- 100% said they were “very satisfied (96%) or “satisfied” (4%) with their overall experience as an ACCESS Ambassador this year
- 100% strongly agreed “Participation in the ACCESS program has made me a more effective mental health advocate”
- 100% strongly agreed “ACCESS increased my knowledge of the MHSA’s general standards and community program planning requirements”
- 100% strongly agreed “ACCESS empowered me to speak up, ask questions, and share my opinions about mental health policy issues”
- 100% strongly agreed “ACCESS helped me to better represent the interests of clients/consumers in my community (not just my own)”
- 100% agreed “ACCESS clearly explained the duties and expectations of Ambassadors”
- 100% agreed “ACCESS was responsive to my requests for information and support as an Ambassador”
- 95% agreed “ACCESS made it easy for me to complete my assigned Ambassador activities”
- 95% agreed “ACCESS did a good job of explaining its positions on important mental health policy issues”
- 91% agreed “ACCESS was flexible with me if/when I was unable to complete an assigned activity”
- 91% agreed “ACCESS keeps its Ambassadors informed about important mental health policy issues”
What positive advocacy outcomes resulted from your participation as an Ambassador this year?

- I advocated for a new initiative dealing with TAY issues which brought about a number of supporters. I recruited at least 5 local & statewide stakeholders to attend the Annual Conf & at least 4 interested in becoming Ambassadors.

- I advocate[d] for more and better disability accommodations to be provided for stakeholders in Los Angeles County. We know have CART/Real Time Captions, ASL, Braille, and Spanish translators at all stakeholder involvement process. I also advocated for more services for the Latinx communities in Los Angeles County to access and develop mental health services. I was elected as the Chair for the Hispanic/Latino Under Served Cultural Community Subcommittee.

- I recruited 5 local stakeholders to participate in Meetings and activities. I started a Cultural Advocacy Group with Asian/Pacific Islander interests and backgrounds to address issues specific to this culture. One issue is that the Stigma of getting MH Treatment is extremely high. I joined a Tenants’ Union to work with Tenants on Advocacy for MH Rights and tenancy issues.

- I am part of the conversation with BHRS leadership on transforming local systems to be more inclusive and supportive of peers in the planning process at all levels.

- I used my voice to change perspectives on mental health at a governmental level. I educated people on their rights and the duties that the MHSA has to them. I have developed grant writing skills, public speaking skills, knowledge of government workings and so much more. Currently, I am working on a grant to bring mental health first aid classes to underserved cultural communities resulting in earlier detection and prevention of severe mental illness in the TAY population.

- I provided feedback regarding MHSA and in attempting to follow intent of the MHSA. I supported peer support program (respite house in Aptos California). The program was going to shut down and seems like the Mental Health Advisory Board didn't support but ended up supporting it to include MHSA funding after articles came out in news media. See email sent of articles related to this. Unable to copy and paste to this. Just sad that the MHSA Committee meetings do not meet regularly and the Administrator isn't much at the Mental Health Advisory Board (as required by the Grand Jury report and County policy regarding Advisory Boards)

- I advocated in support of suicide prevention strategies catered to children younger than middle school age at the suicide prevention subcommittee meeting, which helped bring about a discussion to include this population in the MHSOAC’s 1st Draft of their Suicide Prevention Plan.

- Through my assigned speeches with the National Alliance for Mental Illness (NAMI), I took the opportunity to share and educate the audience on my work as a mental health ambassador and the purpose of proposition 63. To my surprise, many mental health leaders and consumers had never heard of proposition 63 or how to go about navigating the mental health system. Many times I became a source of hope for the Spanish speaking community completing the 12 step NAMI program. Many had a family member that was mentally ill and not functioning. I shared my personal recovery strategies with great detail.

- Butte County now has an MHSA steering committee. Peer support is undergoing an expansion and overhaul within the county system. Peer stakeholders now feel empowered and are participating in proposing new innovations that will impact hundreds of people.

- I advocated in support of more services and meetings to be available in Spanish. As a collective LA region ambassadors wrote a letter requested "mydmh" be translated to Spanish to so that Spanish speakers could be part of the process. I was initially told flat out "no" it is too hard, but I’m glad I persisted because they
ended up translating it to 4 languages! [Another Ambassador] and I presented at a DMH SAAC 4 meeting on the power stakeholders hold, and how they could better advocate for themselves.

- Two positive outcomes I experienced were an increase in the level of my and some peers’, and stakeholders awareness, attendance, and active participation in the Fresno County Mental Health Board meeting.

- The most positive outcome […] was when I spoke after the [DHCS] policies and procedure meeting in Sacramento and receive not only a letter or an email telling me they had extended the period for extra comments

- I advocated in support of mental health self care in East Los Angeles which helped bring about djs at the park and family competitions for prizes I advocated in opposition of the Commission of health equity and their lack of outreach to the 90022 area which help bring about a discussion with the head of that commission and they called me personally to hear my suggestions. I worked with Amparo O. on developing a program on the recovery model, resulting in collaborations as a future non profit.

- Speaking to our Behavioral Health Board and Board of Supervisors about the need for increased transparency and client involvement in our MHSA planning process resulted in a meeting with our Behavioral Health Director. That, in turn, resulted in five additional slots opened up for consumers on our stakeholder leadership committee. The BH Director also committed to provide written materials in our threshold languages, hold meetings throughout our county in order to allow for increased stakeholder participation, and have meeting agendas and minutes posted on the MHSA website. I also asked our BH Director to help distribute the ACCESS annual survey designed to assess recovery-oriented services and encourage providers and clients to complete it. She agreed only if ACCESS could share results specific to our county with her. After she was assured this could be done, she emailed all behavioral health staff directing clinic and other behavioral health managers to disseminate and encourage completion of the survey. Now we have a small, but powerful team involved in my Transforming the System group. This would not have happened if I hadn't become an ACCESS Ambassador!

**What did you like best about participating as an Ambassador this year?**

- Partnering w/ other Ambassadors in other parts of the state to be able to advance initiatives in the Los Angeles County and the rest of the state of California

- I liked getting hands on training for being an advocate and new knowledge of what I can do for clients and their families.

- Meeting some of the best Advocates in the field from the LA Region. These Ambassadors display the best of LA in outreach, engagement, education, etc. I am proud to be a Regional Co-Leader for Los Angeles and would like to continue on as Co-Leader for Year 3.

- The VAST amount of knowledge I gained and the awesome people I met and worked with.

- Got needed support from all staff at ACCESS California. They all rock 😎👍 Networking with community based organizations in my community Supporting ACCESS California as an Ambassador.

- The information and trainings provided. Working as a region. Support given to prepare for advocacy meetings.

- My term as a Mental Health Ambassador with [ACCESS] was an experience of a lifetime. I was in a very low place in my life when I applied. I was having flashbacks of when I was a child sex traffic victim. I have always been very level headed about how to manage misfortunes in my life, but these new flashbacks felt
were greater than me. I felt frustrated to learn I was one of many victims. Just procession the trauma and taking medication for it was not enough justice for me. I felt [ACCESS] has given me the knowledge, the tools and outlet to channel the need to address the injustice that is still happening to other innocent children. The entire [ACCESS] team is so intelligent on how to positively shape policy where it will benefit large populations rather than one person. My encounters with other mental health workers at conferences and subcommittee meetings was heartfelt and empowering. I felt that we were all there putting our hardest efforts to help the disadvantaged. Please [ACCESS], select me for another term as an ambassador. I feel I have a lot more to do and more to learn.

- For me, the best part was having authority in my advocacy because of the training we were given through ACCESS. I felt confident in what I was speaking about and I felt prepared for going into meetings about what to do and how to do it. Because of the backing of this program, the work we had as peers was recognized and supported. I was so honored to be a part of this.
- For me having a better understanding of how mental health services work has made me feel empowered. I continue to crave knowledge and I am so thankful for the opportunity.
- Building a network of other passionate people working toward the same goal. Building community with them made me feel less stressed, and they taught me to be a better advocate and person. They gave me tools/hope for my own recovery as well.
- Solid proof that I can make improvements for consumers by speaking up. Being an ACCESS Ambassador motivated me to support, inspire, and give hope to consumers that they also have the power to improve our mental health system by speaking up. I am able to speak, and be heard, as an ACCESS Ambassador, with more power than I have speaking as Mental Health Peer Support Worker. R-E-S-P-E-C-T!!
- I appreciate the bond I feel with the other Los Angeles Ambassadors. I’m happy my husband was also chosen as an Ambassador so we can do this work together.
- The best part was the training. The knowledge has given me and others authority in our advocacy and prepared us to go into meetings knowing how to address the panels and stay informed. I also understood all the acronyms and why things were the way they were. It helped in getting the message across.

**In what ways can we improve the Ambassador experience next year? Please be specific:**

- My least favorite part was feeling disconnected from the program. I felt very much on my own sometimes. I know there were webinars and phone calls, but it is hard not seeing people face-to-face ... I also, personally, felt disappointed in not being able to connect more across the Region. I stayed focused on my own County, which needed support and advocacy, but I failed to organize with our other Ambassadors or to reach out to other Counties.
- Suggest that Ambassadors have a celebration at the end of each quarter and the Entire Group with Andrea, Tiffany, Dawniell, Noah, etc. Celebrating, maybe after the ACCESS Conference is over. Also, find ways to work more times together. We will bond better and act more cohesive as a team. Suggest that ACCESS Heads stay with the Group in the Hotel before the ACCESS Conference to show support and solidarity.
- Hire more staff, ACCESS does so much, and is a great investment/project. We need more staff because there were many times I could have been a more effective ambassador but was lacking materials/literature, and I know it is not easy when one person does 3 or more different roles. I don't want to see the staff burn out, there is enough stress out there. We spoke on how [ACCESS] asks for better pay for our peer support mentors, but practice what you preach. Peer support should just do peer support, not administrative, and
janitor, and case management. I felt like ACCESS was not walking the walk. Get the team some more hands! That will make ambassadors more efficient.

- More connections - I would like to meet face-to-face with our team across the state. We feed off of each other's ideas and enthusiasm. I would also like to have organized regional meetings and recruitment of Ambassadors in other counties, maybe with travel funds to support this. Our large region is vastly under-represented statewide. I want to change this.
2019 ACTIVITIES AND ACCOMPLISHMENTS: MENTAL HEALTH POLICY UPDATE

ACCESS’ legislative advocacy and public policy team monitors legislation and mental health policy matters that impact PMHS client and/or the overall functions of California’s PMHS. We focus on issues affecting stakeholder involvement in PMHS decision-making, recovery-oriented systems of care, recovery-based and client-driven services delivery, meaningful recovery outcomes for clients receiving services in the PMHS, and policies that support and empower peers and consumer-operated services. ACCESS offers meaningful input on proposed legislation and administrative policies to further these principles, and oppose policies and legislation that are detrimental to them.

2019 LEGISLATIVE ISSUES AND UPDATES

Peer support was a prominent subject in this year’s legislative session, most notably California’s third attempt at passing State Peer Certification (SB 10, Beall). California’s first attempt at state peer certification ended with the bill being pulled after concerns were voiced by DHCS. The second attempt resulted in a veto by Governor Brown. With this third attempt, there was hope that California will be able to create a state peer certification program, however SB 10 was vetoed by the Governor.

Additional peer bills included AB 1116 (Grayson) to create a confidential peer support and crisis referral services pilot program for firefighters and a similar bill, AB 1117 (Grayson) to create a similar peer support pilot program for peace officers. AB 803 (Gipson), would require the Department of Corrections to develop standardized policies for their existing peer support program. All three bills were signed by the Governor to become law.

Several bills intended to increase the transparency and functioning of the MHSA programs were introduced, but all were held in committee. These include AB 43 (Gloria), sponsored by Cal Voices, which would mandate the MHSA’s fiscal transparency tools, define meaningful stakeholder involvement, and require that MHSA stakeholder meetings be subject to open meeting laws. AB 1126 (O’Donnell) would have required the MHSA to do several things including: take specific measures to increase the transparency and accountability of mental health expenditures, create an innovation incubator, and create technical assistance centers to assist the Counties. Two additional bills were also introduced to require the MHSA to assist the Counties with technical assistance. SB 604 (Bates) would have required the MHSA to establish “centers of excellence” and AB 1443 (Maienschein) would have required the MHSA to create technical assistance centers to aid the Counties.

A third theme this legislative session was the attempt to broaden the definition of “gravely disabled”, partially in response to the increasing homelessness problem in California. Several bills were introduced, including SB 640 (Moorlach) and AB 1572 (Chen), to broaden the definition of gravely disabled, in an attempt to allow for the involuntary commitment of greater numbers of people. Facing opposition from civil rights groups and community groups, both of these bills were held in their first house.

Another bill was introduced to increase conservatorships for people living with a substance use disorder. SB 590 (Stone) would add chronic alcoholism to the definition of “gravely disabled”, thus allowing for the possible
involuntary commitment of a person without a diagnosed mental health condition who lives with alcoholism and who is deemed unable to care for him or herself. AB 1275 (Santiago) took a different approach to the homeless issue, proposing a pilot program where participating Counties create outreach teams to provide services to people experiencing homelessness or at risk of homelessness. Both of these bills were held in committee.

Other notable bills this session included AB 512 (Ting) which would have required each Medi-Cal mental health plan to develop a cultural competency assessment plan and AB 1352 (Waldron) which would clarify the role of Mental Health Boards and Commissions. While AB 1352 was signed into law, AB 512 was vetoed by the Governor. In the area of criminal justice, SB 389 (Hertzberg), which was signed by the Governor, will allow MHSA funds to be spent on services for parolees. SB 665 (Umberg) would create a pilot project to allow MHSA innovation funds to be spent inside jails to provide services to incarcerated people. SB 665 became a 2-year bill, and will continue to be heard next year.

2019 REGULATORY ISSUES AND UPDATES

In response to the California State Auditor’s Report 2017-117, which recommended that DHCS develop, through regulations, a fiscal reversion process and a County prudent reserve level; and SB 192 (Beall), which capped the prudent reserve level at 33% of the average CSS revenue received by the County in the preceding five years, DHCS released draft fiscal regulations (DHCS 16-009), outlining a fiscal reversion process and prudent reserve guidelines for Counties.

Under WIC § 5898, DHCS is required to develop MHSA regulations “with the maximum feasible opportunity for public participation and comments”. According to DHCS’ Statement of Reasons for these fiscal regulations, no public stakeholder meetings were held during the development of these regulations. The initial MHSA Fiscal Regulations proposed by DHCS not only included a maximum prudent reserve level for Counties, but also added a minimum prudent reserve requirement of 23% of the average amount the County allocated to its CSS Account over the previous five fiscal years. The proposed regulations also would change the plain language of the MHSA to limit the amount of money Counties can spend on PEI to 19% of their annual distribution. The MHSA, as currently written, states that 20% of a County’s annual MHSA distribution shall be used for PEI and that this amount can be increased at the County’s discretion.

While the proposed DHCS MHSA fiscal regulations specified distinct percentages that Counties must allocate to INN, PEI and CSS, those proposed regulations are silent on the fourth area of required MHSA spending, Community Program Planning. Under the MHSA, Counties are required to spend MHSA money on community planning processes to a maximum of 5% of their annual allocations.

After a public hearing, and input from stakeholders, those regulations have not yet moved on to the Office of Administrative Law for final approval.

OTHER MENTAL HEALTH POLICY ISSUES IN 2019

CLIENT DATA PRIVACY AND DIGITAL PHENOTYPING

California tech companies are developing apps that use algorithms to track and measure clients’ mental states based on device use and behaviors, also known as digital phenotyping. The data collected from clients’
smartphones, web-connected devices, and wearable technology with apps such as 7 Cups of Tea and Mindstrong, is used for mental health screening and monitoring. The collected anonymous data also becomes private corporate property and could be resold for profit for targeted advertising, among other things. Counties are approving these apps and programs, often without stakeholder involvement, as the multi-County “Tech Suite” Innovation program to utilize Mental Health Services Act money. ACCESS published a paper in September 2018 to explain the risks associated with these programs, and the questions that client stakeholders should be asking their Counties prior to implementing them.

**PEER CERTIFICATION**

Peer support, recognized as an evidence-based model of care by the Centers for Medicare and Medicaid Services since 2007 is a cost-effective practice that is proven to reduce hospitalization, increase service experience, and encourage hope, empowerment, and personal advocacy in clients receiving services. Peer support specialists are self-identified consumers who use their lived experience along with skills learned in formal training to assist others in their own recovery from mental illness.

Empowering peer support specialists with a statewide certification process will encourage more consumers to become trained service providers with credentials that earn them livable wages. This will also reduce the 90% unemployment rate among California mental health consumers. Peer support specialists provide a vital role in clients’ recovery from mental health challenges.

Current legislation to establish peer certification in California, SB 10 (Beall), would have created a standardized curriculum and core competencies for those providing peer support services. While several California Counties currently bill for peer support services under the rehabilitation option or as “other qualified provider”, SB 10 would have required unique Medi-Cal billing codes to be created specifically for peer support services. SB 10 was California’s third attempt at creating peer support specialist certification. In 2016, SB 614 (Leno) was pulled by sponsors after DHCS publicly stated its refusal to create unique billing codes for peer services. In 2018, Governor Brown vetoed California’s second attempt, SB 906 (Beall and Anderson), citing high costs in instituting and sustaining a program to oversee certification in the Department of Health Care Services.

Ultimately, SB 10 was vetoed by California’s Governor on October 13, 2019. Governor Newsom’s veto message stated: “As the administration, in partnership with the Legislature and counties, works to transform the state’s behavioral health care delivery system, we have an opportunity to more comprehensively include peer support services in these transformation plans.” ACCESS will continue to monitor pending changes to existing PMHS legislation and will analyze potential impacts on PMHS clients in the coming year.

**HOMELESSNESS**

California’s homeless population had been decreasing for seven consecutive years to reach a low of 113,952 people in 2014. However, in the last four years, California has experienced a 14% increase statewide, and according to the 2018 point in time count, there were 129,972 Californians experiencing homelessness. California’s unsheltered population is comprised of 66% unsheltered, chronically homeless individuals, unlike the next most populous state, New York, which has 95% of their homeless population sheltered as a result of their right to Shelter Policy.
California’s homeless increase is correlated to rising cost of rent and overall unaffordable housing paired with stagnant wages. In Los Angeles, less than 1% of rental units’ average monthly cost is under $1,000. A rent payment of $1,000 a month constitutes more than 50% of the discretionary income of someone earning $12.00 per hour (CA 2019 minimum wage) working 40 hours a week. Housing markets have shifted toward targeting double-income families, rather than single and low-income individuals and families since the 1960’s.

Approximately 27% of California’s homeless individuals live with Serious Mental Illness (SMI), compared to California’s statewide average of about 5% of the population who live with SMI. It is more likely that chronic stress of poverty or an unsheltered lifestyle and the experience of homelessness exacerbate SMI and Substance Use Disorder (SUD), rather than SMI/SUD being the cause of homelessness.

In 2018, SAMHSA reported an employment rate of just 9.8% for all adult PMHS clients in California. The national rate of employment for consumers receiving public mental health services is 22%. Unemployment leaves many impoverished behavioral health clients in their community without sufficient behavioral health services and consequently they are at risk of further encounters with the criminal justice system. Between 2000-2018, statewide arrests for “vagrancy” offenses increased by 77%, even as arrests for “drunkenness” and “disorderly conduct” decreased by 16% and 48%, respectively, suggesting that police may be arresting people experiencing homelessness for their status, not their behavior.

Veterans also represent a relatively large percentage of the homeless population. In 2018, 10,836 homeless veterans resided in California. Nearly 30% of all US veterans who are homeless are in California. Veterans are more likely than civilians to experience homelessness due to combat-related injury or illness, such as Post Traumatic Stress Disorder, Traumatic Brain Injury, or a sexual trauma while serving. The impact of service related trauma has physical, mental, and social effects that can leave veterans unable to rehabilitate to civilian life and can lead to homelessness at higher rates.

GOVERNOR NEWSOM’S HOMELESS AND MENTAL HEALTH EFFORTS

Governor Newsom stated during his campaign that he intended to make mental health care a priority, with early intervention the focus, and “to prevent mental health before we punish mental health”. Shortly after becoming Governor, Newsom created a Supportive Housing Advisory Task Force and appointed a statewide Mental Health Czar. Newsom’s 2019-2020 final budget includes $2.5 billion to address California’s housing and homelessness crisis.

The Supportive Housing Advisory Task Force, led by Sacramento Mayor Darrell Steinberg and Los Angeles County Supervisor Mark Ridley-Thomas was created in May, 2019 to address California’s Homelessness crisis. Darrell Steinberg has proposed a “right to shelter” policy in California which could, if enacted, force people into shelters. He is modeling this idea after New York’s “right to shelter” policy which requires the state of New York to provide adequate shelter for all citizens, but does not mandate that people are sheltered.

California Governor Gavin Newsom appointed Tom Insel, MD to be the Governor’s Mental Health Czar. This role makes Insel the Governor’s principal adviser on mental health, to assist with the reorganization of the state’s mental health delivery system. Insel was the director of the National Institutes of Mental Health from 2002-2015. In 2015, he began working at the Life Science division of Google X (now called Verily Life Sciences). After leaving Verily in 2017, he started his own company named Mindstrong. Mindstrong’s primary product is a digital phenotyping phone application which monitors cell phone usage through a special keyboard with the goal of
detecting patterns, based on factors such as typing speed, or increased/decreased cell phone usage which may indicate mental health concerns. Since 2017, Mindstrong has been awarded multimillion-dollar contracts through CalMHSA to pilot their application in thirteen California Counties and cities.

**PROPOSITION 2: NO PLACE LIKE HOME ACT OF 2018**

The No Place Like Home (NPLH) Act, passed by California voter initiative in 2018 with 63.4% of the statewide vote, dedicates $2 billion in bond proceeds to acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who need mental health services and are experiencing homelessness, chronic homelessness, or are at-risk of chronic homelessness. A portion of MHSA money is also used for the program. Housing created under the program must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services. Counties must also commit to providing mental health services and linkage to other community-based supportive services.

