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STATE OF PEER SUPPORT | 2020

PEER SUPPORT IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM



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ABOUT ACCESS CALIFORNIA

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.

2018 & 2019 REFLECTIONS AND UPDATES: ADVOCACY IN CALIFORNIA'S PMHS

"At the root of this dilemma is the way we view mental health in this country. Whether an illness affects your heart, your leg or your brain, it's still an illness, and there should be no distinction."

~Michelle Obama

ADVOCACY FOR MENTAL HEALTH

Without authentic stakeholder involvement, the MHSA's critical mandates remain impotent and render system transformation an unfulfilled promise. Even when clients are actively engaged in MHSA stakeholder processes, they often lack essential knowledge of system navigation, budget allocations, integrated service delivery, and funding streams. Without this understanding, clients are unable to make meaningful contributions to program planning, development, implementation, and oversight functions in the PMHS. Meaningful stakeholder involvement requires an investment in training and education of the populace. Counties may allocate up to 5% of their total annual MHSA fund for the CPP (WIC § 5892(c); 9 CCR § 3300(d)). Yet, since the closing of the State Department of Mental Health, few Counties have actually invested this funding into their planning efforts, or provided resources related to training of clients, family members, and underserved communities about the public mental health system's inner workings. Advocacy means meaningful stakeholder participation in the PMHS. This requires Counties to actively solicit community feedback prior to making programming decisions and expand opportunities for meaningful ongoing client involvement in MHSA program creation, development, planning, services delivery, oversight, and evaluation (WIC § 5848(a); 9 CCR §§ 3200.070, 3300, 3310). Client inclusion must be expanded at all levels within the PMHS, from the time MHSA-funded programs are conceived, through their implementation, and in the continuous assessment of outcomes from such programs.

The concept of mental health advocacy has been developed to promote the human rights of persons with mental disorders and to reduce stigma and discrimination.¹ According to the World Health Organization (WHO), advocacy is one of the 11 areas for action in any mental health policy because of the benefits that are produced for consumers and families. The advocacy movement has substantially influenced mental health policy and legislation and is believed to be a major factor in the improvement of services. Additionally, mental health advocacy is responsible for an increased awareness of the role of mental health in the quality of life. Actions typically associated with mental health advocacy include the raising of awareness, the dissemination of information, education, training, mutual help, counseling, mediation, defending and denouncing.²

In 2001, the importance of mental health advocacy became quite prominent. This is when the WHO held a world health assembly where health ministers were unanimous and mental health became the **first** priority. "Policy-makers in government and civil society should be sensitized about the huge and complex nature of the economic

¹https://www.who.int/mental_health/policy/services/1_advocacy_WEB_07.pdf?ua=1 , p.2

² Id. at p. 3

burden of mental illness and the need for more resources to treat mental illness.”³ As a result, the need for mental health advocacy has been recognized by health ministers throughout the world and the WHO.⁴

Advocacy groups need independence from government in order to achieve their goals.⁵ While good relationships and even financial support from government can be very useful to both parties, there is often a need for outside advocacy.⁶ History has repeatedly shown that governments can seriously violate human rights, including those of people with mental disorders.⁷ Advocacy groups should be careful not to lose strength by developing too close a relationship with government.⁸ In any event, they should ensure that they develop sufficient financial and organizational independence in order to refuse government support that would compromise any positions they wish to adopt.⁹ From a government standpoint, it is important to work with advocacy groups that may oppose government policy and try to understand their perspectives.¹⁰

RECOVERY FROM MENTAL HEALTH

ACCESS envisions a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice. Consistent with this philosophy, ACCESS supports and promotes services and systems that facilitate and promote the capacity of people with mental health conditions to live a life that they value. This goal has become the aim of the recovery movement, led by people with lived experience of their own recovery journey. ACCESS embodies the recovery movement.

ACCESS believes mental health systems transformation will occur only when all stakeholders view recovery as the primary goal, defined broadly as a journey of healing and transformation enabling a person with a mental health condition to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.¹¹

Although the recovery movement was a response to the discouragement and dependency experienced by people with serious and persistent psychiatric disorders, recovery applies to the entire continuum of mental health needs: Those experiencing life crises, declining mood or other prodromal symptoms can embrace recovery early to ensure that they can continue their life in the community and thrive, while those with serious and persistent mental health needs can begin working toward defining and establishing the life they want for themselves in the community. Note that recovery is separate from, but can work in tandem with, wellness, which is the positive aspect of mental health promotion, whether or not the individual is experiencing specific mental health treatment needs.

ACCESS is committed to the principle that every individual with a mental health or substance use condition can enjoy recovery and wellness. Individuals must define for themselves what recovery means to them – what their personal goals are, what it means to live a fulfilling and productive life, and how to manage their condition

³ Id. at p.15

⁴ Id. at p.16

⁵ Id. at p.24

⁶ Id. at p.24

⁷ Id. at p.24

⁸ Id. at p.24

⁹ Id. at p.25

¹⁰ Id. at p.25

¹¹ Retrieved: <https://www.samhsa.gov/brss-tacs/recovery-support-tools-resources#what-is-recovery>

effectively. The individual must be able to define his or her recovery free from cultural judgments about what constitutes a meaningful and productive life. This is important not only for the individual's autonomy, but also for the community, allowing it to grow in acceptance of people in recovery, living with behavioral health conditions. For an individual to engage in the recovery process, it is important that she or he possess hope that recovery is possible, have choices regarding community-based services and supports, have access to resources that allow for basic needs to be met such as food, clothing and housing, and have a strong community network. Such a network can include but is not limited to friends, family and faith-based organizations.