The program includes $190 million in noncompetitive allocation, which is distributed to Counties based on their homeless populations, with a minimum allocation of $500,000 per County. The program also includes a competitive allocation, with up to $1.8 billion available for multiple funding rounds. Under this allocation, Counties compete for funding with Counties of similar size.

In the first funding round NPLH awarded $179,206,725 to 37 projects throughout the state. These projects are primarily new construction with only six acquisition/rehabilitation projects awarded. In total 805 units will be dedicated as NPLH units with the project units totaling 2,153. Three to four more NPLH rounds will take place, with the second round expected to be announced in Fall of 2019.

**CRIMINAL JUSTICE REFORM**

California’s Jail and Prison system has become the largest de-facto mental health service provider for low- or no-income individuals over the last 15 years. The Prison Policy Initiative reported in 2015 that the average income of an individual prior to incarceration was $10,000-$20,000 less than non-incarcerated people nationwide, and still less than minimum wage. Further analysis reveals that in California an income and wealth gap generations-long between white and minority communities persists in 2019. Similar to homelessness, the chronic stress of poverty and other Social Determinants of Health lead to over-representation of impoverished individuals of minority demographic groups in SMI/SUD diagnoses and who are involved with the criminal justice system.

In an analysis produced by the United States Bureau of Justice Statistics, more than one in four (26%) jail inmates and one in seven (14%) prison inmates met the threshold for experiencing psychological distress in the last 30 days. This same study found that 37% of prisoners and 44% of jail inmates had been told in the past by a mental health professional that they had a mental disorder. For individuals in jail, three in four have a diagnosis of both a substance use disorder and a mental illness.

In comparison, the national average of individuals living with a mental illness in the United States is 18%. California’s Department of Corrections and Rehabilitation spends nearly 27% of its $12.7 billion budget on physical, dental, and mental health care on incarcerated adults because many are living with co-morbid SMI and SUD diagnoses that result in other chronic health conditions. California’s average cost per inmate is approximately $81,458 and can double or even triple in expense if an inmate has co-morbid SMI and SUD. Many impoverished and/or homeless individuals are picked up because of pan-handling, public health concerns,
and their need for treatment. Many of them receive treatment in jail and prison facilities that can further increase traumatic experiences in detention.

California legislators have heard of the increased needs for behavioral health services in jails and prisons and responded with legislative initiatives to meet the population’s needs. Senate Bill 389 (Hertzberg), which was signed by the Governor, will amend the MHSA to authorize Counties to use MHSA moneys to provide services to persons who are participating in a presentencing or post-sentencing diversion program, or who are on parole, probation, post-release community supervision, or mandatory supervision. Senate Bill 665 (Umberg) would create a pilot project to allow MHSA innovation funds to be spent inside jails to provide services to incarcerated people. Senate Bill 665 became a two-year bill, and will continue to be heard next year.
.Id.

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http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB389

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http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB389
ACCESS takes a unique approach to the completion of its annual State of the Community Report. Since we intend for our program to be truly collaborative, we look for ways to place the common interests of client stakeholders first and foremost. We do not presume to know with any degree of certainly what is happening in each County or local community throughout the state, nor do we assume what stakeholders currently want from their PMHS. California is a collective of diverse communities, all with different priorities and needs. Rather than merely advancing the priorities the ACCESS program thinks are important, we will first assess the status of public mental health services throughout the state. Upon analyzing the information collected, ACCESS uses this data to identify local and statewide trends, determine the geographic Regions most in need of trainings and supports, and develop a comprehensive summary, talking points, and action plan based on the data we have gathered.

This program year, ACCESS focused its research and data collection activities on analyzing and measuring the following factors in California’s PMHS:

- The extent to which clients, community stakeholders, and PMHS leadership understand and have effectively operationalized the MHSA’s mandates for community collaboration, recovery-oriented adult systems of care, and recovery-based client-driven services;
- The extent of client participation in the planning, development, and oversight of local mental health services;
- The quality and appropriateness of local mental health services and the ease of accessing them;
- Whether Counties are providing recovery-oriented mental health services and the level to which they have integrated evidence-based recovery practices within their adult systems of care; and
- The barriers that hinder Counties’ ability to implement recovery-oriented systems of care, provide recovery-based and client-driven services, and capture and utilize meaningful recovery outcomes data for MHSA-funded programs.

In seeking this information, we not only engage with clients and community stakeholders, we also invite public mental health agencies and providers to participate in our research and data collection efforts, which helps us determine the extent to which each group’s perceptions diverge and gather important insights from the various entities that comprise the PMHS. It is imperative that we not only gather information from the target population (current and former PMHS clients), but also from the government entities and organizations which provide and oversee the quantity and quality of services available, influencing clients’ recovery experiences and outcomes. These agencies have unmet needs of their own that significantly impact client care. Therefore, ACCESS works with providers, local mental health agencies, and statewide oversight bodies to identify these needs and better understand how they impact various aspects of services delivery within the PMHS. Only after understanding the fuller picture, can ACCESS effectively advocate for realistic changes both consumers and Counties are likely to embrace.

Due to ACCESS’ extensive research and the high volumes of data and historical documentation uncovered during the writing of this year’s Report, ACCESS will be releasing an addendum (Volume II) to this Report sometime before January 2020.
Upon its passage in November 2004, California’s former Department of Mental Health (DMH) declared the MHSA “a unique opportunity to transform the California community mental health system.”\(^5^4\) In implementing and overseeing the newly-passed MHSA, the DMH pledged to work toward significant changes in the existing PMHS in the following areas:

- Consumer and Family Participation and Involvement
- Programs and Services
- Age-Specific Needs
- Community Partnerships
- Cultural Competence
- Outcomes and Accountability
- Taking a Comprehensive Viewpoint\(^5^5\)

Several key provisions in the MHSA’s statutes and regulations impose requirements on Counties to create recovery-oriented adult systems of care, deliver recovery-based and client-driven adult mental health services, and to collect and analyze meaningful recovery outcomes in MHSA-funded programs. To wit:

The MHSA imposes the following mandates for all County mental health services provided in the adult and older adult systems of care (and particularly those services funded as a part of the MHSA’s Community Services and Supports (CSS) component):

**Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for Mental health consumers:**

1. To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
2. To promote consumer operated services as a way to support recovery.
3. To reflect the cultural, ethnic, and racial diversity of mental health Consumers.
4. To plan for each consumer’s individual needs.\(^5^6\)

The MHSA’s General Standards, which are codified in the California Code of Regulations state:

**The County shall adopt the following standards in planning, implementing, and evaluating the programs and/or services provided with Mental Health Services Act (MHSA) funds.** The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery.

1. Community Collaboration, as defined in Section 3200.060.
2. Cultural Competence, as defined in Section 3200.100.
3. **Client Driven**, as defined in Section 3200.050.
4. Family Driven, as defined in Section 3200.120.
Wellness, Recovery, and Resilience Focused.

(6) Integrated Service Experiences for clients and their families, as defined in Section 3200.190.\textsuperscript{57}

To ensure Counties would sufficiently enact the MHSA’s vision for total system transformation, the former DMH required counties to embed and continually address these General Standards throughout Counties’ entire MHSA Program and Expenditure Plans.\textsuperscript{58}

The California Code of Regulations defines “Client Driven,” the MHSA’s third General Standard, as follows:

“Client Driven” means that the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.\textsuperscript{59}

The DMH further explained the MHSA’s mandate that planning, implementation, evaluation, and delivery of MHSA-funded programs and services be “Client Driven”:

Adult clients identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client-centered; with providers working in full partnership with the clients they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

Many adults with serious mental illness have limited influence over the services they [...] receive. Increasing opportunities for clients to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality.\textsuperscript{60}

WHAT IS RECOVERY?

MHSA DEFINITION

Beyond the recovery-related mandates listed in the sections of the Welfare and Institutions Code and California Code of Regulations cited above, the MHSA statutes and regulations do not define the concept of “Recovery,” nor do they elaborate on the meaning of the “Recovery Vision” cited in WIC § 5813.5(d). However, upon the MHSA’s passage, the DMH offered this definition to Counties for the purposes of MHSA program planning:

Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.\textsuperscript{61}
**OTHER DEFINITIONS**

According to Boston University’s Center for Psychiatric Rehabilitation, “[w]hile there is no consensus on the definition of recovery, people describe it as a process of empowering individuals with hope and self-esteem to find new meaning and purpose in their lives.”

Unlike the Medical Model, which is disease-focused and looks at recovery in terms of reduced symptomology and ongoing illness management, “[the] Recovery [Model] does not imply curing the mental illness, but learning to work within and beyond the limits of the disability so that individuals’ personal rights of friendships, homes, families, satisfying jobs, access to education, and decent pay can become realities.”

In 2012, SAMHSA published its Working Definition of Recovery, which defines the concept as:

> A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**WHAT ARE RECOVERY-ORIENTED SYSTEMS OF CARE?**

In California, the MHSA mandates adoption of a recovery-oriented system of care. Evidence reveals that peer support programs have positive impacts on people in their recovery while also providing valuable advocacy support to the public mental health service system. ACCESS California has a unique opportunity to move the ball forward in the recovery movement by elevating diverse, client advocacy efforts towards the establishment of consistent recovery outcome measures throughout California’s public mental health system. Ensuring California’s public mental health system establishes a comprehensive recovery orientation is essential to achieving positive outcomes associated with an individual’s recovery and improved quality of life.

The MHSA was intended to transform the entire PMHS. In 2005, Darrell Steinberg and Rusty Selix, two of the MHSA’s co-authors, released a joint statement describing the Act thusly: “The first and foremost thing that everyone needs to recognize is that [the MHSA] is not increased funding for the old mental health system that we have known for the past decades. Instead, it is a complete transformation to a new system.”

In light of the MHSA’s explicit endorsement of the “Recovery Vision” for adult mental health services at WIC § 5813.5(d) and the Act’s six General Standards enumerated at 9 CCR § 3320(a), this new system is presumably one that is recovery-oriented. So what does a recovery-oriented system look like?

If we think about a “system” as a type of culture, then recovery-based system transformation really refers to a cultural shift within the PMHS from one that predominantly adheres to Medical Model traditions, values, thinking, and practices to one that embraces recovery as the ultimate goal of all public mental health services.

In 2005, immediately after the MHSA’s passage, Dr. Mark Ragins, a pioneer in the field of recovery medicine and a co-founder of MHA-LA’s highly successful Village program (upon which the MHSA’s adult CSS component is based) said this about the recovery-based system transformation required under the MHSA:
Unless we truly incorporate the Recovery Vision in our programs we will not succeed. The most successful innovative programs have created a new culture: a recovery culture. The traditional treatment culture may have been successful in the asylums and university hospitals where it was developed, but it is ill suited to our present needs. The major goals of this act – reaching out to underserved populations, employment, inclusion of consumers and their families, social responsibility and outcomes, integration of treatment and support services, reduction in stigma – cannot be addressed effectively within the traditional treatment culture, but they can be achieved within a recovery culture. **In other words, the Recovery Vision is the tool that can finally make the dream of deinstitutionalization a proud reality.**

How prescient he was! Throughout history, the public has looked to the medical community to cure us from a multitude of ills, with patients telling doctors their problems as they assessed, examined, ordered tests, sought diagnoses and forecast long-term prognoses and outcomes. Rarely did this culture incorporate the perspectives of its patients or accept differing points of view. This is particularly the case with mental health disorders. Yet, despite decades of medical approaches to mental illness, we find that persistent mental health disorders continue to cause millions disabling symptoms limiting our ability to regain our prior employment, relationships and social role in society.

Dr. Ragins further noted in 2005,

**There is a lot of talk about transforming our mental health system into a consumer-driven, recovery-based system, but very little talk about transforming staff to work successfully in this new system.** Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. **Transforming existing programs with existing staff requires a proactively guided process of staff transformation to succeed.**

He went on to identify 12 specific aspects of system transformation that must occur before the MHSA’s vision and potential could be fully realized:

1. **Looking Inward and Rebuilding the Passion:** Recovery work requires staff to use all of themselves in passionate ways to help people. It can’t be done effectively in a detached, routine way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, as staff, we need to remember why our hearts brought us to this field in the first place. ... Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must treat its staff well before further transformation can occur.

2. **Building Inspiration and Belief in Recovery:** Staff spend the vast majority of our time and emotions on people who are doing poorly or are in crisis. We neglect success stories of those we help and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and known in darker times. We need to be familiar with the extensive research that documents recovery and the concept of the “clinicians’ illusion” that gets in the way of us believing in this research.

3. **Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives:** Recovery staff treat “people like people,” not like cases of different illnesses. To achieve this, we need to fight the numerous ways in which the pervasive culture of medicalization is reflected in the infrastructure. Goal setting
needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected.
Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness
with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical
goals.

4. **Moving from Caretaking to Empowering and Sharing Power and Control:** Staff have generally
adopted a caretaking role toward people with a mental illness. We act protectively, make decisions for them
because of their impairments, even force them to do what we think is best for them at times. Recovery
practice rejects those roles, although many staff and consumers are comfortable with them. Analogous to
how parents must stop being caretakers for our children to become successful adults, staff must stop being
caretakers for the people we work with to recover.

5. **Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles:** Recovery requires breaking down the
“us vs. them” walls. People with mental illnesses must be included as collaborators, co-workers, and even
trainers. To work alongside them as peers (not as segregated, second-rate staff) is probably the single most
powerful stigma reducing and transforming experience for staff. For people with mental illnesses to recover
and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment
roles.

6. **Valuing the Subjective Experience:** Staff have been taught to observe, collect, and record objective
information about people to make reliable diagnoses and rational treatment plans. Recovery plans are
collaborative. To achieve a partnership, staff must appreciate not just what’s wrong with a person, but how
that person understands and experiences what’s happening. Knowing what it would be like to be that person,
what they’re frightened of, what motivates them, what their hopes and dreams are, are all part of a subjective
assessment.

7. **Creating Therapeutic Relationships:** Recovery work emphasizes therapeutic work more than symptom
relief. Our present system relies on illness diagnosis, treatment planning, prescription, and compliance. Staff
can be interchangeable, professionally distant, even strangers, as long as the diagnosis, plan and compliance
are preserved. Recovery work relies on the same foundations as psychotherapy: (1) an ongoing, trusting,
collaborative, working relationship, (2) a shared, explanatory story of how the person got to this point, and
(3) a shared plan of how to achieve the person’s goals together.

8. **Lowering Emotional Walls and Becoming a Guiding Partner:** People repeatedly tell us that we are
the most helpful when we are personally involved, genuinely caring, and “real.” Psychotherapeutic and
medical practice traditions, ethical guidelines, risk management rules, and personal reluctance are barriers
to lowering emotional walls. Staff needs lots of discussion and administrative support to change because of
these strong contrary forces. To best support people on their path of recovery, staff need to act not as
detached experts giving them maps and directions, but as guides, becoming involved and walking alongside
them, sharing the trip.

9. **Understanding the Process of Recovery:** Staff are familiar with monitoring progress as a medical
process. We follow how well illnesses are diagnosed and treated, symptoms are relieved, and function is
regained. We alter our interventions and plans based on our assessment of this process. Recovery work
monitors a different process – the process of recovery. Analogous to the grief process found in hospices,
this process can be described by four stages: (1) hope – believing something better is possible, (2)
empowerment – believing in ourselves, (3) self-responsibility – taking actions to recover, and (4) attaining
meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help
people live with dignity.
10. **Becoming Involved in the Community:** Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, and to find their niches. Recovery cannot be achieved while people are segregated from their communities. To support this, staff must work in the community. This is a substantial change for most staff and may trigger personal insecurities.

11. **Reaching Out to the Rejected:** Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well in the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, “non-compliant” people, people with severe socio-economic problems, and people lacking “insight.” All of these people have different serious obstacles to engagement and treatment. Because staff may bring our own prejudices against them, a “counter-culture of acceptance” needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. System transformation will not be considered a success if we continue to reject these people in need.

12. **Living Recovery Values:** “Do as I say, not as I do” is never a good practice. When the walls and barriers are reduced and emotional relationships are enhanced in a good recovery program, it’s even harder for staff to hide. We must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.

One thing is certain: leadership buy-in is essential to fostering a system of care that is recovery-oriented. Therefore, engaging system advocates, providing training, education and outreach opportunities for meaningful involvement can assist in moving the system forward towards a recovery orientation. System change occurs by engaging diverse stakeholders, as well as leadership impacted most by transformative efforts. A truly recovery-oriented system of care involves a framework whereby services and supports are coordinated and delivered in a person centered and community defined atmosphere. Such a system includes services that include both prevention and treatment, peer support and community defined services, and allow for flexibility to meet a person’s needs.

**WHAT ARE RECOVERY-BASED AND CLIENT-DRIVEN SERVICES?**

Despite sound evidence challenging the traditional medical model of care for individuals with mental health disorders, it has taken decades for sincere belief in recovery to gain credibility in the medical community and California’s PMHS. The movement sprung from a grassroots community of individuals who experienced recovery from a mental health condition themselves and began using their agency to help transform a broken system. In fact, the roots of the Recovery Movement occurred as a result of clients, patients, survivors becoming involved in their own treatment process, through self-advocacy and in turn discovering the power that peer support made in their lives. These victories in people’s lives all had something in common in that they were directed by the clients themselves. In short, the quintessential thread through all first-person narrative accounts of recovery is that services must be client directed in order to be recovery-oriented.

On the most basic level, recovery-based services are those that place the client’s individual needs and preferences at the forefront of each and every treatment plan, not just in the array of programs offered, but in the ways in which these services are actually delivered.
WHAT DO PEOPLE NEED TO RECOVER?

SAMHSA’s Working Definition of Recovery identified four major dimensions that support a life in recovery:

1. **Health**: Overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

2. **Home**: A stable and safe place to live.

3. **Purpose**: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

4. **Community**: Relationships and social networks that provide support, friendship, love, and hope.

The Working Definition also included ten guiding principles of recovery:

1. **Recovery emerges from hope**. The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

2. **Recovery is person-driven**. Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

3. **Recovery occurs via many pathways**. Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families.

4. **Recovery is holistic**. Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

5. **Recovery is supported by peers and allies**. Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths.
6. **Recovery is supported through relationships and social networks.** An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

7. **Recovery is culturally-based and influenced.** Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.

8. **Recovery is supported by addressing trauma.** The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

9. **Recovery involves individual, family, and community strengths and responsibility.** Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

10. **Recovery is based on respect.** Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important.

To be truly recovery-oriented and client-driven, mental health services must move well past the Medical Model’s focus on illness management by incorporating all of these aspects into the culture of their systems, their services practices and delivery models, and outcomes tracking and measurement activities.

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54 http://web.archive.org/web/20060518021631/http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-01.pdf (p. 1)
56 WIC § 5813.5(d) (emphasis added)
57 9 CCR § 3320 (emphasis added)
58 https://web.archive.org/web/20100528131402/http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-05CSS.pdf (p. 4)
59 9 CCR § 3200.050 (emphasis added)
60 https://web.archive.org/web/20100528131402/http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-05CSS.pdf (p. 5)
61 https://web.archive.org/web/20100528131402/http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-05CSS.pdf (pp. 5-6, emphasis added)
62 https://cpr.bu.edu/resources/newsletter/recovery-center
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64 https://store.samhsa.gov/system/files/pep12-recdef.pdf
66 https://web.archive.org/web/20060521134819/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 10)
67 https://web.archive.org/web/20060521134819/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 22)
68 Id. (pp. 23-24)
70 https://store.samhsa.gov/system/files/pep12-recdef.pdf
To gather the information needed to thoroughly analyze the various issues relevant to this Report, ACCESS executed a multi-pronged strategy to engage target groups and encourage them to participate in our research and data collection efforts. This strategy included the development of three surveys that we disseminated both digitally and physically, each of which were designed to capture different data points:

- Annual Stakeholder Inclusion and Feedback Survey
- Annual Client and Leadership Survey
- Annual Participation Barriers Survey

The purposes of each survey are discussed in greater detail in the following subsection of this Report, along with an in-depth analysis of each survey’s results.

**ENGAGEMENT STRATEGIES**

To engage stakeholders, generate interest in our research efforts, and encourage individuals to complete our data collection tools, ACCESS:

- Held statewide informational webinars upon the release of our Annual Stakeholder Inclusion and Feedback Survey and Annual Client and Leadership Survey, explaining the purpose of these data collection tools, answering any questions participants had about these surveys, and encouraging individuals to respond;
- Provided on-call support and technical assistance to help individuals complete our data collection tools;
- Provided in-person support to individuals completing our Annual Client and Leadership Survey at community outreach events, ACCESS-sponsored trainings and workshops, and Regional Leadership Roundtables and Stakeholder Focus Groups;
- Relyed on our Regional ACCESS Ambassadors to help generate local interest in and responses to our data collection tools; and
- Raffled off multiple $20 gift cards to randomly selected survey participants to encourage greater participation.

**DISSEMINATION STRATEGIES**

Our surveys were electronically disseminated using the following methods:

- Email blasts to ACCESS’ existing statewide contacts database, which includes:
  - Clients/consumers
  - Peer support workers and volunteers
  - Members of local mental health boards and MHSA steering committees in all 59 local mental health agencies
  - County mental health leadership and staff in all 59 local mental health agencies
  - Statewide mental health agency leadership and staff
  - Mental health providers and community-based organizations
• County-designated client/consumer liaisons
• Employees of peer-run agencies and programs
• Stakeholder/community advocates

- Posts linking to the survey on both Cal Voices’ agency website and the ACCESS program’s website
- Social media posts on Twitter and Facebook

Furthermore, ACCESS physically disseminated our surveys at:
- One annual ACCESS Ambassador Boot Camp
- Six Regional Stakeholder Focus Groups
- Seven Regional Leadership Roundtables
- Six Regional Community Empowerment Workshops
- Nine Regional Leadership Trainings
- Ten Regional community outreach events

**RESEARCH STRATEGIES**

In addition to the creation and dissemination of various data collection tools, ACCESS conducted extensive research to better understand the landscape of the PMHS and context in which the MHSA’s recovery-related mandated were developed. Such research reviewed the following subject matters:

- The origins of the Recovery Model of mental health care, including the origins of the modern consumer-led Recovery Movement
- The efficacy of and scientific support behind the Recovery Model of care
- Models and methods for the creation of recovery-oriented systems of care
- Best practices for recovery-based and client-driven services delivery
- Evidence-based tools for the collection and measurement of meaningful recovery outcomes
- The political, social, and public policy origins of the MHSA, including the laws and programs that paved the way for Prop 63’s passage in 2004
- The MHSA’s transformative vision for the PMHS, and the meanings of and intentions behind its recovery-related mandates when viewed in the MHSA’s historical context
- How the MHSA was originally interpreted and implemented from 2005 - 2009
- The MHSA’s administrative and oversight structure, including enforcement mechanisms and remedies for noncompliance
- The reasons California’s PMHS has not fulfilled the MHSA’s recovery-related mandates, including key legal, economic, and political factors arising between 2005 and present day that have significantly hindered realization of the MHSA’s transformative intent
- The MHSA’s inherent structural vulnerabilities illuminated by the confluence of factors that have contributed to its weakened state
- Consequences of leaving the MHSA’s transformative vision and recovery-related mandates unfulfilled
- Feasible social, political, administrative, and legislative solutions to resolve the existing barriers to the MHSA’s full implementation
ACCESS lacked capacity to completely address these matters within the confines of this Report. As such, we briefly touch upon some of these factors in the next subsection, and have reserved our full analysis for Volume II of this Report, which we will release by early 2020.

**ANALYSIS STRATEGIES**

At the close of the data collection period, ACCESS staff met internally to analyze survey responses and other relevant data collected throughout the program year. We also discussed the success of our data collection methods and strategies to determine improvements to make in the following program year. ACCESS summarized the completed survey responses (included with this Report), identified trends and common themes, and compared information reported to the publicly available data, wherever possible. ACCESS conducted additional research, as needed, on subjects raised in participants’ survey responses to gain a comprehensive understanding of the issues mentioned. Additionally, the ACCESS team worked together to identify recommendations, strategies, and potential solutions to resolve the issues and trends brought to light through our data collection and research efforts.

To honor transparency and support the credibility of the data and analysis contained in this Report, ACCESS has provided links to the aggregated survey responses (with all identifying information redacted) for each of the data collection tools we have relied upon. See the list of Appendices included at the end of this Report.
RECOVERY IN CALIFORNIA’S PMHS: A REVIEW OF THE DATA

ANNUAL STAKEHOLDER INCLUSION AND FEEDBACK SURVEY

As a follow up to ACCESS’ annual theme for the 2017-2018 program year (Meaningful Stakeholder Involvement in the PMHS), we disseminated an Annual Stakeholder Inclusion and Feedback Survey at the beginning of this program year to measure respondents’ general knowledge of the MHSA’s Community Collaboration and Community Program Planning (CPP) process requirements, and to gauge levels of community inclusion in local- and state-level MHSA policy discussions, program planning, and oversight.

In theory, the more stakeholders and PMHS leadership truly understand and implement the MHSA’s fundamental stakeholder inclusion requirements, the more likely local mental health agencies and the statewide PMHS are to develop recovery-oriented systems of care, provide mental health services that are client-driven and recovery-focused, and utilize meaningful recovery outcomes data to make evidence-based programming and funding decisions that align with the MHSA’s core principles, goals, and values.

The Annual Stakeholder Inclusion and Feedback Survey contained three components:

1. A section for clients, community stakeholders, and PMHS leadership to gauge respondents' knowledge and understanding of the MHSA's CPP process and stakeholder inclusion requirements. (a 15-question quiz)
2. A section just for local PMHS leadership to identify CPP practices implemented in California Counties. (8 questions)
3. A section for local and statewide PMHS leadership to identify various stakeholder inclusion practices implemented throughout California. (5 questions)

ACCESS disseminated the Annual Stakeholder Inclusion and Feedback Survey between November 30, 2018 – December 31, 2018, and gathered 271 responses. A link to the aggregated responses (with all identifying information redacted) for this survey is included in the list of Appendices at the end of this Report. (See Appendix 1.) The results of this survey are discussed below.

KEY FINDINGS: ANNUAL STAKEHOLDER INCLUSION AND FEEDBACK SURVEY

Survey respondents represented a wide variety of PMHS stakeholder groups:

- 65% identified as an adult client or consumer
- 3% identified as a transition age youth (TAY)
  - 67% of those identifying as a client/consumer or TAY have received services in the PMHS
- 46% identified as a family member of an adult client/consumer
- 20% identified as a parent/caregiver
- 49% have worked in the PMHS
- 29% have served on a state or local PMHS policy-making/oversight body
The Annual Stakeholder Inclusion and Feedback Survey quizzed respondents on their knowledge of the MHSA’s stakeholder inclusion and CPP process mandates, revealing:

- 75% of respondents were unaware Counties’ Annual Updates to their MHSA Three-Year Program and Expenditure Plans must go through the same CPP process as the Three-Year Plans themselves.
- 59% of respondents did not know County MHSA funds cannot be used to pay for programs and services that were not developed through a County’s CPP process.
- 58% of respondents did not know County MHSA funds cannot be used to pay for programs and services that were not included in a County’s MHSA Three-Year Program and Expenditure Plan or Annual Update.
- 56% of respondents were unaware of the MHSA requires Counties to spend up to 5% of their total annual MHSA revenues on annual planning costs (the CPP process).
- 54% of respondents did not correctly identify the MHSA’s definition of “Family-Driven” (one of the MHSA’s six General Standards).
- 47% of respondents did not know the MHSA requires Counties to provide trainings to stakeholders, clients, and family members who are participating in the CPP process.
- 28% did not know the MHSA requires Counties to utilize peer support services in some MHSA-funded programs.
- 27% of respondents were unaware the MHSA requires Counties to provide trainings to their own staff who are responsible for establishing and sustaining their local CPP processes.
- 21% of respondents did not correctly identify the MHSA’s definition of “Client Driven” (another of the MHSA’s six General Standards).
- 21% of respondents did not know the MHSA requires Counties to develop their MHSA Three-Year Program and Expenditure Plans in collaboration with mental health clients and other community stakeholders through a local CPP Process.

The Survey also asked respondents to share information about community inclusion and MHSA planning practices within their own local mental health systems:

- Just 53% of respondents reported their County convenes a local CPP process before developing an initial draft of its MHSA Three-Year Program and Expenditure Plan.
- Just 44% of respondents reported all of the programs and services included in their County’s MHSA Three-Year Program and Expenditure Plan and Annual Update are developed and/or approved through their local CPP process.
- Just 37% of respondents reported their County convenes a local CPP process before developing an initial draft of the Annual Update to its MHSA Three-Year Program and Expenditure Plan.
- Just 35% of respondents reported all of their County’s MHSA funding allocations are developed and/or approved through their local CPP process.
- Just 26% of respondents reported their County provides internal trainings to its own staff responsible for coordinating and managing their local CPP process; 15% said their County does NOT provide such trainings, and 59% were unsure whether their County provided these trainings.
- Just 20% of respondents reported their County provides trainings to community stakeholders on the MHSA and CPP process to ensure they have the requisite knowledge to meaningfully participate.
  - 24% said their County does NOT provide such trainings.
  - 57% were unsure whether their County provided these trainings.
Of the Annual Stakeholder Inclusion and Feedback Survey respondents who were either employed by a County or state mental health oversight agency, or who have served on a local or state mental health oversight body:

- Just 27% reported their agency provides stakeholder trainings on mental health policy matters.
- Just 21% reported their agency provides stakeholder trainings on MHSA program planning, development, and implementation.
- Just 17% reported their agency provides stakeholder trainings on the general budgeting process and specific MHSA funding provisions/restrictions.
- Just 10% reported their agency provides stakeholder trainings on MHSA program oversight and evaluation.

**CONCLUSIONS: ANNUAL STAKEHOLDER INCLUSION AND FEEDBACK SURVEY**

We theorized that the more stakeholders and PMHS leadership truly understand and implement the MHSA’s fundamental stakeholder inclusion requirements, the more likely local mental health agencies and the statewide PMHS are to develop recovery-oriented systems of care, provide mental health services that are client-driven and recovery-focused, and utilize meaningful recovery outcomes data to make evidence-based programming and funding decisions that align with the MHSA’s core principles, goals, and values.

These Survey responses reveal a dearth of knowledge within the PMHS regarding the MHSA’s most basic requirements related to stakeholder inclusion at all levels of mental health policy planning and decision-making. If system leaders are unaware of and/or do not fully understand these requirements, they cannot adequately implement them within the systems they oversee. And without this foundation, PMHS leaders are ill-equipped to engage local stakeholders and provide them with the vital information needed to make meaningful contributions to state and local mental health decision-making and policy planning discussions.

Counties and statewide agencies need frequent comprehensive training on the MHSA’s fundamental legal mandates and a reliable source of technical assistance and support in their implementation. Once PMHS leaders have developed a sufficient working knowledge of these requirements, they must invest in widespread and ongoing stakeholder engagement and training activities. The PMHS experiences high levels of turnover and burnout amongst staff, membership on state and local oversight bodies, and community advocates. Leadership needs to invest in maintaining and preserving its institutional knowledge and best practices related to stakeholder engagement, education, and inclusion at all levels. Until meaningful stakeholder involvement is realized and mental health programming decisions are truly driven by client and community needs, local mental health agencies will continue to struggle in their efforts to create recovery-oriented systems of care, deliver recovery-based services, and achieve lasting recovery outcomes for the adult client population.
ANNUAL CLIENT AND LEADERSHIP SURVEY

ACCESS disseminated its Annual Client and Leadership Survey between January 28, 2019 – October 1, 2019, and gathered a total of 707 responses. A link to the aggregated responses (with all identifying information redacted) for this survey is included in the list of Appendices at the end of this Report. (See Appendix 8.) The results of this survey are discussed herein.

INITIAL RESEARCH

The Annual Client and Leadership Survey focuses solely on gathering information relevant to ACCESS’ theme for the year’s State of the Community Report. Therefore, in crafting this year’s Survey, ACCESS first researched the MHSA’s requirements related to overall systems transformation, the provision of recovery-based adult mental health services, and the collection and utilization of meaningful recovery outcomes in PMHS programs. We then benchmarked evidence-based best practices related to recovery-oriented systems, services, and outcomes. Once we established a foundation of what these systems, services, and outcomes should look like, we crafted our Survey questions to capture whether and to what extent these principles and methods have been adopted throughout California’s PMHS.

ACCESS then developed its Annual Client and Leadership Survey to determine the extent to which California’s PMHS is recovery-oriented, whether the services it provides are client-driven and recovery-focused, and how it gathers and uses meaningful recovery outcomes to make evidence-based MHSA programming and funding decisions.

SURVEY COMPONENTS

This survey contained four sections, all of which focused solely on adult mental health services in the PMHS:

1. A section for Clients and Family Members of adult clients to provide feedback regarding recovery-oriented services for adult mental health clients in their local mental health systems. (350 completed responses)

2. A section for State Mental Health Agency Leadership to determine how oversight agencies are ensuring Counties/Local Mental Health Systems integrate the Recovery Model of care into adult mental health services. (26 completed responses)

3. A section for Local Mental Health System Leadership to gauge levels of integration of the Recovery Model of care in adult mental health services. (140 completed responses)

4. A section for all Stakeholders (everyone) to provide insights and feedback regarding the types of recovery-oriented services that they believe are most effective and valuable for clients. (474 completed responses)

Based on their current and past roles within the PMHS, respondents were steered towards the section(s) of the survey where their feedback was most valuable to this Report.
KEY QUESTIONS: ANNUAL CLIENT AND LEADERSHIP SURVEY
The four sections of the Survey contained various questions for each target group listed above, designed to elicit responses from each group’s perspective to determine:

1. What kinds of services and supports do adult mental health clients need to achieve and maintain recovery?
2. Are adult systems of care, services, and practices in the PMHS recovery-oriented?
3. Are agencies within the PMHS consistently tracking, collecting, and analyzing meaningful recovery outcomes for adult mental health clients?
4. What barriers exist at the state and local levels that hinder PMHS agencies’ ability to implement a recovery-oriented organizational culture, and what training, supports, and resources do these agencies need to overcome these barriers?

RESPONDENT DEMOGRAPHICS

Members of Peer Communities
- 48% identified as an adult client or consumer
- 5% identified as a transition age youth (TAY)
  - 71% of those identifying as clients/consumers or TAY have received services in the PMHS
- 16% identified as a family member of an adult client/consumer
  - 76% of those identifying as family members said their loved one received services in the PMHS
- 7% identified as a parent/caregiver of a child/youth

Employment/Service in the PMHS
- 71% have worked or volunteered in the PMHS
- 31% have served on a state or local PMHS policy-making/oversight body

Other Demographic Data
- 53% identified as a racial or ethnic minority
- 39% identified as having a disability
- 32% speak languages other than English
- 22% have experienced homelessness
- 18% identified as having a dual disability (mental health + physical health condition)
- 16% identified as having a co-occurring condition
- 16% identified as an older adult
- 13% identified as LGBTQ+
- 13% had past contact with the criminal justice system
- 5% identified as a former foster youth
- 5% identified as an immigrant or refugee
KEY FINDINGS: ANNUAL CLIENT AND LEADERSHIP SURVEY

1. WHAT KINDS OF SERVICES AND SUPPORTS DO ADULT MENTAL HEALTH CLIENTS NEED TO ACHIEVE AND MAINTAIN RECOVERY?

Clients/Consumers and TAY

We provided a list of factors directly related to SAMHSA’s four Major Dimensions of Recovery and ten Guiding Principles of Recovery, along with the factors listed in the MHSA FSP data collection requirements (9 CCR § 3620.10) to all respondents identifying as clients/consumers or TAY. We then asked respondents which of these factors are/were important to them in achieving or maintaining their personal recovery. Respondents could check all factors that applied. The top ten factors clients/consumers and TAY identified as important to their personal recovery were:

1. 87%: Having a safe and stable place to live
2. 84%: Having relationships that provide support, friendship, and love
3. 82%: Improving my overall health and wellness
4. 82%: Having financial stability or a steady source of income
5. 81%: Engaging in meaningful daily activities
6. 79%: Having a sense of hope and optimism
7. 74%: Developing resilience and effective coping skills
8. 71%: Increasing my overall life satisfaction
9. 71%: Managing or reducing the symptoms of my mental health condition(s)
10. 71%: Eating healthy foods on a regular basis

Notably, the three factors on the list that respondents least identified as important to their personal recovery (and the only three factors that fewer than 50% of respondents selected) were:

- 27%: Resolving any outstanding legal issues in my life
- 36%: Minimizing or eliminating my use of alcohol and/or other substances
- 41%: Preventing future hospitalizations (or incarcerations)

Family Members of Adult Clients/Consumers

We provided the same list of recovery-related factors to respondents identifying as family members of adult clients/consumers. We then asked respondents, if known, which of these factors are important to their adult family member in achieving or maintaining their recovery. The top ten factors family members identified as important to their adult loved ones’ recovery were remarkably similar to the top ten factors identified by clients/consumers and TAY:

1. 89%: Having a safe and stable place to live
2. 82%: Having relationships that provide support, friendship, and love
3. 80%: Having financial stability or a steady source of income
4. 75%: Improving their overall health and wellness
5. 70%: Having a sense of hope and optimism
6. 68%: Managing or reducing the symptoms of their mental health condition(s)
7. 65%: Engaging in meaningful daily activities
8. 64%: Eating healthy foods on a regular basis
9. 62%: Increasing their overall life satisfaction
10. 62%: Developing resilience and effective coping skills

The three factors that family members least identified as being important to their loved ones’ recovery were:

- 32%: Resolving any outstanding legal issues in their life
- 44%: Minimizing or eliminating their use of alcohol and/or other substances
- 47%: Accomplishing their employment goals

2. **DO AGENCIES WITHIN THE PMHS CONSISTENTLY DEMONSTRATE A RECOVERY-ORIENTED ORGANIZATIONAL CULTURE?**

**RECOVERY-ORIENTED CULTURE: PMHS PROVIDERS**

**Clients/Consumers and TAY**

We asked the clients/consumers and TAY who have received services in the PMHS to rate their experiences with their current or most recent PMHS services provider to gauge the extent to which providers’ services settings and delivery practices were recovery-oriented and client-driven. The factors listed were developed from SAMHSA’s four Major Dimensions of Recovery and extensive research ACCESS has conducted into data points correlated with meaningful recovery outcomes.

<table>
<thead>
<tr>
<th>CLIENTS’ ASSESSMENT OF PMHS PROVIDERS</th>
<th>AGREE</th>
<th>DISAGREE/ NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Provider offers a warm and welcoming atmosphere for clients (e.g., the client areas are bright, open, and clean; coffee, water, and/or snacks are offered; staff are friendly and helpful; educational and reading materials are available and up-to-date; appointment check-in system runs smoothly, etc.)</td>
<td>73%</td>
<td>26%</td>
</tr>
<tr>
<td>I receive services from the Provider in a timely fashion</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>The Provider gives me choices and options in the treatments and services I receive</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>The Provider takes the time to explain my options and explore alternatives with me</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>The Provider listens to me and respects my choices and preferences</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>The Provider encourages me to make decisions for myself and advocate for my own needs</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>The Provider believes I can and will recover</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>The Provider values my individual strengths and abilities</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>The Provider asks about my personal recovery goals and how I want to achieve them</td>
<td>72%</td>
<td>28%</td>
</tr>
</tbody>
</table>
**CLIENTS’ ASSESSMENT OF PMHS PROVIDERS**

<table>
<thead>
<tr>
<th>Description</th>
<th>AGREE</th>
<th>DISAGREE/NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Provider offers me services that are matched to my personal recovery goals</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>I am in control of my own services and recovery plan</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>The Provider is flexible and responsive if I request a different doctor, social worker, case manager, peer support worker, etc.</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help me achieve my recovery goals</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help clients prepare to leave the PMHS when ready/appropriate</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help Family Members support clients’ recovery</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help Family Members care for themselves while they are supporting clients</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>

**Family Members of Adult Clients/Consumers**

We asked the family members of adult clients/consumers who have received services in the PMHS to rate their experiences with their family member’s current or most recent PMHS services provider to gauge the extent to which providers’ services settings and delivery practices were recovery-oriented and client-driven. The factors listed were developed from SAMHSA’s four Major Dimensions of Recovery and extensive research ACCESS has conducted into data points correlated with meaningful recovery outcomes.

**FAMILY MEMBERS’ ASSESSMENT OF PMHS PROVIDERS**

<table>
<thead>
<tr>
<th>Description</th>
<th>AGREE</th>
<th>DISAGREE/NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Provider offers a warm and welcoming atmosphere for clients (e.g., the client areas are bright, open, and clean; coffee, water, and/or snacks are offered; staff are friendly and helpful; educational and reading materials are available and up-to-date; appointment check-in system runs smoothly, etc.)</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>My family member receives services from the Provider in a timely fashion</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>The Provider gives my family member choices and options in the treatments and services they receive</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>The Provider takes the time to explain my family member’s options and explore alternatives with my family member</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>The Provider listens to my family member and respects their choices and preferences</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>The Provider encourages my family member to make decisions for themself and advocate for their own needs</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>The Provider believes my family member can and will recover</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>The Provider values my family member’s individual strengths and abilities</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>The Provider asks about my family member’s personal recovery goals and how they want to achieve them</td>
<td>58%</td>
<td>42%</td>
</tr>
</tbody>
</table>
FAMILY MEMBERS’ ASSESSMENT OF PMHS PROVIDERS

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree/Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Provider offers my family member services that are matched to their personal recovery goals</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>My family member is in control of their own services and recovery plan</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>The Provider is flexible and responsive if my family member requests a different doctor, social worker, case manager, peer support worker, etc.</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help my family member achieve their recovery goals</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help my family member prepare to leave the PMHS when ready/appropriate</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help ME support my family member's recovery</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>The Provider offers training or support groups to help ME care for myself while supporting my family member</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

RECOVERY-ORIENTED CULTURE: STATE MENTAL HEALTH AGENCIES

The factors listed below are correlated with an organization's ability to establish and maintain a recovery-oriented culture. We asked respondents representing state mental health agencies: Please indicate your level of agreement with the following statements as they relate to your agency’s organizational culture.