BACKGROUND

ACCESS is a program of Cal Voices, which is a chapter of National Mental Health America which was established in 1909 by former *psychiatric patient*, Clifford W. Beers. During his stays in public and private institutions, Beers witnessed and was subjected to horrible abuse. From these experiences, Beers set into motion a reform movement that took shape as Mental Health America. The efforts of Beers and other early pioneers of this movement set a course for reform, to the point where today, and increasingly, if treatment and support are provided, recovery from mental health conditions is the expected outcome for many people with lived experience of mental health conditions.

In July 2003, the President's New Freedom Commission on Mental Health issued its report, "Achieving the Promise: Transforming Mental Health Care in America."¹² An overarching recommendation in the report was that services and treatments for persons with psychiatric disabilities must be recovery-oriented and consumer-driven.

On December 16-17, 2004, the Center for Mental Health Services (CMHS) convened a National Consensus Conference on Mental Health Recovery and Systems Transformation. Over 110 consumers, family members, providers, researchers, advocates, State and local mental health authorities, Federal partners and others met to develop a consensus statement on mental health recovery.

The resulting National Consensus Statement identified the 10 key elements of recovery as follows:

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

¹² Retrieved from: <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.htm>

- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.¹³

ACCESS agrees that each of the tenets articulated by the National Consensus Statement should be incorporated into behavioral health systems transformation, at both the individual and systems levels. The National Consensus Statement sets ambitious goals for the recovery movement, which ACCESS enthusiastically supports.

Subsequently, in August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and SAMHSA (the Substance Abuse and Mental Health Services Administration, the parent of CMHS), adopted a new working definition of recovery, which departs slightly from the 2004 definition quoted above: "**A process of change through which individuals improve their health**

¹³ Retrieved from: https://en.wikipedia.org/wiki/Recovery_model

and wellness, live a self-directed life, and strive to reach their full potential.¹⁴ Through the Recovery Support Strategic Initiative, SAMHSA subsequently delineated four major dimensions that support a life in recovery:

- **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.
- **Home:** A stable and safe place to live.
- **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.
- **Community:** Relationships and social networks that provide support, friendship, love, and hope.

The new definition also includes ten "Guiding Principles in Recovery:"

1. **Hope**
2. **Person-Driven**
3. **Many Pathways**
4. **Holistic**
5. **Peer Support**
6. **Relational**
7. **Culture**
8. **Addresses Trauma**
9. **Strengths/Responsibility**
10. **Respect**

Significantly, the Consensus Statement includes self-direction and empowerment, which are reflective of the broader aspirations of the recovery movement, but these principles were deleted from the Guiding Principles. The Guiding Principles are quite similar to the Consensus Statement in other respects, but the important additions of cultural competence and trauma-informed treatment in the 2010 definition remedy gaps in the original definition:

- **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.
- **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.

Call To Action

ACCESS supports individuals in recovery from mental health conditions to:

¹⁴ Retrieved from: https://www.aclu.org/sites/default/files/field_document/document_0.pdf

- Understand their illness and that recovery is possible;
- Explore treatment options and supports that match their desires, goals and strengths;
- Participate in peer support programs and explore leadership roles that can help others recover; and
- Participate at all levels of the behavioral health system of care, including the formulation of policy.

ACCESS calls on public behavioral health systems and policy-makers to:

- Incorporate the principles of recovery-based care into the mission and day-to-day activities of local, state and federal mental health departments and agencies;
- Invest in evidence-based and emerging practices that are community-based and consumer/family-driven and promote recovery-oriented outcomes;
- Increase federal reimbursement for and state investment in recovery-oriented services, including exploration of a specific mental health enhanced Federal Medical Assistance Percentage (eFMAP), so long as any enhancement includes additional funds for the entire system of care, not just late-stage services; and
- Ensure that people in recovery have meaningful involvement in the planning, delivery and evaluation of mental health service systems.

ACCESS encourages stakeholders to:

- Educate decision makers that recovery is possible and is the expected outcome of proper treatment and supports;
- Encourage state and county officials to adequately fund recovery-oriented systems of care;
- Encourage public and private health plans and provider groups to use recovery outcome measures and recovery-oriented planning tools, to continuously improve the delivery of services;
- Correct misinformation reported in the media with positive, factual, and prompt responses expressed with the dignity we demand for those who suffer from behavioral illnesses;
- Encourage the community to be welcoming and inclusive of all individuals and appreciate the value of diversity that self-directed recovery can provide;
- Promote policies which are consistent with the recovery philosophy; and
- Identify opportunities for people in recovery to have meaningful involvement in advocacy efforts in addition to the planning, delivery and evaluation of behavioral health services.