SELF-ASSESSMENT: STATE MENTAL HEALTH AGENCIES

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree/Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Agency receives client stakeholders in a warm and welcoming atmosphere (e.g., the Agency is easily accessible, staff are friendly and helpful, etc.)</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>The Agency freely adapts its organizational policies and practices to better meet client stakeholders’ needs</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>The Agency actively fosters hope and optimism that recovery is not only possible for all clients, it is expected</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>The Agency ensures that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness is a significant factor in all of its decisions and recommendations (WIC § 5846(d))</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>The Agency’s leadership and employees working in management, planning, oversight, and evaluation roles receive comprehensive training on the Recovery Model of care, the qualities of Recovery-Oriented Services and methods of delivering them, and the collection and utilization of Meaningful Recovery Outcomes data to assess and improve services for adult mental health clients in the PMHS</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>The Agency provides ongoing training and technical assistance to Counties to ensure they fully understand the MHSA's recovery-related services requirements and are supported in operationalizing these mandates (WIC §§ 4050-4061, 5846(c))</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>The Agency actively promotes the Recovery Model and the delivery of Recovery-Oriented Services within its own organization and in the Counties it oversees</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>The Agency consistently monitors and measures Meaningful Recovery Outcomes in the County programs and plans it oversees</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>The Agency relies on Meaningful Recovery Outcomes data in shaping its organizational priorities, policies, practices, and standards for services delivery</td>
<td>44%</td>
<td>56%</td>
</tr>
</tbody>
</table>
### SELF-ASSESSMENT: STATE MENTAL HEALTH AGENCIES

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree/Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Agency ensures Counties conduct a robust Community Program Planning process and meaningfully includes client stakeholders in all aspects of local MHSA policy, program planning, implementation, monitoring, quality improvement, evaluation and budget allocations (WIC § 5848(a))</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>The Agency ensures County programs and services promote concepts key to recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination (WIC § 5813.5(d)(1))</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The Agency ensures County programs and services promote consumer-operated services as a way to support recovery (WIC § 5813.5(d)(2))</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>The Agency ensures County programs and services reflect the cultural, ethnic, and racial diversity of mental health consumers (WIC § 5813.5(d)(3))</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The Agency ensures County programs and services plan for each consumer's individual needs (WIC § 5813.5(d)(4))</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>The Agency prohibits Counties from requiring clients to accept medication as a condition of receiving ongoing services</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>The Agency ensures Counties respect and uphold clients' primary decision-making role in identifying their own needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for them (9 CCR §3200.050)</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>The Agency ensures County programs and services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes (9 CCR §3200.050)</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>The Agency ensures Counties employ current or former clients in peer support and advocacy roles throughout their Local Mental Health Systems (9 CCR § 3610(b))</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>The Agency, in collaboration with other State Mental Health Agencies, has developed (or is developing) a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system (WIC § 5845(d)(12))</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>The Agency, in consultation with mental health stakeholders, has revised (or is revising) the MHSA PEI program elements applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for adults and seniors (WIC § 5840(f))</td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td>The Agency assists consumers and family members to ensure the appropriate state and County agencies give full consideration to concerns about quality, structure of service delivery, or access to services (WIC § 5892(d))</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>The Agency conducts adequate research and evaluation regarding the effectiveness of services being provided and achievement of the MHSA's outcome measures (WIC § 5892(d))</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>The Agency holds Counties accountable when their programs, plans, services, and/or outcomes do not comply with the MHSA's General Standards (9 CCR § 3320)</td>
<td>42%</td>
<td>58%</td>
</tr>
</tbody>
</table>
RECOVERY-ORIENTED CULTURE: COUNTIES AND LOCAL MENTAL HEALTH SYSTEMS

The factors listed below are correlated with an organization's ability to establish and maintain a recovery-oriented culture. We asked respondents representing Counties, local mental health systems and provider agencies: **Please indicate your level of agreement with the following statements as they relate to your overall County/local mental health system (not just the agency you personally work/serve in).**

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: COUNTIES/LOCAL MENTAL HEALTH SYSTEMS</th>
<th>AGREE</th>
<th>DISAGREE/NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The System actively discourages &quot;gatekeeping&quot; practices and takes affirmative steps to remove barriers to clients' timely receipt of services</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>The System offers clients a choice of providers where they can receive services</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>The System offers clients a holistic range of options to meet their medical, physical, social, occupational, psychological, emotional, intellectual, spiritual, and religious needs</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>The System does not require clients to accept medication as a condition for receiving ongoing services</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>The System is flexible and responsive when clients request a different provider, practitioner, social worker, services coordinator, peer provider, etc.</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>The System freely adapts its organizational policies and practices to better meet clients' needs</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>System services, policies, and practices promote clients' self-determination, autonomy, and independence, including the dignity of risk and the right to fail</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>System services are designed to reintegrate clients into society to live as fully equal citizens</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>The System receives clients in a warm and welcoming atmosphere (e.g., the client areas are bright, open, and clean; coffee, water, and/or snacks are offered; staff are friendly and helpful; educational and reading materials are available and up-to-date; appointment check-in system runs smoothly, etc.)</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>System leadership and employees actively foster hope and optimism that recovery is not only possible for all clients, it is expected</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td>System leadership, managers, practitioners, QA/QI/evaluation staff, monitoring/oversight staff, and direct services staff receive comprehensive training on the Recovery Model and delivery of Recovery-Oriented Services</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Practitioners and direct services staff receive ongoing guidance and support in practicing the Recovery Model and delivering Recovery-Oriented Services</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>The System consistently monitors and measures clients' Meaningful Recovery Outcomes throughout its adult programs</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>The System relies on Meaningful Recovery Outcomes data in shaping its organizational policies, practices, standards for services delivery, and MHSA-funded programming priorities</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>The System employs a Client (or Consumer) Advocate/Liaison or Client Affairs Coordinator as part of the System's executive leadership team</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Current or former clients are employed in peer support and advocacy roles throughout the System</td>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>
### SELF-ASSESSMENT: COUNTIES/LOCAL MENTAL HEALTH SYSTEMS

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree/Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>System practitioners and providers acknowledge and promote clients' individual strengths, and incorporate them into recovery planning and services delivery</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>System practitioners and providers treat client as essential and co-equal partners in all aspects of their own recovery process, including treatment planning and services decisions</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>System practitioners and providers encourage clients to define their own needs, goals, dreams, and plans for the future</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>System practitioners and providers give clients timely and accurate information to promote fully informed consent and shared decision-making</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>System practitioners and providers recognize and celebrate clients' achievement of recovery milestones</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>System practitioners and providers demonstrate a genuine desire to support clients in fulfilling their potential and to shaping their own future</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>System leadership and employees use person-first language rather than referring to clients primarily by their illness or diagnosis</td>
<td>66%</td>
<td>34%</td>
</tr>
<tr>
<td>System leadership and employees use strengths-based language rather than deficits-based language when referring to clients (e.g., &quot;resourceful,&quot; not &quot;manipulative&quot;)</td>
<td>58%</td>
<td>42%</td>
</tr>
<tr>
<td>The System offers trainings and support groups to help clients in achieving their individual recovery goals</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>The System offers trainings and support groups to help family members in supporting clients' recovery</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>The System offers trainings and support groups to help family members care for themselves while supporting their loved ones</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>The System adequately prepares clients to leave the PMHS (or discontinue services) when ready and appropriate</td>
<td>39%</td>
<td>61%</td>
</tr>
</tbody>
</table>

### RECOVERY-ORIENTED CULTURE: MEDICATION PREREQUISITES IN THE PMHS

The MHSA requires that community-based adult mental health services be client-driven and consistent with the Recovery Model (which recognizes many pathways to recovery), promote clients’ self-determination, and plan for each consumer's individual needs. (9 CCR § 3200.050; WIC §§ 5815.5(d).) As such, services funded through the MHSA are designed to be voluntary. (9 CCR § 3400(b)(2).) A system that coerces clients to take medication is not one that is recovery-oriented.

### Clients/Consumers and TAY

We asked self-identified clients/consumers and TAY who have received services in the PMHS: **Is medication a condition for ongoing services in your County/local mental health system? In other words, did you have to accept medication to continue receiving services or get referred to new services?**

- **YES:** 28%
- **NO:** 40%:
- **NOT SURE:** 32%:
Family Members of Adult Clients/Consumers

We asked self-identified family members of adult clients/consumers whose loved ones have received services in the PMHS: **Is medication a condition for ongoing services in your family member's County/Local Mental Health System? In other words, did your family member have to accept medication to continue receiving services or get referred to new services?**

- YES: 36%
- NO: 40%
- NOT SURE: 24%

Local System Leadership

We asked self-identified County and local system leadership: **Is medication a condition for ongoing services in your County/local mental health system? In other words, must adult mental health clients accept medication in order to continue receiving services or be referred to new services?**

- YES, ALWAYS: 9%
- YES, SOMETIMES: 12%
- NO, NEVER: 50%
- NOT SURE: 30%

To those local system leaders who said their Counties “always” or “sometimes” require clients to accept medication to receive other services, we asked this follow-up question: **How does this practice comport with the MHSA’s requirements that services be client-driven and consistent with the Recovery Model (which recognizes many pathways to recovery), promote self-determination, and plan for each consumer’s individual needs?** We received the following (relevant) write-in responses:

- This practice is unfortunate and is not a representation of the recovery model or in the spirit of MHSA. The term "med compliant" is used frequently on this campus.
- To participate in the county MHP, medication is a requirement for continued on-going participation.
- Some individuals are not able to function in the community without medication. Some can progress with short term medication treatment. For those with SMI, accepting diagnosis and understanding medication benefits may be necessary for survival. If they are non-adherent or non-compliant, they may not be able to benefit from other treatment modalities. Informed consent for medication is always essential.
- When persons are on a 5150 there is sometimes a hearing that allows the dispensing of medications. If a person is in the community - they are not required to be medicated.
- Medications are prescribed by a physician (psychiatrist or medical provider) initially at admission based on prior medication orders, and then the physician will meet with the client on a consistent basis for assessment and [ongoing] determination of medication based on current status (with feedback from staff) and direct client feedback.
- It does not [comport with the MHSA’s requirements] but that is the reality of our funding constraints.
- They are on conservatorship and the right to refuse medication has been taken away.
- I don't think it does [comport with the MHSA’s requirements].
- If individuals do not desire to take medications it is opposite of the MHSA’s plan and it does hinder providing services to the individual.
• It differs w/ each person. Some people are ok w/o all the meds. They only need counseling. Whereas some need meds because they are violent & want to cause harm to themselves.

• For certain programs, services, or resources (ex. shelter housing) clients/consumers must have medication upon admission to housing or residential tx centers as criteria for admission. The communicated rationale is stabilization for client/consumer while they are residing at the facility and out of safety concerns for residents and staff. There are some field based programs (non-clinical modality) that acknowledge not all clients are willing/ready to take medication.

• I have seen requirement to take medication as a gateway to needed survival resources (shelter, services, housing) with NUMEROUS of my clients, here. Although our county BH states that they do not require this, nor do their contract agency partners. When this happens, it often causes an enormous amount of distress in the person being so compelled. It is a real Catch-22 for many people, because, as we ALL know, finding medication(s) that actually give symptom relief...and without exacting horrible side effects that zero out all benefits—is like ‘a science project in a garage.’ That is, it is ridiculously UN-scientific, and it is most often painful, scary, and/or actively debilitating for the person subject to the process (of trying to find/get the right medication(s). ALL WHILE this ubiquitous difficulty is NOT acknowledged by MUCH of the public MH system.

Providers in the PMHS are SO violently overworked and under-supported that they are scrambling just to try to help people survive...and they have SO FEW other support resources to offer. For example, in my county, all our BH providers’ case loads are between 60 and 100 clients/patients. SAMHSA recommends a case load of no more than 12 to 15 in this population. Providers are almost as crushed in this system as consumers are. :-( (Though they, unlike us, do not die in larger numbers as a result of the system's [brokenness]. They are instead merely profoundly exhausted and burned out...and legitimately so.)”

• It doesn’t [comport with the MHSA’s requirements].

• This eliminates stigma. And provides an all encompassing team working together w/strength evidence based practices.

Comparison to Prior Survey Responses

In prior Survey questions, we asked leaders from Counties/local mental health systems and state mental health agencies and state mental health agencies to rate their levels of agreement with the following statements related to medication prerequisites in the PMHS:

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: LOCAL SYSTEM LEADERSHIP</th>
<th>STATEWIDE AGENCY LEADERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
</tr>
<tr>
<td>COUNTIES/LOCAL MENTAL HEALTH SYSTEMS</td>
<td></td>
</tr>
<tr>
<td>The System does not require clients to accept medication as a condition for receiving ongoing services</td>
<td>24.7%</td>
</tr>
<tr>
<td>STATE MENTAL HEALTH AGENCIES</td>
<td></td>
</tr>
<tr>
<td>The Agency prohibits Counties from requiring clients to accept medication as a condition of receiving ongoing services</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

We would therefore expect greater consistency between the following responses provided by representatives of Counties and other local system leadership:
<table>
<thead>
<tr>
<th>THE [COUNTY/LOCAL MENTAL HEALTH] SYSTEM DOES NOT REQUIRE CLIENTS TO ACCEPT MEDICATION AS A CONDITION FOR RECEIVING ONGOING SERVICES</th>
<th>IS MEDICATION A CONDITION FOR ONGOING SERVICES IN YOUR COUNTY/LOCAL MENTAL HEALTH SYSTEM? IN OTHER WORDS, MUST ADULT MENTAL HEALTH CLIENTS ACCEPT MEDICATION IN ORDER TO CONTINUE RECEIVING SERVICES OR BE REFERRED TO NEW SERVICES?</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ STRONGLY AGREE: 24.7%</td>
<td>▪ STRONGLY AGREE: 24.7%</td>
</tr>
<tr>
<td>▪ AGREE: 40.4%</td>
<td>▪ AGREE: 40.4%</td>
</tr>
<tr>
<td>▪ DISAGREE: 25.7%</td>
<td>▪ DISAGREE: 25.7%</td>
</tr>
<tr>
<td>▪ STRONGLY DISAGREE: 2.2%</td>
<td>▪ STRONGLY DISAGREE: 2.2%</td>
</tr>
<tr>
<td>▪ NOT SURE: 16.9%</td>
<td>▪ NOT SURE: 16.9%</td>
</tr>
<tr>
<td><strong>EXPECTED RESPONSES</strong></td>
<td><strong>EXPECTED RESPONSES</strong></td>
</tr>
<tr>
<td>▪ YES, ALWAYS: 2%</td>
<td>▪ YES, ALWAYS: 2%</td>
</tr>
<tr>
<td>▪ YES, SOMETIMES: 26%</td>
<td>▪ YES, SOMETIMES: 26%</td>
</tr>
<tr>
<td>▪ NO, NEVER: 66%</td>
<td>▪ NO, NEVER: 66%</td>
</tr>
<tr>
<td>▪ NOT SURE: 17%</td>
<td>▪ NOT SURE: 17%</td>
</tr>
<tr>
<td><strong>ACTUAL RESPONSES</strong></td>
<td><strong>ACTUAL RESPONSES</strong></td>
</tr>
<tr>
<td>▪ YES, ALWAYS: 9%</td>
<td>▪ YES, ALWAYS: 9%</td>
</tr>
<tr>
<td>▪ YES, SOMETIMES: 12%</td>
<td>▪ YES, SOMETIMES: 12%</td>
</tr>
<tr>
<td>▪ NO, NEVER: 50%</td>
<td>▪ NO, NEVER: 50%</td>
</tr>
<tr>
<td>▪ NOT SURE: 30%</td>
<td>▪ NOT SURE: 30%</td>
</tr>
</tbody>
</table>
3. ARE AGENCIES WITHIN THE PMHS CONSISTENTLY TRACKING, COLLECTING, AND ANALYZING MEANINGFUL RECOVERY OUTCOMES FOR ADULT MENTAL HEALTH CLIENTS?

**TRACKING MEANINGFUL RECOVERY OUTCOMES: PMHS PROVIDERS**

**Clients/Consumers and TAY**

We asked clients/consumers and TAY who have received services in the PMHS whether their current or most recent PMHS services provider is tracking the following recovery outcomes. The data points listed below that begin with [FSP] must be tracked for all adult clients receiving services in MHSA-funded FSP programs, pursuant to 9 CCR § 3620.10.

<table>
<thead>
<tr>
<th>CLIENTS’ ASSESSMENT OF PMHS PROVIDERS</th>
<th>AGREE</th>
<th>DISAGREE/ NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[FSP] The Provider asks about my housing status and living conditions</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my educational achievement and goals</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my employment status and goals</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any legal issues I may be experiencing</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my sources of financial support and income stability</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my overall health and wellness, including my physical health conditions and dental health</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any alcohol/substance use issues I may be experiencing</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my daily living functions and meaningful activities</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any hospitalizations or emergency interventions I have recently experienced</td>
<td>66%</td>
<td>34%</td>
</tr>
<tr>
<td>The Provider asks about my overall life satisfaction</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>The Provider asks about my interpersonal relationships and social support system</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td>The Provider asks about the progress I’m making towards my self-identified goals</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

We then asked self-identified clients/consumers and TAY who have received services in the PMHS whether their current or most recent services provider tracks and shares their recovery outcomes with them.

<table>
<thead>
<tr>
<th>CLIENTS’ ASSESSMENT OF PMHS PROVIDERS</th>
<th>YES, ALWAYS</th>
<th>YES, SOMETIMES</th>
<th>YES, OCCASIONALLY</th>
<th>NO, NEVER</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your provider share any documentation with you that tracks or celebrates achievement of your recovery milestones?</td>
<td>15.7%</td>
<td>19.2%</td>
<td>14.0%</td>
<td>40.1%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Does your provider give you any tangible evidence that the path you are taking to achieve your personal recovery goals is working?</td>
<td>21.8%</td>
<td>22.9%</td>
<td>14.1%</td>
<td>31.8%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Is your provider flexible in altering your recovery plan and/or exploring new alternatives if your current plan isn't working as expected?</td>
<td>30.4%</td>
<td>19.3%</td>
<td>9.9%</td>
<td>24.6%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>
Family Members of Adult Clients/Consumers

We asked the family members of adult clients/consumers whose loved ones have received services in the PMHS the same questions about their family member’s current or most recent services provider.

<table>
<thead>
<tr>
<th>FAMILY MEMBERS’ ASSESSMENT OF PMHS PROVIDERS</th>
<th>AGREE</th>
<th>DISAGREE/ NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[FSP] The Provider asks about my family member’s housing status and living conditions</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my family member’s educational achievement and goals</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my family member’s employment status and goals</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any legal issues my family member may be experiencing</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my family member’s sources of financial support and income stability</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my family member’s overall health and wellness, including their physical health conditions and dental health</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any alcohol/substance use issues my family member may be experiencing</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about my family member’s daily living functions and meaningful activities</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>[FSP] The Provider asks about any hospitalizations or emergency interventions my family member has recently experienced</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>The Provider asks about my family member’s overall life satisfaction</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>The Provider asks about my family member’s interpersonal relationships and social support system</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The Provider asks about the progress my family member is making towards their self-identified goals</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>

We asked family members the same questions about whether their loved ones’ current or most recent PMHS providers track and share their family member’s recovery milestones:

<table>
<thead>
<tr>
<th>FAMILY MEMBERS’ ASSESSMENT OF PMHS PROVIDERS</th>
<th>YES, ALWAYS</th>
<th>YES, SOMETIMES</th>
<th>YES, OCCASIONALLY</th>
<th>NO, NEVER</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the provider share any documentation with your family member that tracks or celebrates achievement of their recovery milestones?</td>
<td>9.4%</td>
<td>11.3%</td>
<td>11.3%</td>
<td>41.5%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Does the provider give your family member any tangible evidence that the path they are taking to achieve their personal recovery goals is working?</td>
<td>9.6%</td>
<td>21.2%</td>
<td>9.6%</td>
<td>34.6%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Is the provider flexible in altering your family member’s recovery plan and/or exploring new alternatives if their current plan isn't working as expected?</td>
<td>17.0%</td>
<td>18.9%</td>
<td>11.3%</td>
<td>26.4%</td>
<td>26.4%</td>
</tr>
</tbody>
</table>
TRACKING MEANINGFUL RECOVERY OUTCOMES: STATE MENTAL HEALTH AGENCIES

In a prior Survey question, we asked respondents representing state mental health agencies: **Please indicate your level of agreement with the following statements as they relate to your agency’s organizational culture.** The data points below directly relate to state mental health agencies’ collection and utilization of clients’ meaningful recovery outcomes.

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: STATE MENTAL HEALTH AGENCIES</th>
<th>AGREE</th>
<th>DISAGREE/ NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Agency’s leadership and employees working in management, planning, oversight, and evaluation roles receive comprehensive training on the Recovery Model of care, the qualities of Recovery-Oriented Services and methods of delivering them, and the collection and utilization of Meaningful Recovery Outcomes data to assess and improve services for adult mental health clients in the PMHS</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>The Agency consistently monitors and measures Meaningful Recovery Outcomes in the County programs and plans it oversees</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>The Agency relies on Meaningful Recovery Outcomes data in shaping its organizational priorities, policies, practices, and standards for services delivery</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>The Agency, in collaboration with other State Mental Health Agencies, has developed (or is developing) a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system (WIC § 5845(d)(12))</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>The Agency conducts adequate research and evaluation regarding the effectiveness of services being provided and achievement of the MHSA’s outcome measures (WIC § 5892(d))</td>
<td>63%</td>
<td>37%</td>
</tr>
</tbody>
</table>

We asked self-identified statewide mental health policy makers and executive and management-level employees at statewide mental health agencies: **Which of the following meaningful recovery outcomes does your agency currently collect from the Counties/local mental health systems it oversees, and for what types of programs does it collect them?** The data points listed below that begin with [FSP] must be tracked for all adult clients receiving services in MHSA-funded FSP programs, pursuant to 9 CCR § 3620.10.