ACCESS encourages behavioral health practitioners to:

- Utilize a strengths-based, individualized, recovery-oriented approach for all people in treatment;
- Encourage and guide people in treatment to an active role in leading their own recovery; and
- See individuals as whole human beings, not just as their illness.

ACCESS urges the media to:

- Learn the facts about mental health and substance use conditions;
- Report upon and portray mental illnesses and addictions with appropriate sensitivity; and
- Recognize that stigmatizing language and attitudes impede effective treatment.

PEER SUPPORT

ACCESS believes that peer support is an essential element of successful communities and is an integral component for individuals to achieve recovery from a mental illness. ACCESS calls on the State and local PMHS to incorporate Peer Support into community based PMHS services and treatment facilities. A decades-long study by the World Health Organization found that individuals diagnosed with schizophrenia usually do better in countries in the developing world – such as India, Nigeria and Colombia – than they do in such Western nations as Denmark, England and the United States.¹⁵ According to an analysis of results, “Patients in developing countries experienced significantly longer periods of unimpaired functioning in the community, although only 16% of them were on continuous antipsychotic medication (compared with 61% in the developed countries). . . . The sobering experience of high rates of chronic disability and dependency associated with schizophrenia in high-income countries, despite access to costly biomedical treatment, suggest that something essential to resilience and recovery is missing in the social fabric.”¹⁶

One such essential factor is peer support, which the Substance Abuse and Mental Health Services Administration (SAMHSA) has identified as a vital component in recovery.¹⁷ Since the mid-20th century, individuals who have psychiatric diagnoses have been creating effective and cost-efficient services that provide that missing factor.¹⁸ Peer-run services are based on the principle that individuals who have shared similar experiences can help themselves and each other. ACCESS believes that a peer-led vision of recovery needs to be the aim of all, even those most profoundly troubled, for whom friendship and belonging to a community in recovery can work wonders.

Peer support programs provide an opportunity for communities of individuals who have significantly recovered from their illnesses to help others direct their own recoveries by teaching one another the skills necessary to lead meaningful lives in the community.¹⁹ Peer support services have demonstrated effective outcomes such as reduced isolation and increased empathic responses.²⁰ Research has also shown that outcomes improve when individuals serve as peer specialists on care teams.²¹ Serving others also helps to sustain recovery. The only downside is the “glass ceiling” that can relegate people with lived experience of mental health conditions to peer-serving jobs, precluding advancement.

Peer support services present six advantages over traditional mental health and substance abuse services:

¹⁵ Retrieved from: <https://academic.oup.com/schizophreniabulletin/article/34/2/253/1925460>

¹⁶ Id

¹⁷ Retrieved from: <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

¹⁸ id

¹⁹ Sabin, J. & Daniels, N. 2003. "Strengthening the Consumer Voice in Managed Care: VII. The Georgia Peer Specialist Program," *Psychiatric Services*. 54(4):497-498 (2003).

²⁰ Powell (1994), Kurtz (1997), Mowbray, *et al.* (1996), as cited in U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute for Mental Health (1999).

²¹ Felton *et al.* (1995), as cited in U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute for Mental Health (1999).

- **First, there is a sense of gratitude that is manifested in compassion and commitment.**

The peer specialist's compassion and commitment come out of a deep sense of gratitude. There is something different about caring for another person because you see yourself in that person. You see where you were at one time in your life. Their pain, loneliness, and despair was once your pain, loneliness and despair. Because of this awareness, peer specialists find it more difficult to give up on someone because people did not give up on them.

- **Second, there is insight into the experience of internalized stigma.**

Most peer specialists know that what they believe about themselves because they have a mental health condition can often be more disabling than the condition itself. They are aware that when they have the symptoms of the condition under control, their fears, low self-esteem and negative self-talk can still make it difficult for them to function in the way society expects people to function.

- **Third, peer specialists have been there through lived experience.**

There is no more freeing experience than meeting a peer and truly feeling one is not alone. This experience of "I am not alone" brings a sense of understanding, trust and hope.

- **Fourth, they have had the experience of moving from hopelessness to hope.**

When one believes that there is nothing that she can do to improve the quality of her life, the person does nothing – not out of laziness or apathy, but out of hopelessness, despair and resignation. Most peer specialists have experienced this at one time in their lives. Yet they have been able to move through and beyond that hopelessness to believe they can act on their own behalf to create the life that they want. There is nothing more empowering to a person who has given up.

- **Fifth, they are in a unique position to develop a relationship of trust with their peers.**

People are often more willing to share their real issues, concerns, hopes and dreams with a peer specialist than with non-peer, clinical staff.

- **Sixth, they have developed the gift of monitoring their illness and managing their lives holistically, including both mind and body.**

Peer specialists are in a unique position to teach and motivate their peers toward whole health self-management. They have learned to recognize triggers and early warning signs, counteract the negative impact of stress, and create plans for taking care of themselves. They understand what it takes to integrate medical care with peer support and wellness in order to help others to recover from disabilities and respond to challenges.

The Centers for Medicare & Medicaid Services (CMS) issued the following statement as part of a letter to state Medicaid offices encouraging the use of peer specialists:²²

"States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of support services to Medicaid eligible adults with mental illnesses and/or substance abuse disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance abuse disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance abuse services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its

²² Center for Medicare and Medicaid Services, letter to state Medicaid offices, August 15, 2007.

commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services.”

Peer support services are part of the array of services necessary for a culturally competent, recovery-based mental health and substance abuse system. Peer support services are equal partners with more traditional clinical services and may extend services to underserved populations. However, ACCESS recognizes that peer support should not be used as a cost-saving substitute for clinical services, especially during the current era of budgetary constraints. As a means of securing reimbursement and ensuring quality care, peer services may include a certification process and should be available on a parity basis to all in need, regardless of the financing mechanism.

ACCESS recognizes that while peer support programs today are often funded through state revenue, Medicaid, largely through managed care, has become a major funding stream. Medicaid is increasingly being viewed as a means to fund mental health services and an increasing number of states are successfully implementing independent peer support services programs that bill Medicaid directly or through managed care organizations.

Call To Action

- ACCESS Stakeholders, service provider organizations, and other advocates should advocate for making peer support an integral part of mental health and substance abuse service delivery.
- To successfully recruit and retain excellent peer supporters, people with extensive experience in peer support should be involved at multiple levels of planning and implementation of peer support services, including senior management positions in service programs.
- California should set aside an appropriate percentage of state funds for peer support programs.
- California, and local governments should assure that trained peer advocates are included among the groups of people permitted to provide crisis support in emergency preparedness and response plans.
- Academic institutions should support research on the efficacy of peer support programs and different structural and training considerations that promote greater efficacy.
- Since peer support services are often located in small and frequently consumer-run agencies, ACCESS encourages Medical and other authorities to minimize the reporting burden while maintaining accountability in order to facilitate service provision and entry of peers into the services environment.
- Certification and advanced certification play a critical role in promoting professionalism and in obtaining reimbursement for services, but opportunities for peers without certification to provide support should be available. Prior experience is a prerequisite for certification.
- Medicare and private health insurers should reimburse for peer support services when provided by peer specialists who have achieved advanced level national certification. National certification provides uniformity of standards and professionalism across the state.
- ACCESS supports the expansion of the availability of peer support services throughout health care, and opportunities for career advancement and pay increases for qualified peer support workers.
- ACCESS also supports the evolving role of peers trained for whole health recovery to help reduce the 10-25-year average premature death of those served by public mental health services.

PART I.

ACCESS 2020: YEAR IN REVIEW

"Mental health needs a great deal of attention. It's the final taboo and it needs to be faced and dealt with."

~Adam Ant

This State of the Community Report reflects ACCESS' cumulative efforts and outcomes for the third year of its client/consumer stakeholder advocacy contract with the MHSOAC (September 1, 2019 – August 31, 2020). 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 MHSOAC's policies and programs, and to conduct local-level advocacy in their home communities, state-level advocacy; 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.

2020 ACTIVITIES AND ACCOMPLISHMENTS: ADVOCACY

"It doesn't have to take over your life, it doesn't have to define you as a person, it's just important that you ask for help. It's not a sign of weakness."

~Demi Lovato

LOCAL-LEVEL ADVOCACY ACTIVITIES

(150+) Local Policy Planning Meetings and Discussions

ACCESS California's primary goals of engaging in local-level advocacy activities are to strengthen and expand consumer advocacy through individual and community empowerment. Within the 2019-20-year, ACCESS Ambassadors, ACCESS team members, and local systems advocates have successfully participated and advocated in over 150 local-level advocacy meetings, activities, and events. Throughout ACCESS' engagement in local-level advocacy opportunities, we were able to reach over 5,100 stakeholders throughout the five MHSA Regions of California; Bay Area (12 jurisdictions), Superior (16 counties), Central (20 counties), Los Angeles (8 service planning areas), and Southern (10 jurisdictions). Advocating on the local-level can vary on topics and platforms. A sample of issues and concerns ACCESS Ambassadors have addressed at local-level meetings include:

REGION	MEETING ATTENDED	ISSUE(S) ADDRESSED
Bay Area	Board of Supervisors	<ul style="list-style-type: none"> Advocated against the reduction of beds in psych emergency services which was proposed by the County Health Department. Discussed the importance of the beds, and repercussions of social factors, and increased costs for other departments
Bay Area	Santa Clara MHSA Public Hearing	<ul style="list-style-type: none"> The importance of the CPP and consumer voice within the MHSA
Bay Area	QIC Committee Meeting	<ul style="list-style-type: none"> Advocated for more peer involvement at discharge planning and for the importance of the underserved and underprivileged to be included in the community planning process
Superior	MHSA Stakeholder meeting	<ul style="list-style-type: none"> Spoke on the essential need for more peer support and peer-run support groups, and peer involvement in commissions and committees
Superior	BH Advisory Board	<ul style="list-style-type: none"> Presented on CalAIM concerns and provided updates on the ongoing peer trainings in Butte County, and SB 803
Superior	MHSA Steering Committee	<ul style="list-style-type: none"> Advocated for the CPP to continue and be more assertive in community advertising to have more stakeholders involved. Additionally, advocated for the consumer voice in allocating money to NPLH
Central	BHB	<ul style="list-style-type: none"> Access to care is an issue as well as culturally driven policies and procedures, and being linguistically inclusive does not make an organization culturally competent