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: STATE MENTAL HEALTH AGENCIES</th>
<th>ALL MHSA-FUNDED ADULT PROGRAMS</th>
<th>ALL ADULT CSS PROGRAMS</th>
<th>ALL ADULT FSP PROGRAMS</th>
<th>ALL ADULT INN PROGRAMS</th>
<th>N/A OR NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I DON'T KNOW ANY OF THIS INFO: Just click &quot;N/A or Not Sure&quot; for this row and move on to the next question</td>
<td>21.1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>78.9%</td>
</tr>
<tr>
<td>[FSP] Housing Status and Stability</td>
<td>40.0%</td>
<td>5.0%</td>
<td>15.0%</td>
<td>0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>[FSP] Educational Status and Attainment</td>
<td>27.8%</td>
<td>16.7%</td>
<td>5.6%</td>
<td>0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>[FSP] Employment Status and Stability</td>
<td>36.8%</td>
<td>5.3%</td>
<td>10.5%</td>
<td>0%</td>
<td>47.4%</td>
</tr>
<tr>
<td>[FSP] Legal Issues (including contact with law enforcement)</td>
<td>15.8%</td>
<td>15.8%</td>
<td>10.5%</td>
<td>5.3%</td>
<td>52.6%</td>
</tr>
<tr>
<td>[FSP] Sources of Financial Support and Income Stability</td>
<td>21.1%</td>
<td>5.3%</td>
<td>15.8%</td>
<td>5.3%</td>
<td>52.6%</td>
</tr>
<tr>
<td>[FSP] Overall Health and Wellness</td>
<td>55.0%</td>
<td>5.0%</td>
<td>0%</td>
<td>0%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
### SELF-ASSESSMENT: STATE MENTAL HEALTH AGENCIES

<table>
<thead>
<tr>
<th></th>
<th>ALL MHSA-FUNDED ADULT PROGRAMS</th>
<th>ALL ADULT CSS PROGRAMS</th>
<th>ALL ADULT FSP PROGRAMS</th>
<th>ALL ADULT INN PROGRAMS</th>
<th>N/A OR NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[FSP] Alcohol and Substance Use</td>
<td>45.0%</td>
<td>5.0%</td>
<td>0%</td>
<td>0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[FSP] Daily Living Functions</td>
<td>42.1%</td>
<td>15.8%</td>
<td>0%</td>
<td>0%</td>
<td>42.1%</td>
</tr>
<tr>
<td>[FSP] Emergency Interventions</td>
<td>45.0%</td>
<td>10.0%</td>
<td>0%</td>
<td>0%</td>
<td>45.0%</td>
</tr>
<tr>
<td>(including hospitalization and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incarceration)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Life Satisfaction</td>
<td>42.1%</td>
<td>5.3%</td>
<td>0%</td>
<td>0%</td>
<td>52.6%</td>
</tr>
<tr>
<td>Symptom Management and</td>
<td>36.8%</td>
<td>10.5%</td>
<td>5.3%</td>
<td>0%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Improvement</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Progress Towards Self-Identified</td>
<td>44.4%</td>
<td>11.1%</td>
<td>5.6%</td>
<td>0%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Interaction and Isolation</td>
<td>47.4%</td>
<td>10.5%</td>
<td>0%</td>
<td>5.3%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Quality of Relationships and</td>
<td>38.9%</td>
<td>11.1%</td>
<td>5.6%</td>
<td>0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Social Supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation Access and Issues</td>
<td>27.8%</td>
<td>11.1%</td>
<td>16.7%</td>
<td>0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Food Security and Nutrition</td>
<td>16.7%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Levels of Exercise and Physical</td>
<td>38.9%</td>
<td>5.6%</td>
<td>0%</td>
<td>5.6%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of Physical Health</td>
<td>52.6%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience and Effective Coping</td>
<td>35.0%</td>
<td>25.0%</td>
<td>5.0%</td>
<td>0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Determination and Self-Efficacy</td>
<td>50.0%</td>
<td>15.0%</td>
<td>0%</td>
<td>0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>57.9%</td>
<td>5.3%</td>
<td>5.3%</td>
<td>0%</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

We also asked: **How is your agency currently using Meaningful Recovery Outcomes data to inform its MHSA evaluation, funding, programming, and/or policy decisions?**

<table>
<thead>
<tr>
<th>UTILIZATION OF RECOVERY OUTCOMES DATA: STATE MENTAL HEALTH AGENCIES</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Recovery Outcomes data are used to expand MHSA funding for effective programs</td>
<td>38.5%</td>
</tr>
<tr>
<td><strong>Not Sure</strong></td>
<td>34.6%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to evaluate the effectiveness of MHSA-funded programs</td>
<td>34.6%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to shape internal organizational policies, procedures, practices, and standards for services delivery</td>
<td>34.6%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to clarify or refine the scopes of work for MHSA-funded programs</td>
<td>26.9%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to define goals and objectives for MHSA-funded programs</td>
<td>23.1%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to determine additional training and/or support needs within MHSA-funded programs</td>
<td>23.1%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to shape my State Mental Health Agency's legislative priorities</td>
<td>23.1%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to decrease or eliminate MHSA funding for ineffective programs</td>
<td>11.5%</td>
</tr>
<tr>
<td>N/A - My State Mental Health Agency doesn’t collect Meaningful Recovery Outcomes data</td>
<td>11.5%</td>
</tr>
<tr>
<td>N/A - My State Mental Health Agency doesn’t use Meaningful Recovery Outcomes data in MHSA evaluation, funding, programming, and/or policy decisions</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

**TRACKING MEANINGFUL RECOVERY OUTCOMES: COUNTIES/LOCAL MENTAL HEALTH AGENCIES**

In a prior Survey question, we asked respondents representing Counties, local mental health systems and provider agencies: **Please indicate your level of agreement with the following statements as they relate to your overall County/local mental health system (not just the agency you personally work/serve in).** The data points below directly relate to Counties’ collection and utilization of clients’ meaningful recovery outcomes.

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: COUNTIES/LOCAL MENTAL HEALTH SYSTEMS</th>
<th>AGREE</th>
<th>DISAGREE/ NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The System consistently monitors and measures clients' Meaningful Recovery Outcomes throughout its adult programs</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>The System relies on Meaningful Recovery Outcomes data in shaping its organizational policies, practices, standards for services delivery, and MHSA-funded programming priorities</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>System practitioners and providers recognize and celebrate clients' achievement of recovery milestones</td>
<td>70%</td>
<td>30%</td>
</tr>
</tbody>
</table>

We asked self-identified local mental health policy makers and executive and management-level employees at Counties and local provider agencies: **Which of the following meaningful recovery outcomes does your County/local mental health system currently collect for adult mental health clients, and in what types of programs does it collect them?** The data points listed below that begin with **[FSP]** must be tracked for all adult clients receiving services in MHSA-funded FSP programs, pursuant to 9 CCR § 3620.10.

<table>
<thead>
<tr>
<th>SELF-ASSESSMENT: COUNTIES AND LOCAL MENTAL HEALTH SYSTEMS</th>
<th>ALL MHSA-FUNDED ADULT PROGRAMS</th>
<th>ALL ADULT CSS PROGRAMS</th>
<th>ALL ADULT FSP PROGRAMS</th>
<th>ALL ADULT INN PROGRAMS</th>
<th>N/A OR NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I DON'T KNOW ANY OF THIS INFO: Just click &quot;N/A or Not Sure&quot; for this row and move on to the next question</td>
<td>19.0%</td>
<td>1.6%</td>
<td>3.2%</td>
<td>1.6%</td>
<td>74.6%</td>
</tr>
<tr>
<td>[FSP] Housing Status and Stability</td>
<td>35.5%</td>
<td>4.3%</td>
<td>20.4%</td>
<td>3.2%</td>
<td>36.6%</td>
</tr>
<tr>
<td><strong>SELF-ASSESSMENT:</strong> COUNTIES AND LOCAL MENTAL HEALTH SYSTEMS</td>
<td><strong>ALL MHSA-FUNDED ADULT PROGRAMS</strong></td>
<td><strong>ALL ADULT CSS PROGRAMS</strong></td>
<td><strong>ALL ADULT FSP PROGRAMS</strong></td>
<td><strong>ALL ADULT INN PROGRAMS</strong></td>
<td><strong>N/A OR NOT SURE</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>[FSP] Educational Status and Attainment</td>
<td>20.0%</td>
<td>6.7%</td>
<td>13.3%</td>
<td>3.3%</td>
<td>56.7%</td>
</tr>
<tr>
<td>[FSP] Employment Status and Stability</td>
<td>26.1%</td>
<td>4.5%</td>
<td>18.2%</td>
<td>4.5%</td>
<td>46.6%</td>
</tr>
<tr>
<td>[FSP] Legal Issues (including contact with law enforcement)</td>
<td>15.7%</td>
<td>4.5%</td>
<td>18.0%</td>
<td>4.5%</td>
<td>57.3%</td>
</tr>
<tr>
<td>[FSP] Sources of Financial Support and Income Stability</td>
<td>24.7%</td>
<td>7.9%</td>
<td>14.6%</td>
<td>2.2%</td>
<td>50.6%</td>
</tr>
<tr>
<td>[FSP] Overall Health and Wellness</td>
<td>44.3%</td>
<td>3.4%</td>
<td>9.1%</td>
<td>2.3%</td>
<td>40.9%</td>
</tr>
<tr>
<td>[FSP] Alcohol and Substance Use Issues</td>
<td>36.0%</td>
<td>8.1%</td>
<td>10.5%</td>
<td>2.3%</td>
<td>43.0%</td>
</tr>
<tr>
<td>[FSP] Daily Living Functions</td>
<td>32.6%</td>
<td>9.3%</td>
<td>12.8%</td>
<td>3.5%</td>
<td>41.9%</td>
</tr>
<tr>
<td>[FSP] Emergency Interventions (including hospitalization and incarceration)</td>
<td>42.0%</td>
<td>8.0%</td>
<td>18.2%</td>
<td>3.4%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Overall Life Satisfaction</td>
<td>42.4%</td>
<td>7.1%</td>
<td>8.2%</td>
<td>1.2%</td>
<td>41.2%</td>
</tr>
<tr>
<td>Symptom Management and Improvement</td>
<td>39.8%</td>
<td>9.1%</td>
<td>11.4%</td>
<td>2.3%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Progress Towards Self-Identified Goals</td>
<td>39.3%</td>
<td>5.6%</td>
<td>13.5%</td>
<td>2.2%</td>
<td>39.3%</td>
</tr>
<tr>
<td>Social Interaction and Isolation</td>
<td>36.8%</td>
<td>5.7%</td>
<td>9.2%</td>
<td>2.3%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Quality of Relationships and Social Supports</td>
<td>37.9%</td>
<td>3.4%</td>
<td>9.2%</td>
<td>2.3%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Transportation Access and Issues</td>
<td>23.0%</td>
<td>6.9%</td>
<td>10.3%</td>
<td>2.3%</td>
<td>57.5%</td>
</tr>
<tr>
<td>Food Security and Nutrition</td>
<td>22.4%</td>
<td>5.9%</td>
<td>7.1%</td>
<td>1.2%</td>
<td>63.5%</td>
</tr>
<tr>
<td>Levels of Exercise and Physical Activity</td>
<td>17.4%</td>
<td>4.7%</td>
<td>3.5%</td>
<td>1.2%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Management of Physical Health Conditions</td>
<td>23.8%</td>
<td>6.0%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Resilience and Effective Coping Skills</td>
<td>38.8%</td>
<td>5.9%</td>
<td>7.1%</td>
<td>2.4%</td>
<td>45.9%</td>
</tr>
<tr>
<td>Self-Determination and Self-Efficacy</td>
<td>40.7%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>48.8%</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>44.0%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>45.2%</td>
</tr>
</tbody>
</table>
We also asked: **How is your County/local mental health system currently using the Meaningful Recovery Outcomes data it collects to inform MHSA funding and programming decisions?**

<table>
<thead>
<tr>
<th>UTILIZATION OF RECOVERY OUTCOMES DATA: COUNTIES/LOCAL MH SYSTEMS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Sure</td>
<td>46.6%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to evaluate the effectiveness of MHSA-funded programs</td>
<td>36.2%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to expand MHSA funding for effective programs</td>
<td>34.5%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to determine gaps in services and local MHSA programming priorities</td>
<td>34.5%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to define goals and objectives for MHSA-funded programs</td>
<td>32.8%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to identify opportunities and methods to improve services for adult mental health clients</td>
<td>31.9%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to determine additional training or support needs within MHSA-funded programs</td>
<td>31.0%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to clarify or refine the scopes of work for MHSA-funded programs</td>
<td>26.7%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to develop standards for services delivery</td>
<td>25.0%</td>
</tr>
<tr>
<td>Meaningful Recovery Outcomes data are used to decrease or eliminate MHSA funding for ineffective programs</td>
<td>20.7%</td>
</tr>
<tr>
<td><strong>N/A - My County/Local Mental Health System doesn't use Meaningful Recovery Outcomes data in MHSA funding and/or programming decisions</strong></td>
<td><strong>2.6%</strong></td>
</tr>
<tr>
<td><strong>N/A - My County/Local Mental Health System doesn't collect Meaningful Recovery Outcomes data</strong></td>
<td><strong>1.7%</strong></td>
</tr>
<tr>
<td>Other (please describe) [Response: Justify continued funding for favorite programs]</td>
<td>0.9%</td>
</tr>
</tbody>
</table>
4. **WHAT BARRIERS EXIST AT THE STATE AND LOCAL LEVELS THAT HINDER PMHS AGENCIES’ ABILITY TO IMPLEMENT A RECOVERY-ORIENTED ORGANIZATIONAL CULTURE, AND WHAT TRAINING, SUPPORTS, AND RESOURCES DO THESE AGENCIES NEED TO OVERCOME THESE BARRIERS?**

**BARRIERS TO RECOVERY ORIENTATION ON THE STATE LEVEL**

**State Agency Leadership Self-Assessment**

We asked self-identified leaders from state mental health agencies and state oversight/policy-making bodies:

- What barriers to recovery orientation have you observed or experienced in your State Mental Health Agency?
- What resources, training, or support does your State Mental Health Agency need to become more recovery-oriented?
- What specific actions can your State Mental Health Agency take to become more recovery-oriented?

The write-in responses listed below were most relevant to these questions. Some responses have been edited for clarity, brevity, or to remove personally identifying information.

- Barriers-the mhsoac is not collecting any meaningful recovery outcomes resources, training & support needed-training on the MHSA WIC and regs, ongoing meaningful stakeholder input, to work closely with the stakeholder contractors in order to inform leg priorities and ensure the intent of mhsa is being upheld

- There is no State Mental Health Agency. The Department of Mental Health needs to become reinstated. The State needs a central point in order to accomplish the goals most family members are looking for. Right now - it is a "hodge podge" to find the right county to provide the right services for their family member. I'm really not sure which agency is providing the complete Oversight and Accountability our mental health system needs - but someone needs to. In general, services feel scattered. There should be interagency meetings to develop common goals that benefit the consumer/family member constituency of the state. Then these common goals should be delivered to those persons receiving - or who may receive services.

- One of the barriers is that Stakeholders are not fully recognized in their roles as the voice of the consumers. There should be an ongoing training process for stakeholders as they come and go to understand and thoroughly define what their role is as an SH. Another problem is that the meeting for the SH are for the most part in isolated locations and away from public transportation, which is a major issue and total distraction for many who would love to have the experience and serve on the committee at large.


- innovations contracts have been rewritten to diminish recovery practices from being systems outcomes as originally designed by MHSA Stakeholders

- Agency has no onboarding support for new committee members

- CalMHSA is tracking consumer outcomes and strength-based design on several projects.
I served on the Peer-Consumer/Family Member-Caregiver WET Board for the state of California. I found my team members to be diverse ethnically (SO important!), but they were all family members. I was the only MH Peer, and our agency leaders and facilitators were very kind, but also not peers---and seemed to have no lived experience of any kind, at least that they disclosed. I spent a LOT of focus and energy on amending language for what came out of our team's meetings, and really, honestly, TEACHING our whole team about the concepts of recovery, peer self-help and services, and trauma-informed care. I very much enjoyed my time on that team, and did feel like I contributed...at least to the policy documents we produced. I am not at all sure what efficacy that work had for my, or any of, our CA counties. There is, as you know, an enormous amount of disjointed incongruity that is normative in ALL of these public/govt systems and processes. And in that constant dislocation, breaking up of teams, loss of participants----MASSIVE GOOD WORK IS LOST. It is a shame, and consumers are the ones who pay the most price for this. The peer/recovery movement overall ALSO pays a huge price for this.

NAMI does not really have any barriers as we are very welcoming and open to all. While we have a Family Support Group and Family to Family groups in Spanish, we need more Spanish speakers to open up other groups. We have the support of our agency but we need to help families remove stigma. We need to reach out more to others. This can only be done by helping those in the groups to realize they can be role models by speaking up about themselves/their loved ones.

**BARRIERS TO RECOVERY ORIENTATION ON THE COUNTY/LOCAL SYSTEM LEVEL**

**Client/Consumer, TAY, and Family Member Assessment of Local Providers**

We asked self-identified clients/consumers and TAY who have received services in the PMHS and their family members:

- What barriers to recovery orientation have you observed or experienced at your/your family member's current or most recent PMHS provider agency?
- What resources, training, or support does this provider need to become more recovery-oriented?

The write-in responses listed below were most relevant to these questions. Some responses have been edited for clarity, brevity, or to remove identifying information.

- This provider should begin the services by acknowledging that recovery happens and then support clients with identifying and achieving their personal recovery goals.
- THEY DIDN'T TALK TO EACH OTHER - THE SOCIAL WORKER, THE PSYCHIATRIST AND THE ADMINISTRATIVE PEOPLE. ASK THE SAME QUESTION 100 TIMES.
- Everyone is not the same and one size does not fit all. When someone is unwilling or unable to use the recovery tool given, give them a new tool, and never use family visits as a motivating or compliance tool. If that is all there is to take away, you have taken to much.
- Sometimes I need to meet with my Therapist/Social Worker and/or Case Manager more often than every 2 or 3 weeks because I need more assistance from them in my goal plan work or when my emotional stability is not great. They are not always available, but not because they do not want to be available, but because their case load of clients is very high and they often don't have the time to meet with me bi-weekly, or at times when I am in crisis--weekly.
- Need for career support groups

- If the center does not have WiFi service, what is BCMH afraid of? It's time to stop the stigma. We need the WiFi service. Also the clients have been trying to ask the powers that be for crosswalks in front of the center. We need the crosswalks. Thanks!

- [Center] providing peer driven model, venue, education. Employment, parity, opportunity, wages, inclusion in systems engagement.

- I have observed overmedicating ....and on the flip side I have seen providers berating patients that self advocate. I have experienced a provider that wouldn't provide paperwork in a timely manner to for medication dispensing ...and forced appts.. due to patient address change (when said patient did not have insurance)...

- They still need to include family input more

- I would like to see my provider include ongoing classes on the following topics: how to live life when out of care How to build self-esteem How to build self-worth Dealing with triggers Dealing with Social Anxieties

- Barrier: If the provide knows [client] has family, they back off, so then we have to do everything. Part of her coming home, was knowing that we would have support from the Provider. Feels like we are doing their job. Provider visits once a week for less than 10 minutes, and asks the same Yes/No questions. They don't spend meaningful time with her, nor help her in actually achieving her goals. Resources: Communicating with families, if they are they are involved. How to actually help people in achieving their goals (i.e. create a plan, steps to take, support when things get difficult). Recovery oriented goals: Provider only helps if the focus is on medication and symptoms. Otherwise they just list goals and send her off to figure it out.

- Provider has not demonstrated any meaningful support in their service delivery.

- They generally have not had enough time to spend with me developing a plan that encompasses all the aspects of my recovery

- The office is too far away from where I live. It is impractical to travel that distance often enuf to really get good care. Services are needed in [City]. But [City] won't provide services because they don't want the "riff-raff". [Provider] staff (not counting the receptionists) seem to be mostly burned out and indifferent to my Truth and my needs. They are too limited by their procedures and technology and facility to help me effectively. I cannot choose who I'm interacting with without a big ordeal of filling out forms. I don't do well with "appointments". I prefer to drop in and talk to Peers. But since I have to make appointments for formal services like "Therapy" and "Meds", I went thru the motions. Neither of those "services" were delivered with any satisfaction and actually traumatized me significantly. I don't think I should have to make appointments to get help with things that I just have a hard time with due to my symptoms. If my needs weren't taken care of by one worker, I had to wait another extended period of time for an appointment with another with no knowledge or control about who that would be or whether they could even help me. I need to come in when I'm ready to come in, stay all day and get everything taken care of in one go. I cannot rely on myself being ready in advance. They are drug-pushers. I hate drugs and don't want to be dependent on a pill that I have to take every day, but they told me that's what was "indicated" for my "symptoms". I don't feel safe around people pushing drugs on me. And ironically, they also implied that I was an addict because of WHICH drugs I preferred to take - even tho I only want to take them very rarely IF AT ALL! This is insulting and violates my right to be treated with dignity. I don't care if all public service agencies are forbidden to prescribe certain drugs! That doesn't mean they get to assume that I'm an addict just because I can take those drugs without abusing them and I prefer to do so! I anticipate a day when I don't need to take drugs at all, but if I have to deal with service agency staff accusing me of crimes or
bad behavior with nothing but statistics and absolutely ZERO knowledge about my actual behavior and history, then I'm gonna need to medicate myself just to get thru those interactions!!

- More focus on helping patients live independently and set goals and what to do to achieve them. She has a case worker but those things aren't set.

- Too many cancellations for appts made by clinician and poor follow up with medication supports

- Agency has made changes to be recovery oriented. Frequent staff turnover requires continued training and emphasis on recovery. Family member has persistent, serious, chronic mental illness and is considered "too high functioning" for most county consumer group activities.

- The barriers are numerous, but out of control of the provider agency. There is no housing available for my family member to move, subsequently he is "coasting" until an appropriate housing facility can be found. I would suggest more programming for older adults, at the provider agency, because more and more of the "tenants" are in the same situation as my family member. Progress is possible for all - even the older clients.

- Community communication of more training towards recovery

- Education on the power of Peer Support

- Threatening to drop my family member if they don't complete certain goals.

- Unless you have a co-occurring disorder, they don't offer any sort of groups to help you on your path to wellness or once you've gotten there.

- ALL about medication management, inputting data in computer, scheduling next appointment. Everything I read about "recovery and wellness model" as opposed to "medical model" was mere theory and not reflected in practice of the the County MHD when I was a client. My sense is that what the psychiatrists are taught in college is lacking courses on recovery/compassion/empathy/trauma informed/peer specialists/holistic approach. Once they are employed with the PMHA with all its bureaucracy and their caseload does not allow them the time to take the continuous learning trainings offered to learn about recovery/compassion/empathy/trauma informed/peer specialists/holistic approach... It's meds, computer data entry, schedule appointment, repeat. Our county has adopted the MORS scale which codifies the client's recovery. Reducing clients to more numbers DSM number/label, patient number, rather than the quality of the client–therapist alliance... It has employed peer workers to facilitate WRAP groups the last 5 years. Virtually eliminated therapy sessions. I believe our former Director did not do an adequate/proper job in integrating/introducing the peer workers to the "providers/clinicians" since 2009, and we have been trying ever since to education "providers/clinicians" on the benefits of peers as part of the treatment team and having something unique to offer and not to be seen as unqualified. We have a Trauma Transformed Initiative which so far has included a one time mandatory training which was very general, and nothing more since. When I expressed to one of my psychiatrists that I wanted to reduce my meds he said that I was "going against medical advice". Sometimes I think some doctors do not know the concept of "self-directed" "client driven" "strength based"... I would love to see our County adopt Dr. Pat Deegan's CommonGround a Web-based application that helps people prepare to meet with psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery.

- Accept and promote peer support

- Did not promote peer recovery assistance and wellness centers - did not present recovery model only medical model
I feel that our community wellness center is a wonderful place and I hope to bring different Digital Arts skills more so into our Computer Lab where I work. I have requested and received Graphics as well as Audio & Video Editing softwares and I hope for a small budget to expand our software and perhaps hardware such as a Camera and Microphone.. etc.

When I had to use a substitute case manager when mine was on maternity leave, the one I had didn't believe me when I told her I was a hoarder. I had just had a forced clear-out, so my apartment didn't look as bad as usual. I kept insisting I was, and she refused to believe it. Then when she came back at a later date, when things had started to get worse, she said, "Have you ever thought you might be a hoarder?" She didn't even care enough about me, take good enough notes, or remember that I had so emphatically told her I was a hoarder. She was so dismissive of my needs. I really didn't like my sub. My usual case manager was the most amazing woman ever. She was recovery oriented before the rest of her coworkers were. She went to amazing lengths to help me become a more functional and stable member of the community. She was the best. I'm sad I got discharged because I miss her and now I'm in between therapists and can't find one and need help, but no longer have a case manager, because her supervisor made her discharge me to take on sicker clients.

It takes a long time to get appointments especially if you struggle to get to them.

No older adult provisions under MHSA contracts. Not enough availability or staff of peer support activities, or has been largely curtailed.

Recovery should not only be looked at as [clients being] employed or healthy but on an individual basis per I.S.P. My agency never keeps up with my annual plan. They are never there unless you do a WALK-IN and need assistance THAT day!

They think I am ready to move on my own and I do not believe I am and I don't believe that is a good idea, More support groups, needs rides to appointments and to support groups.

I don't believe in recovery, per se. Late stage capitalism is devouring us all, and resiliency culture places blame on people for their problems rather than blaming social determinants.

I was an inpatient at [Hospital] when I was a teenager back in 2009, the services I received don't reflect how well they are doing now. This is only based off of my experience and what I can recollect of my time there. The nurses/staff were all kind, however, when it came to meeting with a clinician/psychiatrist (who I met with only once) I spent approximately 30 minutes to 45 minutes with him and within that time I was diagnosed which seemed rushed. He did not check in with me after that. We did have groups but there was no individual time. I was given Prozac to take while I was a patient there and a bottle for a months worth upon release. The medication was given to me by a nurse and I don't recall being informed by about the medication by the clinician himself. I was just given the medication and expected to take it. As a teen who did not know how to advocate for myself I simply did not ask questions and just did what I was told. There was no other resources that were given to me upon release or a warm hand off. It was much more so, here is your medication and good luck.

I have a psychiatric dr. I haven't seen him in 5 months. He had to take a personal leave and my clinic hasn't hired another one. I am furious that this has happened. We in Butte county can't pay a decent wage for a psychiatrist. So we have Doc in the box. The Dr's want us to follow his recommendation but that's not the issue I'm having. The Dr gives me a medication to be monitored every 2 months. I have the responsibility to take my medication and any changes that need it. I want to find another psychiatrist. I will have to skip my insurance and pay cash.

Attrition of consumer models, recovery based practices and systems
The most difficult barrier for our family is the distance my daughter is from us because there is no supported care in [County].

A judge mentalism type predominant attitude based on a bias mindset against those with lived experiences.

I prefer weekly therapy vs monthly therapy. I don't like that the clinic cancelled most individual therapy in the clinic.

Weekly therapy is more beneficial than monthly.

* My family member is currently receiving [County] services. I have little confidence in the validity of "intensive" case mgmt she is receiving. * I work @ [County] but get my own psychiatric / therapeutic services @ [Provider]. I have had [County] mental health services in the past. * I am glad I am not and would not want to be a client at [County].

Very few peer groups available

More Peer supported recovery practice

[County] BHS was very hard to navigate. I wasn't able to see my provider often. There weren't enough services for for people who didn't have case management.

Providers], two trauma-based care agencies, would be served by integrating more into the local behavioral health community.

Distance from home and loved ones, over a five hour drive to visit because there are no residential beds available closer that except medic-cal. No identified goals for her to work towards coming back home except groups that she refuses, one size does not fit all. Our goal is for her to be stable enough to move back with our family and receive services as an out patient in are community.

Maybe they need more education or experience; they do not have many resources nor trainings

Have unsuccessfully tried to engage psychiatrist in learning about catatonia to be more supportive to self and family. Psychiatrist needs to care to be educated to help me with managing rare symptoms.

Lack of supports and inclusion for immediate family members.

The provider does not work with the family. My brother lives with me and I have never been introduced to his team or asked how he is with the exception of his probation officer.

Employment services

Well, both clinics I receive care in are Trauma-Informed, and therefore inherently recovery (and healing) oriented. In fact, my main doctor, the one I started my trauma/mental health disability recovery journey with, has really enabled me to experience an ALTERNATIVE mental health recovery process over the years of my treatment. So, although I have had to utilize in-patient hospitalization a LOT over the early years (some of which was neutral; some of which was absolutely abusive and devastating), my journey through the PMH system has been mostly safe, dignity-protective, and HOPE-giving, NOT hope-destroying. I have never been treated in county mental health, other than hospitalization, so I've been spared the chaos and horror of what I call "the undiluted medical model" that most people in the specialty mh/spmi population I am close with have had to endure and try to survive. Many people I love deeply, including one family member, did NOT survive the county mental health system/undiluted medical model. I have thus worked very, very, very, very hard to stay OUT of that system. Because it actually RE-INJURES people like me, often to our death. Strong words, but I am speaking from massive personal experience with both loved ones and clients over two decades.
- It can take awhile to get appts.
- better services for those that are considered to be in recovery. What I can see is: at appointments they are asked 2 questions? Do you want to hurt yourself? Do you want to hurt others? If answer is no, then its, ok I'll see you in 3 months, here is your refill prescription. End of visit.
- Training like the [Agency] Provider class. Clinicians are understaffed and overworked. Clinicians are punished indirectly when they choose to spend more time with clients and/or their family because they would have problems meeting their quota of clients they are supposed to see
- The agency is somewhat far from our home so difficulty in getting there for extra activities. Need more wrap around services at this agency.
- They changed the role of case managers. we are no longer assigned a case manager to help us with various issues and check in with. This impacts recovery by eliminating a support system. Also, long-term therapy has been eliminated. Therapy is not offered to everyone, but only on an emergency basis and for 6 visits. Therapy is not offered on a weekly basis. Support groups are not offered. there is no info. offered to clients/patients on recovery or what recovery means, how to achieve it or maintain it or what it looks like. Do the providers know what it is? It's not clear to me what it is. Providers need training and resources on it. Perhaps an interactive workshop for providers would help. Not a lecture because those are boring and people zone out or just play on their phone.
- There are not enough case managers or peer outreach. My son is becoming lost in the system. He always does better when he has access to a case manager. Always!!! They are worth their weight in gold!! Medication and a roof are all that seem to count and it doesn't matter that he is too fearful to step past the pavement outside his board and care.
- Most services are crisis-oriented rather than recovery-oriented. Support & education for family members is lacking, but [Agency] does offer this. Agencies could do much more to solicit family involvement in recovery. Consumers also need better support for finances, housing, skills training.
- II have successfully managed with minimal services from the county being able to manage my life as independently with a bipolar and PTSD diagnosis, but without the support from many I would not be able to be where I am today. The County has provided me with enough services that I can say that the County is doing an outstanding job of providing the best care given the money and time constraints that must be considered.
- The only barrier I have ever been affected by is when a staff member leaves and they are awaiting a replacement so they may not be able to provide therapy on my regular schedule.
- RST's surely needed to listen so much more to consumers needs especially what we need to successfully achieve recovery and the journey we take on that path. Sharing or asking if we are aware of community resources or providing a list of them.
- County therapy has been awful & no help. Resources are not always provided
- I am discouraged. Not just for me. But for the entire client base. I am a survivor of the crack epidemic. Many of my issues are just catching up with me. Much of the funding coming down the chute is being geared to the new opiate crisis. Yet, the Wellness Center is held up as a model for relief of recovery success. Not so. It is run half hazard. Barely scratching the surface of meeting the need of the survivors who frequent this center. Showers and snacks do meet the bare necessities but we, I need more.
A former county staff member, who moved to another county disclosed to us, that the internal culture at our county Behavioral health department does not really find peer involvement and employment at the county desirable, even though under MSHA, ADA, and the Disability department of the labor commission it is required, just like Affirmative action is required. So, at best peer involvement on Advisory boards and contracted peer services are more of a superficial, cosmetic placating rather than a genuine integration. This has to shift. I have also noticed, that even though people are able to manipulate documents to make things look right on paper, that the checks and balances accountability and integrity are missing.

- Housing

Local System Leadership Self-Assessment

We asked self-identified leaders from County mental health agencies and local oversight/policy-making bodies:

- What barriers to recovery orientation have you observed or experienced in your County/local mental health system?
- What resources, training, or support does your County/local mental health system need to become more recovery-oriented?
- What specific actions can your County/local mental health system take to become more recovery-oriented?

The write-in responses listed below were most relevant to these questions. Some responses have been edited for clarity, brevity, or to remove personally identifying information.

- There is not enough training, initially and ongoing for leadership and service providers regarding recovery orientation. Peers/Consumers are not at the table enough to weigh in on services and when they are they have minimal weight in shared-decision making. Drop-in wellness centers are extremely valuable, more respite resources, transportation services, and personal coaches to aid consumers throughout their journey that do not depend on billing quotas with streamlined services that do not promote the flexibility/unique service provisions that MHSA does. However, if billing is necessary I think FSPs should be required to meet a 50% MHSA service delivery to their consumers.

- There is still a clinician knows best attitude. There needs to be more training on trauma informed care, on cultural competency and on the advantages of Peers. Peers are still not hired enough, used enough, paid enough or understood enough. Hire more Peers, have them provide trainings and outreach to administrative personnel as well as clinicians. Standardize the Peer certification state wide so there are better parameters and our roles are more clearly defined. Pay a living wage so that more Peers are drawn toward this role and able to live while doing this work.

- The system is insidiously reverting back to the medical model. Consumers have lost ground and although some providers believe recovery is possible, at the executive level, former consumer liaison employment no longer exists.

- Barriers: Not collecting the data, no consistent data collection. Leadership sends peers to recovery oriented trainings. Non peer staff, supervisors, and managers don’t attend. Programs often don’t provide the same level of support for non-mental health goals, like employment. Very little offered to assist with integrating into the community, building social support, having friends.
- I believe the stakeholder process needs to be more open to community members. There have been no public hearings other than a few minutes at the start of MHB meetings and there has usually been no public comment on annual and three year plans. My family member has been well enough to avoid hospitalization for several years and that has been the "recovery goal"

- Most of my observations are of Leadership and their philosophy and in the local committees I attend. We need permanent staff - some of our most effective employees leave for other jobs - and we are back to ground zero in developing relationships. Those who have been here a long time are indeed recovery oriented. We need more adult residential housing to help ensure recovery.

- One major problem that I constantly hear is that the PMH Practitioners are not always friendly and it feels as if they do not have the cht's best interest at heart. Many have complained that our system is still a medical model and that practitioners need to get onboard that everyone does not want to be on medication and in light of that it should not be held against them and the service provided should still be professional and uplifting. Other options should be offered because medication is not the only way to recovery.

- *There has been a lack of trainings for staff and little to no support for the family members of peers/clients. *WRAP training, Work Force trainings to support clients/peers *I believe it is important to train ALL staff with the recovery model, motivational interviewing, etc.

- *Peer employment opportunities exist within MHS, but more full-time, benefited positions are needed. *We have one half-time Mental Health Advocate (peer providing system navigation) for the entire County. Need up to 3FTE to meet need. *Trauma-Informed Care is catching on; more training and policy crafting to continue the good work *A peer position as part of County Behavioral Health leadership would help immensely

- [County] is an underserved county with housing shortage for clients when living in the community (homeless, mental health, dual recovery); and shortage of physicians (psychiatrists) in the area. The county utilizes its resources to its full extent to really provide services to as many as it can, going over budget to do so. The county, with private, large medical organizations, attempt to recruit physicians to this area and create more service providers with the goal to be available to everyone that needs their services.

- Line staff wants to implement recovery principles but senior leadership policies prohibit or hinder implementation

- Lived Experience employment, Parity, More MHSA funding consumer recovery models, more integration with state level Recovery culture

- It is very difficult to know the answer to many of these questions with complete certainty. The systems are very large, complex and uneven so one answer does not cover the entire system. Also, where are the results of last year's survey? Since their answers would probably be the most accurate, where are the responses from the MHSA coordinators?

- Need more training consistently & regularly scheduled on how to integrate peers in planning, case plans, policy, etc.

- More training on recovery principles & language; medical model or a deficit model is still present.

- (5) Recovery Outcomes Data Collection Tools - pending implementation
(5) Data Collection Tools - In process: We will be using "Reaching Recovery" tool. (10) Additional Feedback - We are in process of (1) hiring new peer positions, (2) offering training on ROSC, (3) integrating MHSA, and (4) implementing new Recovery Outcome Tool

When clients are passive, the system is not proactive in encouraging these clients to get more involved in their recovery. Resources/trainings that could help the county system in developing adjunct resources (such as peer support services) to assist social workers/clinicians/case managers in helping clients move beyond crisis management and symptom & situational stabilization on to wellness and recovery goals. Increasing peer support opportunities.

1) Ongoing stigma issues. Need formal training on recovery model and peer inclusion as a mandatory requirement. 2) Outside evaluation of peer staff and their meaningful inclusion. 3) Peers at all points of entry: * Peers at executive leadership level * Targeted training on peer inclusion and evidence-based practice of peer support to all staff

* Lack of specific services tailored to recovery orientation (recovery orientation is integrated in other services) * Provide specific services with recovery orientation framework (focus on recovery) * Provide opportunities for new companies and agencies to provide services at a smaller level, more service providers to reach more individuals - giving better engagement

1) Observed barriers to recovery orientation that I have witnesses include self-stigma, stigma surrounding MH challenges in the community, and (at times) stigmatizing / non-culturally competent language used by MH professionals / those interfacing with those experiencing MH challenges. 2) More outreach campaigns aimed at reducing stigma in the general community; more consumer / client involvement in stakeholder meetings / processes; reducing significant barriers to accessing therapy (insurance, cost of treatment, transportation). 3) Continue with trauma-informed model of training and support among behavioral health systems / in the community; more interdisciplinary training with medical providers in particular on recovery model and implementation.

Folks like their clients and sometimes keep them longer than they should; maybe in lieu of helping to teach our people how to access and maneuver through the healthcare system independently or w/ some support.

1) The multi-disciplinary team does not embrass peers. 2) How does multi-disciplinary work; what are our roles? 3) Build teams - Team Building

I would love to see the culture of the agency and the county services more broadly change to a culture of recovery. There's very little of it now. It's primarily still medical model, and there's not a lot of values and principles in the various agencies which are in line with recovery principles.

The county focuses most on productively, not enough trauma informed training for all staff and high case loads and inadequate support lead to a revolving door of staff leaving or being fired.

More discussion on person first language, and emphasis on recovery language. Solano County is in the process of hiring 3 full-time peers, a shift is happening in the consciousness and awareness of the County.

If we could be offered a half day training (or a 2 hour --shorter in length training) to do a Recovery 101 or strengths based approaches--just as a refresher for staff.

I wept filling out this survey. The peer/consumer clients I and the other peer service centers serve come to us as REFUGEES from BH and its conventional stakeholder system. The peer-run centers are crisis centers---or
were for 10 and 20 years, respectively, until they recently (about 18 months ago) became far more co-opted into the conventional mh and agency system, here. And how we are losing all but ONE of those four thriving peer-run centers (we get to keep the oldest one, which is funded through SAMHSA, not MHSA). Even before the budget disasters began in early 2018, things were terrible, here---and the only real hope and help resided in peer/recovery---our 30 year old local movement and the services we and our allies have co-created together--ALL of which massively bloomed, just as intended, when MHSA/Prop 63 passed in 2004. It is all about to be erased. Just unbearable. :-(

- All workers (DMH funded agencies) need to be on the same page. Multi-disciplinary teams need trainings to raise awareness, educate with why working together will improve outcomes

### All Stakeholder Assessment of Counties/Local Mental Health Systems

We asked all stakeholders responding to our Survey:

- What barriers to recovery orientation have you observed or experienced in your County/local mental health system?
- What resources, training, or support does your County/local mental health system need to become more recovery-oriented?
- What specific actions can your County/local mental health system take to become more recovery-oriented?

The write-in responses listed below were most relevant to these questions. Some responses have been edited for clarity, brevity, or to remove personally identifying information.

- To become more recovery-oriented, we need to first 1) be mindful of our budget. There is a huge budget deficit and the greatest impact it has had on our Behavioral Health Department has been a significant and detrimental impact to our peer support services. Without peer support it hurts our mentally ill and homeless population. We need support from management and them to understand the importance of peer support and how it impacts the community in a positive way. This is a HUGE barrier and there is a stigma in our department and gap between management and peer support specialists. It's heartbreaking and devastating to see the deterioration of consumers because of the lack of understanding.

- Work with clinic staff to better understand and appreciate peer services. More peer services in other locations (hospitals, walk in).

- While outpatient treatment and the recovery model are ideal, there are those who will only get better with inpatient treatment and must take medication (at least on a temporary basis) to become stable. Then they can transition more to the recovery model.

- I think a barrier to recovery is the idea that people to "stabilize" before they can have a purpose to devote their life to, such as volunteering, working, attending clubs or meetings, having a hobby or otherwise participating in their community. Purpose is a key component of recovery which augments the other components. Many clients I work with may still need a lot of support with their medical care, housing, etc, but they are always eager for something purposeful to do. I've seen the transformation that happens when people have meaningful activity they can devote their time to and the sense of community that can come from devoting themselves to a purpose. I think to have a recovery-oriented system, purpose needs to be supported from the beginning of a client's recovery journey. Purpose could be a small thing like supporting a client in a hobby like reading or drawing.
Even someone in an inpatient environment can be supported to have a purpose in this way. I think this is an area that ought to be emphasized as part of a person's "treatment".

- Ambulatory health system taking over management of mental health services for clients considered mild to moderate. This is a medical model and transition is showing little understanding of services needed to support recovery. We need staff peer providers at higher levels of management, a higher proportion consumers on the behavioral health board, on the MHSA Stakeholder Leadership Committee, and on our Board of Supervisors. Executive management could see that the long-promised career ladder for peer providers is instituted, that the Director of Consumer and Family Affairs with lived experience AS A CONSUMER - is hired, that the role of peer providers is clear and understood by managers and other staff, that peers are accepted as valuable members of treatment and other teams.

- [County] needs peer support specialists who are certified to walk alongside clients. Resources need to be readily available online and through social media as well as mobile phone apps. Mental Health First Aid should be treated as CPR for physical health. There is an inability to advocate for oneself when in the midst of a mental health crisis. Having peers who could advocate for clients and are further along in their recovery could make a big difference in obtaining client's recovery as well.

- Not enough Peer Specialists hired throughout the system, especially in the Patient's Rights Office, Peer Specialists need to be working Department-wide. LA County is not doing enough to put Peer Specialists in all areas where Clients are served so that there are more examples of Peers in Recovery all around other Peers, who need more role models. Peer Specialists all have other skills that can be utilized, but at this time are not being used to encourage, inspire, and get Clients out of their helplessness mode and into active Recovery mode.

- have all stakeholders be part of the decision making process of where the money is actually going to go. i do not believe 'peers' or family members are involved in this in my county - and they should be.

- Carve out more time for Drop-In. As well as more services offered to Drop-Ins. I was insulted by someone when I was unable to get to an appointment on time for something that could easily have been handled in a Drop-In format. Appointments are a burden on and a barrier for those of us who have temporal symptoms and "lower functioning". Being on time for an appointment is not always proof of "respect" or whatever and it's "Ableist" to punish people by public shaming if they can't do it. Non-Crisis services! It's insulting and ineffective to make someone wait and make an appointment when they are not okay just because they are not in danger of hurting themselves or others or in immediate danger of being actively harmed by others. I want to see 24/7 Intentional Peer Support Services (ala Steven Morgan and Shery Mead) available for folks who are just not okay BY THEIR OWN DEFINITION! There are countless scenarios that cause a person to feel not okay and this should not be determined by anyone else! If they have to escalate a situation UNTIL IT ACTUALLY QUALIFIES AS A CRISIS in order to get needed help, then the services that are provided are actually DOING HARM! I've already made other points in my comments above. Lay off the employment push! HART is already sucking up lots of funding because ignorant people believe that employment solves all problems. They are succeeding in taking only the highest functioning individuals off the street (which leaves the street an even more dangerous place to be) and putting employment providers in need of more support for help with difficult people. I spoke with someone who was doing work in my residence for AT&T who said that a tool they relied upon to do their job was no longer provided by their employer because they were being stolen by employees, so they had to provide those tools themselves if they wanted to use them. This is typical of what happens when people are pushed too hard and too fast to get a job in order to qualify for services. Find other ways to help these folks be productive and have a sense of value and meaning. Not only that, there are people who are just too traumatized and anxious to function well in employment relationships and it's destructive to further stigmatize them as being lazy or stupid
just because they are so sensitive and fragile. Work environments are harsh and often dangerous and supervisors disrespectful. Not everyone can sustain performance in those conditions. Being able to stand up and put tab A into slot B and to speak words without falling down dead does not equal employable. Enough already!

- Peer support is ineffective. Unable to listen actively, only passively. No skillful means. No interest in gaining insight or growth. Clients encouraged to avoid self improvement. Money wasted and benefits exaggerated. No outreach efforts. Avoidance of high functioning mental illness. Clients trained to parrot positive feedback, criticism avoided. Only easy low hanging fruit paid attention to and complicated cases avoided. TERRIBLE STATE OF AFFAIRS.

- More supportive services and NAMI educational classes. More help with affordable housing for people with mental illness on SSDI. More psychiatric facilities in our area.

- Lack of transitional housing for those that need time to accomplish permanent housing, income, employment goals and legal issues.

- Housing. Permanent housing. Transition before exiting needs to be complete.

- training for strength based therapy/services. ANY DOOR WILL DO services (NOT mental health or substance first, RATHER housing or food security or transportation or any door) Supported employment.

- Stigma inside the system, by the administration, program supervisors and managers. Firmly entrenched medical model. Mandatory trainings for clinical (ALL-at every level) on recovery and peer support.

- There have been changes and turnover in administration and staff that seem to have made continuing on the recovery model path more challenging. MHSA funds have provided critical support for changing infrastructure and remodeling staff functions.

- Not enough people know about the programs. The entire community needs to be involved i.e., service groups, churches, schools etc. not just the mental health community.