REGION	MEETING ATTENDED	ISSUE(S) ADDRESSED
Central	Cultural Competence and Social Justice Committee	<ul style="list-style-type: none"> Continued inclusion of peers, even with the pandemic
Central	BHRS MHSA Stakeholder Steering Committee	<ul style="list-style-type: none"> Inclusion of homeless peers in CPP and to make sure that peer specific housing like Kansas House, which is funded by MHSA, should give preference to SMI homeless
Los Angeles	LACDMH Access for all UsCC	<ul style="list-style-type: none"> CA state and MHSA budget impacts on the critical needs and services of the disabled community
Los Angeles	LACDMH MHC full Commission	<ul style="list-style-type: none"> Talked about issues impacting our MHSA stakeholders and made recommendations to deploy some of our Latino Peer groups to provide drop in support groups remotely
Los Angeles	Los Angeles County Board of Supervisors Meeting	<ul style="list-style-type: none"> Submitted comments about barriers that LACDMH stakeholders are having obtaining, commenting, and getting information related to MHSA programs, MHSA 3 Year Plan, LACDMH MHSA stakeholder process, as well as significant disability barriers and language access (Spanish).
Southern	Behavioral Wellness Commission Meeting	<ul style="list-style-type: none"> Requested SB County to provide a safe, central location for stakeholders to meet. A vehicle provided by the county could pick up and deliver back ANY stakeholders who want to participate in the upcoming 3-year MHSA CPP forums. ACCESS Ambassador was invited to apply for the vacant 5th district commission seat.
Southern	Behavioral Wellness Commission	<ul style="list-style-type: none"> Lack of digital literacy, stakeholders needing digital devices and consistent internet access
Southern	DBW Commission Meeting	<ul style="list-style-type: none"> Addressed the importance of our stakeholders to be a continued presence at all MHSA CPP meetings and the importance of us being a guiding force when it comes to any decision that may impact MHSA funding from reaching its correct and intended programs and services

(90+) Local Stakeholder Training and Networking Meetings

ACCESS Ambassadors facilitated or attended a variety of Local Stakeholder Training and Networking Meeting throughout the 2019-20 year. ACCESS Ambassadors have developed advocacy skills, obtained knowledge of county issues, and strategize mental health priorities. These subject matter experts then take their knowledge and experience as mental health advocates to their communities in support of educating and empowering community stakeholders by discussing and taking-action on important issues that impact consumers in their region. These meetings support the meaningful participation of consumers and stakeholders in local-level 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 2019-20 ACCESS Ambassadors facilitated/attended 95 local training and networking meetings throughout the state of California. Ambassadors have reported that these meetings/trainings have supported community members obtaining valid, up and empowering information towards their rights as mental health consumers, their ability to share their lived experience as an advocacy tool regarding services needed in their communities and required stakeholder engagement on the local-level for services funded by MHSA. Examples of the meetings conducted include:

REGION	MEETING HOSTED/ATTENDED	ISSUES ADDRESSED
Los Angeles	"Get Out for Advocacy"	This advocacy meeting focused on ways to get involved and how to incite younger adults to become more engaged. We discussed advocacy opportunities and best practices for working with local representatives, issues they are facing, ways to change or resolve. Interest in more advocacy work and grassroots activism
Los Angeles	Stakeholder Networking Meeting	We organized with other community leaders to present at the LA County Board of Supervisors to speak against the combining of the UsCC's and the SAAC's.
Bay Area	Stakeholder Planning Meeting	We met to discuss the 3-year MHSA planning process, presented an overview of the MHSA, discussed the steering committee and how to get onto it
Bay Area	Ambassador Networking Meeting	This was a networking meeting for bay area ambassadors. Discussed status & challenges of the various counties. Discussed the letters by Steinberg Institute & CBHDA to the Governor
Southern	Consumer and Family Members Action Team	Consumer and Family Members Action Team discussing the status of the MHSA 3-year plan and formation of a Peer pool Of Champions. The outcome is the Pool is approved and will be funded with MHSA dollars. This Pool will also be present at all hiring of any new employee who is hired under the "peer" tag.
Southern	Wellness Community Meeting	The planning as well as the actual activity brought MH consumers from all over the southern part of Santa Barbara together to discuss our mutual concerns related to related to mental health
Superior	Online Speakers Event	Shared peer resources and peer experiences
Central	Online Networking	Educate all Ambassadors about finding and participating in virtual advocacy/ overcoming barriers to participation Educate Ambassadors within your region about specific advocacy opportunities Share specific concerns/issues where advocacy can be (or has been) beneficial during the pandemic

(5) 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 2020, ACCESS held the following five Stakeholder Focus Groups, which were attended by a total of 115 individuals:

- [29] Bay Area Region (Santa Cruz): November 21, 2019
- [20] Superior Region (Humboldt): March 6, 2020
- [22] Central Region (Fresno/Virtual): May, 6, 2020
- [21] Southern Region (Santa Barbara/Virtual): June 18, 2020
- [23] Los Angeles Region (LA/Virtual): July 7, 2020

(5) 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 2020, ACCESS held five Leadership Roundtables, which were attended by a total of 96 individuals:

- [13] Bay Area Region (Santa Cruz): November 20, 2019
- [20] Superior Region (Humboldt): March 5, 2020
- [14] Central Region (Fresno/Virtual): May 7, 2020
- [22] Southern Region (Santa Barbara/Virtual): June 17, 2020
- [27] Los Angeles (LA/Virtual): July 8, 2020

STATE-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

More than 350 ACCESS staff, Ambassadors, ACCESS-affiliated local system advocates participated in state-level, advocacy events, including but not limited to: Legislative Hearings MHSOAC meetings, MHSOAC Stakeholder Feedback on MHSOAC Committee meetings, MHSOAC Rules of Procedure Subcommittee Meeting, Youth Innovation Project Planning Committee, MHSOAC CFLC/CLCC meetings, MHSOAC Schools and Mental Health Subcommittee meeting, MHSOAC Community Forum, and LGBTQ Community Listening Session. A sample of the issues and concerns addressed at these meetings included:

MEETING ATTENDED	ISSUE(S) ADDRESSED
DHCS Stakeholder Advisory Committee	<ul style="list-style-type: none"> ▪ Spoke of the COVID-19 challenges facing consumers, including not knowing how to access services, lack of equipment to access telehealth, an increase in mental health challenges during the pandemic
State Assembly on Health	<ul style="list-style-type: none"> ▪ Provided support for SB803 and SB855
CCJBH Meeting	<ul style="list-style-type: none"> ▪ Advocated for housing for 20K already released or being released from jails. Is there housing for these people?
MHSOAC	<ul style="list-style-type: none"> ▪ Requested increased stakeholder involvement in community planning processes, a request that agencies better document stakeholder processes, including numbers of participants
MHSOAC-CLCC	<ul style="list-style-type: none"> ▪ Advocated for them to use culturally specific not race and ethnicity moving forward. Let them know that many cultures have no access to services
State of CA Dept. of Aging	<ul style="list-style-type: none"> ▪ Provided feedback on meeting housing goals for seniors is having accessible housing with Universal Designed features in increasing accessible housing for people with disabilities and seniors. In meeting the needs of seniors and people with disabilities having access to healthcare is to continue the Medicaid buy in program such as the 250% California Working Disabled program. this will not be affordable in accessing healthcare and being able to have access (decrease the high share of cost Medical) with IHSS in being able to age in place at home in our communities throughout the State

2020 ACTIVITIES AND ACCOMPLISHMENTS: TRAINING AND EDUCATION

“Hope is a powerful thing. Some say it’s a different breed of magic altogether.”

~Stephanie Garber

ACCESS promotes the expansion of meaningful consumer-operated services, recovery concepts, 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.

In March, with the statewide shelter in place order imposed because of COVID-19, ACCESS’ training and education gained new importance. Clients were facing increased stress and were seeking information, knowledge and resources. ACCESS transformed these in-person conferences and training forums (from March 2020 on) by conducting them in partnership with preselected counties through a virtual training platform.

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

TRAINING ACTIVITIES

(1) Regional Ambassador Bootcamp

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 2019-2020 program year, ACCESS held its Regional Ambassador Boot Camp in Sacramento from November 6 – November 8, 2019. The three-day Boot Camp hosted 19 Ambassadors from all five MHSA Regions, as well as several local advocates from other Cal Voices programs.

The 19 Ambassadors in attendance completed a post-Boot Camp evaluation (see **Appendix 3**), 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:

- 100% agreed the Boot Camp expanded their knowledge and understanding of the MHSA's General Standards and Program Planning requirements
- 94.8% agreed the Boot Camp increased their advocacy skills and confidence
- 100% agreed the Boot Camp prepared them for explaining the important requirements of the MHSA to other community stakeholders
- 100% agreed the Boot Camp prepared them for participating in their local system's MHSA Community Program Planning Process
- 100% agreed the Boot Camp prepared them for delivering an effective position statement at a public meeting
- 100% agreed the Boot Camp prepared them for evaluating whether a mental health policy or program complies with the MHSA's General Standards and Community Program Planning Requirements

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

- The best thing about the Ambassador Boot Camp is to know that there is actually an organization (Cal Voices) that backed us up for our Plight for Mental Health....and I am Not Alone on this quest. There is a whole room of like-minded folks who want to come together and **Be the Difference** we want to see in this corner of the world we are in.
- We were armed with advocacy tools to use at these meetings.
- All the information that was provided to us.
- Clear written information that I can bring with me
- The Power-Point slides