- Our county has a severe shortage of clinicians, physicians, youth AOD treatment, and permanent supportive housing. I don't know what training would be necessary to address the lack of services we have. We need providers before our county can become more recovery-oriented. Our county lacks the providers address the needs.

- We have several effective programs, but they don't communicate with one another and the clients don't know about them. It would help if there were more ways to integrate services and not operate in silos, as if all of us fit into a box of one diagnosis or type of treatment. Also, our wellness centers are in need of expansion and we need more peer support.

- Housing Services is the BIGGEST problem, lack of proper support in all levels of housing.

- Large rural county... need decentralized system of services. Significant Native American communities/tribes... need to develop long term co-location of services that are culturally appropriate. And there is a need to substantially increase services for transition age youth.

- Seems that I keep seeing upper management level positions being opened and hiring. While our peer workforce continues to slowly fight for a career ladder and reclassification. Stigma amongst staff both providers and peers. Resume hosting event in observance of May is Mental Health Month to bring department, contracted
agency, and community together to share resources and information on "recovery orientation." Purchase tools developed by peers, and hire trainers who are peers, e.g., Pat Deegan's CommonGround web-based application that helps people prepare to meet with psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery; Dan Fisher's Emotional CPR; Sherry Meads Intentional Peer Support; Western Mass Recovery Learning Community Hearing Voices Facilitator training. Now I'm beginning to wonder if "recovery orientation" and County PMHS are mutually exclusive?

- [County] is an underserved county with housing shortage for clients when living in the community (homeless, mental health, dual recovery); and shortage of physicians (psychiatrists) in the area. The county provides as much as it can with its resources to as many clients as they can. The county is working with private providers to create housing opportunities and bring in providers with the goal to reach all clients who need their services.

- I noticed a pick and choose, of who we assist. SMI individuals who are homeless have a slim to no chance of obtaining housing on a section 8 voucher but that is why we need more respite, board and cares and shelters.

- lack of financial support and true understanding of value of peer to peer group WRAP services and value of Wellness Centers - I am a supervisor working only 20 hours and have a 60 hour a week job - I love my job and feel that with my education I can seriously contribute to job and thus the Wellness program - however, I will eventually have to succumb to my underemployment in order to meet the demands of student loan repayment and my mortgage requirements. I have a masters degree in Psychology.

- I find too much push of drugs. I myself was nearly dead because of the meds Doctors insisted i take with subtle threat of non cooperation toward my goals in health. I believe there are many resources for calming methods and peace of mind besides drugs that cause too many problems past short term guidance. I believe that supportiveness and acceptance that MANY SEE LIFE POETICALLY and are not harmful and should be accepted as Colorful :) < 3 < 3 < 3

- We need a large scale healing community with full family and individual support services and housing. We need to utilize a multitude of healing modalities and get outside the box with our method of trauma and addiction recovery.

- More peer-led and peer supported leaders to outreach to individuals

- There are not enough adequate and less expensive mental or behavioral health providers available to receive treatment within a reasonable time. Private health insurers are providing less and less benefits for mental health treatments, procedures and therapies that are so complex to begin to receive so this forces the insured to look elsewhere for help and adds to anxiety, but there are not enough services throughout. In addition, community services are too connected with addictive behavioral programs which is a separate healing/recovery process than non addictive behavioral health. They are not the same - they can be at a particular level of treatment, but not at every step including primary support. For instance, procedures for MDD such as ECT or TSM are not treatments an addict might receive. Please keep these behaviors clearly separated.

- General recovery training for peers and staff. How to set up recovery outcomes in system; macro and micro level.

- The lack of communication and access to information between departments such as social services and mental health is a huge obstacle, as well as county to county for transfers and foster care. Training of correct protocols seems to be lacking in other departments and counties or maybe it is a also a lack of pride in the positions and
being of service. I would love to see more of the incorporation of spiritual and mindfulness practices in wellness and recovery for all ages.

- Diminished or eliminated WRAP classes. Restore [Provider] contracted agency. Share resources and increase collaboration with Recovery Culture

- Lack of mental health workers in jails. Needs to be 25/7 instead of just Monday to Friday 8-5 PM. Lack of adequate funding to organizations that provide peer support services. Needs to be a living wage in retention of staff. Surveys needs to be part of contracted services regarding the services it is receiving with MHSA funded programs/providers. (This is coming from consumers and families)

- They need to stop changing doctors/service coordinators so I may start to establish a relationship and build trust.

- We need universal basic income and guaranteed housing in a housing/income-first strategy. As automation grinds forward, more and more people suffer mental health issues because of the social determinants of the antihuman effects of late stage capitalism.

- We need more housing areas and opportunities for formerly incarcerated people with drug offences; especially parents. ADD regulations so this can be done

- More judicious use of Emergency Housing. The person should either be a vet or quite ill or have minors with them with no availability at the shelter(s). Or, it may be used as bridge housing.

- More awareness of resources available / more classes in recovery

- I see the clinicians as a huge barrier. I feel as a peer staff clinicians use far too much jargon and terminology. Far too much negative language towards clients and families.

- The crisis center in [City] needs actual beds or cots for people to rest & get sleep, NOT chairs. Perhaps more funding for the crisis center.

- More involvement of current clients and advocates in decision making and planning. There is decrease in transparency occurring in our system.

- Strong division between clinical team and peer support. Silos.

- Housing would be the #1 barrier along with food. I believe when basic needs are met people in general are better able to focus on their personal recovery. Another barrier is not having enough staff to meet the needs of the persons coming in for services. Many times when clients come in for services because they’re desperate and at the breaking point, contemplating suicide, they’re asked to wait as long as 2-3 month to get an assessment or see a doctor for medication. Or will use the hospital for a warm bed with a meal due to being homeless or detoxing off drugs instead of going to rehab because the wait time to get into substance abuse inpatient programs is 3 months due to lack of programs. Programs need to be created to assist not only adults but single parents, LGBTQ and those in committed relationships and or those who have a pet. There only 3 shelters that impose their religious belief's and will segregate people from their loved ones, and some of those living on the street with trauma have only had the unconditional love of a pet. Asking those individuals to get rid of the only source of love they’ve had for a life time is immoral and unjust. Just because a couple isn’t married shouldn’t dictate if they are allowed to receive housing together no matter if gay or straight. Mandatory culturally specific to Peer Support specialist who have been discriminated against or stigmatized by the very staff who work within
MH with the language of said staff specifically stating things such as "well, what are you an axis one or two" or been told "I have a bipolar out in the lobby do you think you could meet with them" or "but your high functioning" for the first offense then written up for non-compliance if the behavior continues. Mandatory compassion fatigue training for Nursing staff at our hospitals. mandatory training for OA staff who continually treat consumers with distain and are rude in both gestures and the tone they use, rolling their eyes when challenging consumers walk into the clinic.

- Counties need to focus on building their peer workforce as the provider community ages and retires. Peer support can provide services that will ease the need.
- * Barriers: No means of transportation/communication. Many consumers do not have a phone thus DBH staff cannot contact them. Also, they sometimes don't know day/time. No transportation; attempt to walk to appointments. * Train staff on more recovery-oriented methods/programs. * Make that our goal, our everyday goal.
- * More resources/support for peer employees * More options for supported education *Involve peers in your higher level decision making
- 1) Parolees cannot always seek services w/o the possibility of violation 2) More advocacy and knowledge of MHSA 3) More proactive outreach
- * Lack of affordable housing. * The employment and education system for clients needs to be enhanced. More opportunities & resources need to be made available to clients to assist in educating, employing, and empowering those that want to grow in these areas and also as a way of reintegrating into the community.
- Training of staff, consumers, & family members about what recovery & wellness is.
- * It is difficult for individuals to access services in a timely manner. * Individuals not sure how to access services and how to advocate for self or family member. * Ceding to the consumer, individuals, or family.
- * Staff uninformed of or ignoring recovery model & its importance in all work w/clients. * Ongoing training requirements for all staff to support/inspire recovery work. * Peer-advocate staff organized professionally to be aware of each other's roles, programs, ideas, etc. * Expanded peer-advocate staff * Training for all supervisory/managerial staff in values & principles & effectiveness of peer-advocates. * Paying peer-advocates commensurate w/ professional roles.
- Rural nature of the county and labor pool in those areas. Offices in rural areas manned at consistent times. [...] Maybe a "mobile office" to drive to a rural area.
- The primary barriers I have observed are lack of permanent/supportive housing, transportation (especially for individuals w/ disabilities), and lack of culturally-competent clinicians to serve our diverse populations. More intentional collaboration between BCBH and contracted providers. Person-centered training for staff at ALL levels, including clerical.
- Barriers: education of differences as well as success of recovery orientation awareness. Resources: need more work on entire society not just mental health community
- Because I work in a rural community, being MHSA Coordinator is only 1 of my 4 roles. Dedicated money to support MHSA coordinators only.
- Not enough physicians & case managers. Clients need to talk & vent on what's going with them & how they are feeling.

- 1) Housing. Improperly trained staff. Lack of cultural humility. 2) L.E.A.P. - Listen, Empathize, Agree, & Partner Training (Dr. Xavier Amador) 3) Training - see above. Ongoing professional development of all staff, especially line (boots on the ground) staff. Education support / incentives, etc.

- There is still a great deal of stigma & discrimination around receiving mental health services. Also, discrimination around people with mental illness. More effective outreach and education needs to be done to reduce stigma & discrimination.

- * Barriers exist with physical healthcare partners and the staff in the ED's. Physical health does not want to have our folks in their clinics or ED's. * Good peer development training and empowerment program to lead to employment or sustain employment. * Provide robust support and services / education for families.

- 1) Employment 2) Employment & housing 3) Provide more services to help consumer become more independent.

- * Barriers I have noticed include language spoken & general geographical barriers & everything that comes with that - transportation, child care, mtg times. * I think the county needs to be able to spend more time building relationships with the community on their time & in a culturally sensitive manner.

- * Not enough consumer input * Peer Lead Trainers with peer support background * More peer leadership positions created to help clients navigate our mental health systems * More peer support certified trainings * More peer support programs that are client driven.

- Not enough peer groups. Not enough peer employment. Not enough peer-run recovery center.

- 1) LADMH security, staff discrimination 2) compassion training 3) Employ peers, allow peers to participate in

- 1) Trained medical doctors still believe in converting LGBTQ members into straight. 2) Peer-run support groups. 3) Medical doctors and clinicians need to learn how to switch hats between "evidence based" and "recovery based."

- Permanent housing opportunities for individuals with criminal backgrounds recovering from mental illness/substance abuse. Options for them become limited when you can't find housing options after leaving program.

- Little to no transportation, little to no housing, few options for physical health and educational opportunities, little or no support for clients to utilize holistic treatment and few resources for services outside of mental health such as exercise, groups and hobbies. More trauma informed training needed.

- Lots of barriers the fact we are the poorest county in the state does not help. We have a huge homeless population and substance abuse and domestic violence. I would want the county to be more proactive and allow us to continue to grow as peer supporters and anyone working in mental health to grow and continue trainings. The county needs to understand how important Certified Peer Support Specialist are to the team.

- When MHSA dollars are used as a match for MediCal dollars they become audited by a heavily medical model system. Our system could become smaller and more recovery-oriented by limiting this practice. MediCal is the biggest obstacle to recovery, especially inpatient. Non-profit contractors are likely the most recovery-based
providers, but their contracts include minimal staff development and are often frozen in rates, forcing decreased staffing and recovery suffers.

- Need more affordable housing for MH clients
- Need more public awareness and education
- Housing issues in general in the Bay Area.
- The county mental health system needs to employ more trained and compassionate professionals.
- We need a drop in center for daytime access where we can be with other consumers in a safe place, away from the weather. We could also pick up resource information there, maybe do a load of laundry or take a shower, have use of a microwave. We could play board and card games (no gambling). We could be in there while we wait for our appointments with psychiatrists, nurses, case managers, and other staff.

- 1) time & hours 2) funding & staff 3) not be judgmental
- Number one barrier for the Hispanic community is language, lack of empathy from the professionals. There is the need of more training on empathy training.
- Long waits for appointments for assessments, seeing a therapist, medication coverage.
- Definitive barriers apply to all, learning the BEST way to speak and communicate should be a lesson taught to any and all clients and advocates.
- Work more with the family that is taking care of the basic needs and providing ongoing supports to my family member.
- Lack of awareness by professional providers regarding the needs of clients of PMHS.
- More Peers. Need hand holding to continue on wellness path. It is hard to treat a brain when steps are even difficult for well people to take. Follow up and more peer help to continue onto the next step.
- Lack of peer support
- Train clinicians in solutions-focus therapy and narrative therapy and CBTP(CBT for psychosis). Also train family in CBTP (there is a family version). Also Beckian Recovery Oriented CBT (in Beck Institute).
- Currently we need more comprehensive wrap around services provided in living situations. (Especially for those with severe mental illness.) A supportive and therapeutic environment. Is the most effective recovery oriented setting I can imagine. Medication, and medical services, social support, wellness groups, fitness groups and a "park Like" serene and green environment surrounding it.
- The psychiatrists operate from the medical model instead of the recovery model.
- One barrier is that hope for recovery is not always present because what is hoped for is not possible in this world. I have as Thoreau has, marched to a different "drummer" and I would as one faces the road less traveled do not know which path to take as far as the County Mental Health System should take. The county's bottom line is unfortunately "what is cost effective?" And one cannot serve both God and Mammon, one must choose. It took me 26 years to get my B.A. in Religious Studies from SJSU and have dealt with PTSD since being drafted into the USMC in 1969. I would recommend prayers for the County because prayers are cost effective; they are free. Until our present administration puts a tax on prayers, I will trust Jesus to help me.
Help clients move out of Mental Health and into PCP maybe by stepping down from MH intensity for a while

I have found it very difficult to access mental health services. I have anxiety, depression, bipolar. So I'm not schizophrenic or act out, so I get referred to therapy, counselors, so my friends who go to behavioral health programs get help like I want to get.

I would suggest that providers and workers and volunteers give more direct feedback to the client about how well they are doing and what they think the problem is and make suggestions about how to encourage their recovery.

Finding the right fit as far as medication and the psychiatrist(s) who would agree to such term

Transportation, additional respite programs, housing. Support groups, crisis care. More participation w/client based determination and more wrap around services for community.

Communication of access to services -Marketing/accessibility -Be more transparent and inclusive (cultural competency) Keep in mind the make up (%) of population

Too many overlaps that result in no immediate services when in crisis -Better integration of communication between services and make access to services easier for those that need them -Identify mental health patients upon incarceration and attempt to get them the proper resources. Make access to medications, after leaving incarceration, easier. Spread services throughout the county. The concentration seems to be downtown and south Sacramento. There needs to be a greater investment in dual diagnosis treatment as addiction and mental health issues go hand in hand

Lack of facilitator-led programs for schizophrenics. People need to spend time with the mentally ill, at hospitals and community groups like Grace Community center. Offer more respite for caregivers. Fund the Psynergy program in Gilroy, which is a live-in therapeutic campus. Set up a temporary, overnight drop-off service so caregivers can get away for one or two weeks. It is super expensive to hire a live-in caregiver, especially when they are not really needed.

just dealing with all the mental games & what has felt like torture i've had to deal with with crf's housing dept & impact has been a gigantic challenge in itself. i stopped thinking about/focusing on any possible recovery years ago (in fact as i was checking out of a hospital a nurse told me chances are better than not i would end up killing myself so there's no point in returning as i cannot be helped).

Services need to be linked and locatable when a person needs support and available not just during working hours. We all must be better at linkage support and communication and follow thru. Finally to be willing to help each other in need of help and support, we are way passed pull up your boot straps in CA. Support, and help developing each person we touch with hope.

I used to work for a peer support mental health client run organization (3 1/2 years), over 10 years ago, before they fired me because I had pneumonia and had to be on sick leave for more than the 16-week FMLA period. They weren't truly peer-run because their parent organization was not peer-run (Mental Health Association). It was the MHA that fired me. While I was working I attended a lot of meetings at the DMH, Stakeholder meetings for the MHSA, etc. After I retired I volunteered at the DMH for a while. So I'm very familiar with many of these issues, but I've received all my services from UCLA -- I've never received services at from the County or Local Mental Health system. So I can't give the best possible feedback. However, from my background, I know that Peer Support is vital, it must be TRULY peer-run and should be funded as much as possible. Housing First is
also vital -- only if people have secure housing can they recover. The main point is that providers who are not clients themselves MUST LISTEN TO CLIENTS and take them seriously as intelligent adults, never have a patronizing or condescending attitude. We are the ones with lived experience, so no matter how many college degrees or work experience the providers have, they can't match our lived experience.

CONCLUSIONS AND OBSERVATIONS: ANNUAL CLIENT AND LEADERSHIP SURVEY

The Recovery Model is about helping clients improve aspects of their whole lives and equipping them with the skills and resources necessary to matriculate out of the PMHS and lead independent lives of dignity. This requires intensive ongoing services and individualized care and supports aimed at more than just illness management.

Admittedly, this can be difficult to accomplish, but it is not impossible. And California’s PMHS has already done it. The outcomes of programs funded under Assembly Bills (ABs) 34 and 2034 (passed in 1999 and 2000, respectively), paved the way for the MHSA’s passage in 2004. This legislation funded fully-integrated programs for a specific high-risk subset of adults living with severe mental illness. These programs focused on delivering recovery-oriented mental health treatments, meeting individuals’ basic needs, producing and sustaining quality of life outcomes, coordinating a variety of mental health and social services, and employing a “whatever it takes” approach to reduce rates of homelessness and incarceration for the target population.72

In 2003, California’s DMH issued a comprehensive report to the state legislature entitled “Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness,” detailing the preliminary outcomes of AB 34 and AB 2034 programs.73 For the 4,881 individuals enrolled in these programs as of January 31, 2003, this report found that:

- The number of days of psychiatric hospitalization since enrollment dropped 55.8%.
- The number of days of incarceration dropped 72.1%.
- The number of days spent homeless dropped 67.3%.
- The number of days of full-time employment increased 65.4%
- The number of days of part-time employment increased 53.1%
- 4,071 program enrollees (83.4%) were in some type of housing rather than on the streets74

In fact, the entire structure of adult mental health services funded by the MHSA’s Community Services and Supports (CSS) component was modeled on the successes of AB 34 and AB 2034 programs.

The MHSA’s co-authors further explained that for adult system of care services under the MHSA:

Proposition 63 funds may only be used for the programs specified in [WIC §] 5892. That section lists only the adult system of care (the AB 34 program) as an eligible program for Proposition 63 funds. Accordingly, all Prop 63 funded services to adults with severe mental illness must be in accordance with the AB 34 adult system of care and must follow the rigorous requirements of that program. This means integrated services or a so-called whatever it takes approach with an individual treatment plan that includes not only mental health services but all other support services.75

In essence, the MHSA promised that the funding for adult/older adult CSS services would ensure the expansion and continuation of programs modeled on the successes of AB 34 and AB 2034. Based on the survey responses
we received, this is not occurring. Leadership is unaware of the MHSA’s origins and has lost sight of the goals and objectives the MHSA sought to achieve.

Observations: Recovery-Oriented Systems, Services, and Practices in the PMHS

Clients and family members consistently report Counties’ apparent lack of commitment to the Recovery Model in adult services and systems of care. When viewed in the aggregate, these responses suggest that the PMHS’ adult mental health services are not presently designed to address clients’ broad, holistic needs. Narrow scopes of services within individual programs are primarily aimed at medication management and prevention and stabilization of immediate mental health crises, while neglecting long-term client goals. Services are not meeting clients “where they’re at,” literally or metaphorically. As a result, clients and family members report feeling “managed” by a PMHS that is more focused on stabilization and symptom control (in response to demands of the greater society), rather than supported in achieving meaningful quality of life outcomes.

Tracking clients’ recovery progress and celebrating clients’ achievements of recovery milestones offers multiple benefits for providers and clients alike. First, it encourages providers to focus on clients’ individual needs and creating a services environment sufficiently flexible to meet them. It ensures services are recovery-focused and tailored to each client’s unique strengths and goals. Second, it keeps clients actively engaged in their services and ultimate recovery process. Third, it helps providers and clients recognize when recovery plans may require revisions to keep clients on track. Fourth, it reinforces providers’ commitment to recovery-based and client-driven services. A victory for clients is also a victory for their providers and reminds all involved that recovery is not only possible, it actually happens every day.

While providers may say they believe in recovery, if they are not tracking clients’ recovery milestones and sharing this information with clients, any such professed belief is belied by their actions (or lack thereof). The PMHS can use this information to develop guidelines for providers to ensure clients’ progress is closely monitored and clients remain actively involved in their own recovery, which leads to better overall recovery outcomes.

Observations: Collection and Utilization of Recovery Outcomes in the PMHS

The factors in each list above beginning with [FSP] were taken directly from the MHSA’s FSP data collection requirements (9 CCR § 3620.10). Accordingly, all adult providers serving FSP-designated clients should be regularly monitoring these factors. While not all respondents received services through FSP programs, it would make sense for the PMHS to track these outcomes for all adult clients to maintain consistency and ensure providers remain focused on the same common objectives. Based on the survey responses, this is not happening.

Even where providers are consistently asking clients about and/or tracking these factors, this does not mean providers (or County mental health agencies in general) are offering appropriate services to meet clients’ needs in these domains. Counties can use this list to conduct internal assessments of their providers and identify whether the full County-offered array of services is adequate to meet clients’ needs. If so, Counties should determine where additional linkage and referral services may benefit clients and improve recovery outcomes.

Counties and the overall PMHS can continue to track and analyze this information to develop recovery-based programming objectives and to improve client experiences, data collection practices, and achievement of meaningful recovery outcomes.
ANNUAL PARTICIPATION BARRIERS SURVEY

At the end of each program year, ACCESS disseminates a brief Annual Participation Barriers Survey to its entire network of stakeholder contacts, asking respondents to identify whether and to what extent specific barriers prevent them from taking a more active role in local mental health policy discussions and program planning.