- Meeting and getting to know the ACCESS Ambassadors and the Cal Voices team, and leaving there feeling like I had been adopted into a large family
- I enjoyed being with others who are similarly committed to mental health equity and justice
- I got a chance to meet & work with all the ambassadors & access staff.
- The practice exercise afforded each of us an opportunity to present a concern or advocate on behalf of a stakeholder. I enjoyed meeting the new ambassadors
- 1) I liked that I was able to focus on the task at hand. 2) The Boot Camp was very organized in terms of learning materials and handouts. 3) The class was small and comfortable, not crowded with people sitting on top of each other.
- All of it
- Knowing that one is not alone in the fight for what is right
- The feeling of everyone have a common goal of striving to improve the community and lives of those individuals and families who need to be heard
- Meeting New Ambassadors
- Training on CPP
- Getting the introduction of what I can do and hearing other ambassadors' experiences

(1) State Ambassador Bootcamp

For the 2019-2020 program year, ACCESS held its first state level Ambassador Bootcamp in Sacramento November 12 – November 15, 2019. This four-day Boot Camp hosted 13 State Ambassadors from all five MHSA regions as well as several local advocates in leadership positions from other Cal Voices programs.

The 13 State Ambassadors in attendance completed a post-state boot camp evaluation (see **Appendix 3**) providing ACCESS with useful feedback on which aspects of the State Bootcamp they liked best and least, sharing what they learned and how it impacts them, and offering suggestions on ways to improve the training in future years:

- 100% agreed that attending the State Boot Camp increased their advocacy skills and confidence as a public speaker
- 100% agreed the State Boot Camp prepared them for delivering an effective position statement at a public meeting
- 100% agreed the State Boot Camp prepared them for explaining how decisions are made in their local mental health system to other community stakeholders
- 90.9% agreed the State Boot Camp prepared them for requesting information from their local mental health system to help them make a more informed policy decision
- 90.9% agreed the State Boot Camp expanded their knowledge and understanding of the MHSA's General Standards and Community Program Planning requirements
- 100% agreed the State Boot Camp prepared them for developing an effective position statement to deliver at a public meeting

(8) 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 2020, ACCESS conducted a total on **eight** Leadership Trainings in all five MHSA regions, with a combined total of 192 individuals representing the following California Counties/jurisdictions broken down by region: **Superior Region**-Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity. **Bay Area Region**: Alameda, City of Berkeley, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. **Central Region**: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter-Yuba, Tulare, Tuolumne, Yolo. **Los Angeles Region**: Service Area One, Service Area Two, Service Area Three, Service Area Five, Service Area Six, Service Area Seven, Service Area Eight. **Southern Region**: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tri-Cities Mental Health Services, Ventura.

- [20] Superior Region (Humboldt): March 5, 2020
- [21] Central Region (Stanislaus): October 19, 2019
- [13] Bay Area Region (Santa Cruz): November 20, 2019
- [22] Southern Region (San Diego): January 17, 2020
- [12] Los Angeles (LA): February 13, 2020
- [35] Central Region (Fresno/Virtual): May 7, 2020
- [39] Southern Region (Santa Barbara/Virtual): June 17, 2020
- [30] Los Angeles Region (LA/Virtual): July 8, 2020

ACCESS received 60 post-training evaluations from the 2020 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:

- 100% of respondents agreed the trainers were responsive to the participants
- 97.8% of respondents agreed the trainers appeared well organized and prepared
- 97.7% of respondents agreed a clear understanding of the workshop content was demonstrated

- 97.7% of respondents agreed the content was relevant to their work
- 95.5% of respondents said they would recommend this training to a co-worker

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

- Wonderful information and presentation!! Very enlightening.
- Good presentation. A lot of pertinent information.
- Strong foundational content. Trainers are very knowledgeable.
- So great. So needed. Excellent presenters.
- Very willing to answer questions. Appreciated the diversity of participants and sharing of information
- So much information.
- Instructors are very passionate about representing and educating
- Very illuminating and inspiring!
- Engaging instructors. Good combination of small group, didactic and power-point.

(7) 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 2020, ACCESS held the following **seven** Community Empowerment Workshops, which were attended by a total of 155 individuals representing the following California Counties/jurisdictions broken down by region: **Superior Region**-Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity. **Bay Area Region**: Alameda, City of Berkeley, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. **Central Region**: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter-Yuba, Tulare, Tuolumne, Yolo. **Los Angeles Region**: Service Area One, Service Area Two, Service Area Three, Service Area Five, Service Area Six, Service Area Seven, Service Area Eight. **Southern Region**: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tri-Cities Mental Health Services, Ventura.

- [20] Superior Region (Humboldt): March 6, 2020
- [11] Southern Region (San Diego): January 16, 2020
- [33] Central Region (Fresno/Virtual): May 6, 2020
- [27] Bay Area Region (Santa Cruz): November 20, 2019
- [21] Southern Region (Santa Barbara/Virtual): June 18, 2020
- [23] Los Angeles Region (LA/Virtual): July 7, 2020
- [30] Open to All California Stakeholders (Virtual): June 30, 2020

In 2020, ACCESS conducted **seven** Community Empowerment Workshops in every MHSA Region of the state, with a total attendance of 155 people representing the following California Counties/jurisdictions broken down by region: **Superior Region**-Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity. **Bay Area Region**: Alameda, City of Berkeley, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma. **Central Region**: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter-Yuba, Tulare, Tuolumne, Yolo. **Los Angeles Region**: Service Area One, Service Area Two, Service Area Three, Service Area Five, Service Area Six, Service Area Seven, Service Area Eight. **Southern Region**: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tri-Cities Mental Health Services, Ventura.