As with our Annual Stakeholder Inclusion and Feedback Survey, we theorized that any barriers that significantly hinder stakeholders’ ability to participate in their local PMHS’ policy discussions and program planning will directly impact the extent to which local systems are recovery-oriented, provide client-driven and recovery-based services, and measure and operationalize meaningful recovery outcomes data. In short, if clients are not at the table when key decisions are made, the recovery orientation of the entire system will suffer. Therefore, it is imperative to understand the reasons clients are not making it to the table to participate. Local mental health agencies can use the data collected in this survey to identify and remove any applicable barriers to client participation that are within the agencies’ control.

Survey respondents were given a list of potential barriers to stakeholder participation in their local PMHS and asked to identify the extent to which each barrier impacts their ability to participate in the local MHSA CPP process. Space is provided at the end of the survey to allow respondents to explain or expand upon their answers.

ACCESS disseminated the Annual Participation Barriers Survey between August 1, 2019 – September 3, 2019, and gathered 113 total responses. A link to the aggregated responses (with all identifying information redacted) for this survey is included in the list of Appendices at the end of this Report. (See Appendix 2.) The results of this survey are discussed below.

KEY FINDINGS: ANNUAL PARTICIPATION BARRIERS SURVEY

Of the individuals who responded:

- 78% identified as an adult client or consumer
- 3% identified as a transition age youth
- 64% have received services in the PMHS

The Annual Participation Barriers Survey asked respondents to identify the specific barriers that prevented them from participating in their County’s local CPP process. The barriers respondents reported having the biggest impacts on their ability to participate in the local CPP process were:

- 61%: a lack of information/advertising about local meetings
- 23% of all respondents said this barrier rendered them unable to participate at all in their local CPP
- 53%: personal responsibilities/obligations
- 49%: a lack of understanding of MHSA requirements and standards
- 48%: meeting times
- 47%: meeting locations
- 34%: lack of transportation
Respondents also identified additional participation barriers not listed in our Survey:

- Once I started working it has become almost impossible to participate in the [County] meetings.
- Lack of ADA disability accommodations like closed captions, CART, ASL interpreters. And lack of Spanish translation services for stakeholders.
- Loss of pay for [missing] work.
- Don't hear about opportunities to get involved.
- The security, or police being present.
- [Lack of] Child care prohibits me from attending.
- Pettiness and other things related to the human condition.
- It’s not being advertised enough because I don’t know anything about it really.
- When I have to interpret for others who are in attendance, it limits my ability to participate and follow the flow of conversations and decisions.
- [My County] often has incorrect information on their website, they send out invitations for important meetings last minute. I personally think they do not really want client participation.
- For more than 6 months there was no Program Planning Process sessions until after my county got their 3 year plan approved presently.
- Not sure how we can be useful in the process. Plus meetings just take too long, too much bureaucracy.

CONCLUSIONS: ANNUAL PARTICIPATION BARRIERS SURVEY

We theorized that any barriers substantially hindering stakeholders’ ability to participate in their local PMHS’ policy discussions and program planning would directly impact the extent to which local systems are recovery-oriented, provide client-driven and recovery-based services, and measure and operationalize meaningful recovery outcomes data. In short, if clients are not at the table when key decisions are made, the recovery orientation of the entire system will suffer. Counties and other agencies comprising the PMHS have an affirmative duty to recognize and remove significant participation barriers within their control to ensure clients and community stakeholders have a meaningful opportunity to participate in important mental health policy discussions and planning decisions.

The survey responses reveal that real gaps exist on the County level that must be remedied before clients and stakeholders can truly participate in the local planning process in any meaningful way.

72 http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=199920000AB34
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=199920000AB2034 and
http://histpubmh.semel.ucla.edu/sites/default/files/archival/7904cfd5_20040831AB2034WhatWorks.pdf (pp. 1-2)

73 http://histpubmh.semel.ucla.edu/sites/default/files/archival/8a7e9b94_AB2034_may2003.pdf

74 http://histpubmh.semel.ucla.edu/sites/default/files/archival/8a7e9b94_AB2034_may2003.pdf (Executive Summary, pp. i-ii)

75 http://web.archive.org/web/20050325155912/http://www.dmh.ca.gov/WhatsNew/mhsa/docs/MHServices/FromFailFirsttoHelpFirst.pdf (p. 7)
ACCESS 2020: ON THE HORIZON

ACCESS is learning from the past and looking to the future. With the second year of the program now behind us, we will integrate the lessons learned from the past two years to shape the activities related to our 2019-2020 annual theme: Peer Support Services in California’s PMHS. The MHSA requires Counties to establish peer support and family education support services or to expand these services to meet the needs and preferences of clients and/or family members. Further, Counties must conduct outreach to provide equal opportunities for peers who share the diverse racial/ethnic, cultural and linguistic characteristics of the individuals/clients served.

An essential ingredient to a client driven, recovery-oriented system of care is the development of a robust peer workforce. Individuals in recovery from a mental illness are able to contribute in all areas of the public mental health system, including administrative, quality improvement, peer support workers and advocates. Peer support means that Counties maintain fidelity to the evidence-based model of shared lived experience with the population being served in all positions.

The rate of unemployment for clients in California’s PMHS is staggering, with only 9.8% of PMHS clients employed in the labor force, leaving an abysmal 91.2% who are unemployed or not participating in the workforce. The national average for employment of people with mental health disorders served in the public mental health system is around 22%. Even the availability of MHSA Workforce Education and Training funds (WET), aimed at increasing the peer workforce in California, has failed to move the needle in this critical area.

Despite the MHSA’s mandate to employ individuals with lived experience throughout the PMHS, consumers are starkly underrepresented amongst the staff of county mental health departments and their contracted CBOs. Peers who are fortunate to gain employment in the PMHS are often marginally employed, relegated to stagnant entry-level positions, and struggling to make a living wage. Current training approaches have focused primarily on the peer role and the values/goals of the consumer movement, which – while important – do little to provide peers with practical skills and hands-on training experiences they can later transfer to real life peer support settings. Nor do these courses address systemic impediments to peer job placement and career advancement. As such, peers are often left to chart their own course in low paying positions, while opportunities for professional development and career advancement – both of which are essential to peers’ lasting professional success – remain elusive in the PMHS.

The concepts of peer support are largely supported in the scientific research, yet the expansion of peer support services in the practical realm has been slow and resistant, particularly in California. The basis of peer support comes from people sharing common life experiences helping identify with others in a shared commonality and deep understanding that may be absent from relationships with others. Because the peer relationship is based on mutuality, there are no clearly delineated lines of power identifying helper and helpee, but is rather conducted in an egalitarian manner. Members with access to peer support and other client run services show more significant improvements in subjective outcomes than those in traditional services lacking access to peer support. Most importantly is that the more frequent use of peer support services relates to even greater improvements in measures of recovery, self-determination and empowerment.
The employment of clients in the peer support workforce has inherent positive outcomes, not only for the individual, and for those receiving peer support services, but also because advocacy is a core competency of peer support. Research proves that peer support is an effective, evidence-based practice that cannot be ignored. Studies suggest that outcomes are improved with peer support services, including reduction in symptoms, hospitalizations, incarcerations, and better health outcomes. These are often the most costly of services in the PMHS.

The ever-growing demands on California’s PMHS requires an expansion of the existing mental health workforce, whereby peer support workers could fill essential gaps in service delivery. The current mental health workforce in California is experiencing severe shortfalls in mental health workers, clinicians and psychiatrists in nearly every county, with greater shortages in rural communities. A 2016 estimate by the California Behavioral Health Directors Association estimates that repeal or further weakening of the Affordable Care Act could have an even greater “impact on job creation and workforce development by county behavioral health systems.” Peers can serve as system navigator, link clients losing services with additional community-based resources, provide ongoing emotional support during times of uncertainty, and provide a much-needed safety net to an otherwise vulnerable population.

Therefore, an essential ingredient to a client-driven, recovery-oriented system of care is the development of a robust peer workforce. Individuals living in recovery from mental illness are able to contribute to all areas of the mental health system, including as peer support workers, advocates, self-help group facilitators, volunteers, members of boards and/or commissions. Investing in the capacity building of peers in California’s PMHS not only promotes inclusivity but also evidence-based practices. Research suggests that building the capacity for client(peer workforce is a necessary component to system transformation. As a result, statewide client led advocacy efforts should focus on training, technical assistance, and advocacy for the expansion of peer support workers in the PMHS.

76 9 CCR § 3610(d)
LEGISLATIVE ADVOCACY AND PUBLIC POLICY

Karen Vicari, JD
Policy Director
Phone: (916) 376-7736
Email: kvicari@norcalmha.org

Noah Hampton-Asmus
Legislative Policy Analyst
Phone: (916) 376-7736
Email: nhamptonasmus@norcalmha.org

PUBLIC ADVOCACY, TRAINING, EDUCATION, AND TECHNICAL ASSISTANCE

Andrea L. Crook, NCPS
Director of Advocacy
Phone: (916) 376-7736
Email: acrook@norcalmha.org

ACCESS AMBASSADORS AND COMMUNITY ENGAGEMENT

Tiffany Carter, MS
Statewide Advocacy Liaison
Phone: (916) 376-7736
Email: tcarter@norcalmha.org
ACRONYMS, ABBREVIATIONS, AND DEFINITIONS

ACCESS California (ACCESS): Cal Voices’ consumer-led stakeholder advocacy program that is funded by the California Mental Health Services Act (MHSA) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). ACCESS, which stands for Advancing Client and Community Empowerment through Sustainable Solutions, represents the interests of public mental health clients throughout California.

California Code of Regulations, Title 9 (9 CCR): The standards and rules adopted by California administrative agencies (including the DHCS and MHSOAC) governing the oversight, implementation, and evaluation of rehabilitation and developmental services, including those services provided in California’s PMHS and those provided under the Mental Health Services Act (see 9 CCR §§ 3100 – 3935).

Client: An individual of any age who is receiving or has received mental health services. The term ‘Client’ includes those who refer to themselves as clients, consumers, survivors, patients, or ex patients (9 CCR § 3200.040).

Client-Driven: Under the MHSA, the client has the primary decision-making role in identifying their needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for them. Client driven programs and services use clients’ input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes (CCR § 3200.050).

Community Collaboration: A process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals for MHSA programming and funding decisions (9 CCR § 3200.060).

Community Program Planning Process Component (CPP): The process to be used by the County to develop its MHSA Three-Year Program and Expenditure Plans, and updates [to MHSA-funded plans, projects and programs] in partnership with stakeholders to: (1) identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the MHSA; (2) analyze the mental health needs in the community; and (3) identify and re-evaluate priorities and strategies to meet those mental health needs (9 CCR § 3200.070). Counties may dedicate up to 5% of their total annual MHSA funds to pay the costs of consumers, family members, and other stakeholders to participate in the planning process (WIC § 5892(c)).

Community Services and Supports Component (CSS): The component of the County’s Three-Year MHSA Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et seq (9 CCR § 3200.080). Counties must direct the majority (at least 51%) of its CSS funds to the Full-Service Partnership Service Category (9 CCR § 3620(c)).

Consumer: See “Client.”

County: The County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving funds per Welfare and Institutions Code Section 5701.5 (9 CCR § 3200.090). As used in this Report, “County” and “Counties” refer to the local public mental health agencies
providing MHSA-funded services and supports to public mental health clients and their families. The City of Berkeley’s Mental Health Division and Tri-City Mental Health Services are included in this definition.

**Cultural Competence:** All mental health services and programs at all levels should have the capacity to provide services sensitive to the target populations’ cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs; (2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups; and (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities (WIC § 5600.2(g)). Cultural competence under the MHSA requires Counties to incorporate and work to achieve a set of nine specific goals into all aspects of policy-making, program design, administration and service delivery in the PMHS (9 CCR § 3200.100).

**Cultural Humility:** Increasing understanding of cultural, racial, and ethnic diversity in a way that “incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations” (Tervalon & Murray-Garcia, 1998 p. 117).

**Department of Health Care Services (DHCS):** From 2004 until 2012, the California Department of Mental Health (DMH) was the primary state agency responsible for overseeing the implementation of the MHSA. However, a 2012 change in state law dissolved DMH and transferred the majority of its MHSA duties to the Department of Health Care Services (DHCS) (California State Auditor, 2018).

**Department of Mental Health (DMH):** From 2004 until 2012, the California Department of Mental Health (DMH) was the primary state agency responsible for overseeing the implementation of the MHSA. However, a 2012 change in state law dissolved DMH and transferred the majority of its MHSA duties to the Department of Health Care Services (DHCS) (California State Auditor, 2018).

**Full Service Partnership (FSP):** The service category of the CSS component of the County’s MHSA Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client’s family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals (9 CCR § 3200.140). “Full Service Partnership” can also refer to the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified recovery goals (9 CCR § 3200.130). Counties must direct the majority (at least 51%) of its Community Services and Supports funds to the FSP Service Category (9 CCR § 3620(c)).

**General Standards:** The County shall adopt six foundational standards in planning, implementing, and evaluating the programs and/or services provided with MHSA funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the MHSA Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery. These standards are: (1) Community Collaboration; (2) Cultural Competence; (3) Client Driven; (4) Family Driven; (5) Wellness, Recovery, and Resilience Focused; and (6) Integrated Service Experiences for clients and their families (9 CCR § 3320).

**Innovative Programs/Innovation Component (INN):** The section of the County’s MHSA Three-year Program and Expenditure Plan that consists of one or more Innovative Projects (9 CCR § 3200.182). “Innovative
“Innovative project” means a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports (9 CCR § 3200.184). Counties must set aside 5% of their combined MHSA PEI and CSS funding for Innovative projects to develop and implement promising practices; increase access by underserved groups, increase quality of service, improve outcomes, and promote collaboration (WIC §§ 5830, 5892(a)(6)).

**Local Advocacy Toolkit (Toolkit):** A resource for public mental health clients and other stakeholders intended to aid in training community members to participate in public meetings and effectively advocate for their mental health needs. The toolkit provides handouts and worksheets that can be used to educate community members about the local community planning process and help them craft their own public statements (Appendix Q).

**Mental Health Services Act (MHSA; Prop. 63):** The laws that took effect on January 1, 2005 when Proposition 63 was approved by California voters and codified in the Welfare and Institutions Code (9 CCR § 3200.220). The MHSA establishes a 1% tax on personal income over $1 million, expands mental health care, provides opportunities to design new or adapt old mental health services, and seeks to transform the PMHS through expansion of services, community collaboration, and improved continuum/integration of care (MHSA §§ 2(g), 3). The MHSA encompasses broad portions of the California Welfare and Institutions Code, from sections 5771.1 and 5800 – 5899.1.

**Mental Health Services Oversight and Accountability Commission (MHSOAC):** The MHSOAC was established to oversee Counties’ implementation of the MHSA’s CSS, WET, INN, and PEI components and the public mental health services provided in Counties’ Adult and Children’s Systems of Care. The MHSOAC consists of 16 voting members representing the California Attorney General, the Superintendent of Public Instruction, the Chair of the Senate Health and Human Services Committee, and the Chair of the Assembly Health Committee. Additional members include two persons with SMI, a family member of an adult with SMI, a family member of a child with SMI, and other representatives of interested stakeholder groups in California. The MHSOAC works in collaboration with the DHCS and the California Behavioral Health Planning Council (CBHPC), and in consultation with the California Mental Health Directors Association (CBHDA), in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system (WIC § 5845).

**Outreach and Engagement:** The service category of the CSS component of the County’s MHSA Three-Year Program and Expenditure Plan under which the County may fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County (9 CCR § 3200.240).

**Prevention and Early Intervention Component (PEI):** The section of the County’s Three-Year MHSA Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling (9 CCR § 3200.345). At least 20% of County MHSA funds must be used for PEI programs (WIC §§ 5892(a)(3)-(4)). At least 51% of PEI funds must be used to serve persons age 25 and younger (9 CCR § 3706(b)).

**Prudent Reserve(s):** As of the 2008-2009 fiscal year, Counties may utilize up to 20% of the average annual amount of MHSA funds allocated to that County for the previous five years on CF/TN, WET, and prudent reserves combined. This amount is charged to the County’s CSS services component (WIC § 5892(b)).

**Public Mental Health System (PMHS):** Publicly-funded mental health programs/services and entities that are administered, in whole or in part, by the California Department of Health Care Services or a California County. It does not include programs and/or services administered, in whole or in part, by federal, state, County or private correctional entities or programs or services provided in correctional facilities (9 CCR § 3200.253).
**Recovery:** “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Substance Abuse and Mental Health Services Administration, 2014).

**Serious/Severe Mental Illness (SMI):** A mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders (9 CCR § 3701(e)). In California, SMI is a categorization for adults age 18 and older and is defined as any mental illness that results in substantial impairment in carrying out major life activities (California HealthCare Foundation, 2013).

**Shared Decision Making:** An approach where service providers and clients share the best available evidence when faced with the task of making treatment decisions, and where clients are supported to consider options, to achieve informed preferences.

**Stakeholder(s):** Individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families (9 CCR § 3200.270).

**Substance Abuse and Mental Health Services Administration (SAMHSA):** U.S. Department of Health and Human Services agency whose goal is to advance national behavioral health.

**Transition Age Youth (TAY):** Youth clients served in the PMHS who are between 16 and 25 years of age (9 CCR § 3200.280).

**Welfare and Institutions Code (WIC):** Addresses public services in California relating to welfare, dependent children, mental health, handicapped, elderly, juvenile delinquency and dependency, foster care, Medi-Cal, food stamps, rehabilitation, and long-term care. The MHSA encompasses broad portions of the California Welfare and Institutions Code, from sections 5771.1 and 5800 – 5899.1.

**Workforce Education and Training Component (WET):** The component of the County’s MHSA Three-Year Program and Expenditure Plan that includes education and training programs and activities for prospective and current PMHS employees, contractors and volunteers (9 CCR § 3200.320). From 2005 – 2008, Counties were required to use 10% of their total annual MHSA funding on WET expenditures (WIC § 5892(a)(1)). As of the 2008-2009 fiscal year, Counties may utilize up to 20% of the average annual amount of MHSA funds allocated to that County for the previous five years on CF/TN, WET, and prudent reserves combined. This amount is charged to the County’s CSS services component (WIC § 5892(b)).
APPENDIX 1: ANNUAL STAKEHOLDER INCLUSION AND FEEDBACK SURVEY REPORT

OVERVIEW: The Stakeholder Inclusion and Feedback Survey is for clients, community stakeholders, and Public Mental Health System (PMHS) leadership, to gauge respondents' knowledge and understanding of the MHSA's Community Program Planning (CPP) Process and stakeholder inclusion requirements. Responses help ACCESS identify best practices in stakeholder inclusion and methods of enhancing meaningful stakeholder participation on both the local and state levels.

The survey was circulated between November 30, 2018 - December 31, 2018, and received 271 responses.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da35ef47830f7.12311135

APPENDIX 2: ANNUAL PARTICIPATION BARRIERS SURVEY REPORT

OVERVIEW: The participation barriers survey is intended to determine the types of barriers that prevent clients/consumers throughout California from fully participating in their County’s MHSA Community Program Planning (CPP) process. Survey responses help ACCESS identify the problems that stakeholders want us to research and evaluate for our annual State of the Community Report.

The survey circulated between August 1, 2019 - September 3, 2019, and received 113 responses.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da76590b57ee5.10855248

APPENDIX 3: ANNUAL FOCUS GROUP AND ROUND TABLE DATA SUMMARY

DESCRIPTION: Regional Stakeholder Focus Groups and Leadership Roundtables give ACCESS first-hand knowledge and feedback from people with current or previous experience receiving services from their PMHS, allowing ACCESS a meaningful look at the genuine experiences of mental health clients that other data collection methods are unable to fully capture.

FULL SUMMARY: https://drive.google.com/open?id=1iILbd2JPUBlaXzFK3ABwfkaJALD61yFi
APPENDIX 4: ANNUAL AMBASSADOR SATISFACTION AND REFLECTION SURVEY REPORT

DESCRIPTION: This survey assesses the efficacy of our Ambassador program, documents Ambassador advocacy successes and challenges, and assists ACCESS with continually improving the program. Responses were collected from 22 ACCESS Ambassadors between August 10, 2019 - October 1, 2019.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da384ffa54c58.99397145

APPENDIX 5: YEAR 2 LEADERSHIP TRAINING EVALUATION REPORT

DESCRIPTION: This evaluation assesses the efficacy of our Leadership Training Workshop information, materials, and delivery skills of the presenter, and is used to determine where changes in the educational model are necessary to improve the program. ACCESS received 117 evaluation responses between January 14, 2019 – October 13, 2019.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da37ed90c1d19.86316002

APPENDIX 6: YEAR 2 COMMUNITY EMPOWERMENT WORKSHOP EVALUATION REPORT

DESCRIPTION: This survey assesses the efficacy of our Leadership Training Workshop information, materials, and delivery skills of the presenter, and is used to determine where changes in the educational model are necessary to improve the program. ACCESS gathered 121 Workshop evaluations between January 15, 2019 – October 13, 2019.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da37c91535ca1.38081773

APPENDIX 7: ANNUAL CONFERENCE EVALUATION REPORT

DESCRIPTION: ACCESS collected post-conference evaluations from 125 attendees to gauge the efficacy of our conference content, materials, presenters, and to assess the overall participant experience

FULL REPORT: https://data.surveygizmo.com/r/267733_5da3826a1a3ad9.79577707
OVERVIEW:
The Annual Client and Leadership Survey is designed to identify best practices in the integration of Recovery-Oriented Services in the PMHS and methods of increasing the effectiveness of adult programs and services funded by the MHSA. The survey contains four sections, all of which relate to adult mental health services in the PMHS:

1. A section for Clients and Family Members of adult clients to provide feedback regarding Recovery-Oriented Services for adult mental health clients in their Local Mental Health Systems.

2. A section for State Mental Health Agency Leadership to determine how oversight agencies are ensuring Counties/Local Mental Health Systems integrate the Recovery Model of care into adult mental health services.

3. A section for Local Mental Health System Leadership to gauge levels of integration of the Recovery Model of care in adult mental health services.

4. A section for all Stakeholders (everyone) to provide insights and feedback regarding the types of Recovery-Oriented Services that they believe are most effective and valuable for clients.

The survey was circulated between January 30, 2019- October 1, 2019, and received 707 responses.

FULL REPORT: https://data.surveygizmo.com/r/267733_5da365c6672625.01142279