ACCESS received 62 post-training evaluations from the 2020 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:

- 97.4% of respondents agreed the trainers appeared well organized and prepared
- 94.8% of respondents agreed a clear understanding of the workshop content was demonstrated
- 94.7% agreed to trainers were responsive to the participants

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

- Great knowledge and passion.
- The instructors were well prepared passionate and empathetic, they were wonderful
- Articulate, clear, courteous, informative, well-paced, organized, responsive, pertinent
- Wonderful and engaging
- Engaging and passionate trainers
- Personal experience and ability to engage audience
- Clear explanations and examples
- Extremely well spoken, respectful and affirming for all participants
- Great Job! Both presenters were absolutely wonderful! Andrea Crook really did an amazing job honoring the participant's feedback and keeping the group moving – so impressed!

EDUCATION ACTIVITIES

2020 Annual Advocacy Conference: GET IN THE WAY

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 third annual conference – GET IN THE WAY – on August 21, 2020. The conference was originally to be held at the California Endowment in Oakland. However, due to COVID-19 we moved it to the ZOOM platform. Over 200 individuals attended this event for clients, community stakeholders, County and state mental health agency employees, and PMHS Leadership and key mental health decision-makers. Continuing Education Units (CEU's) were made available for those who are National Certified Peer Specialists (NCPS). Conference attendees hailed from the following California Counties: Alameda, Contra Costa, Los Angeles, Orange, Placer, Sacramento, Butte, Fresno, Humboldt, Kern, Lake, Madera, Mariposa, Merced, Modoc, Monterey, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tehama, Tuolumne.

As ACCESS' annual theme this year was peer support, conference content focused on peer support themes and topics impacting the overall PMHS. Highlights from this conference include:

- Andrea L. Crook, NCPS, ACCESS' Director of Advocacy, delivered the conference's welcome and opening remarks.
- Tiffany C. Carter, MS, ACCESS' Statewide Advocate Liaison and the 2020 ACCESS Ambassadors shared their stories of advocacy, individual and community empowerment, and successful outcomes for the program year.
- Ahmad Bahrami, MBA, Division Manager-Public Behavioral Health/Ethnic Services manager with Fresno County Department of Behavioral Health represented the Central Region's local level leadership by delivering an update on Fresno County's new INN project which will create more peer positions in Fresno County and shared some of the strengths and barriers Fresno County has encountered with elevating the client voice and the expansion of peer support services.
- Holli Drobny, Mental Health Services Act Coordinator and Public Information Officer for Butte County's Behavioral Health Department represented the Superior Region's local level leadership by delivering an update on the work being done in Butte County to create more peer provider positions, these positions are going to their board of supervisors for final approval and if approved will create a county classification for peer providers that incorporates six tiers so that peers will have opportunities for growth embedded in.
- Veronica Kelley, Ph.D., Director, San Bernardino Behavioral Health Department represented the Southern Region by providing an overview of how San Bernardino has incorporated peer providers throughout their system of care, by creating a county classification. Peers in San Bernardino have many pathways to employment. These include but are not limited to: County Department of Behavioral Health, community-based organizations and volunteerism. Dr. Kelly shared a success story of a peer employee who works directly with their police department. San Bernardino PD has fully embraced the peer who works on their crisis response team and have come to rely on the meaningful role of the peer provider.
- Sandra Sinz, LCSW, Deputy Director of Solano County's Behavioral Health Department represented the Bay Area Region and the work they are doing to create a more robust peer workforce.

- Jonathan E. Sherin, M.D., Ph.D., Director, Los Angeles County Department of Mental Health represented the Los Angeles Region, provided an in-depth overview of YourDMH and the work being done to elevate the client voice throughout the Los Angeles Region.
- Patrick Hendry, Vice President for Peer Advocacy, Supports and Services at Mental Health America was one of our three keynote presenters and focused his presentation on human rights, peer provided services, social directed care and social inclusion.
- Kelly Davis, Director of Peer Advocacy, Supports and Services at Mental Health America provided an in-depth overview of the National Certified Peer Specialist (NCPS) which is an advanced credential created by MHA in partnership with the Florida Certification Board and available to veteran peer providers throughout our nation.
- Amy Farrington, M.S., Director of Certification with the Florida Certification Board (FCB), provided an overview to conference participants on how the FCB validated the NCPS. The FCB is the certifying body for the NCPS.
- Thor Freudenthal, Director, Words on Bathroom Walls, introduced participants to his new film and provided 200 free passes for folks to view the film the night before the conference.
- Blia Cha, Program Manager, WISE, provided an overview of the peer training academy offered through WISE U, which when completed meets the minimum training requirement for the NCPS.

The conference was recorded and made available through ACCESS' website for those who were unable to participate on the day of www.accesscalifornia.org.

ACCESS received 116 post-training evaluations from the 2020 GET IN THE WAY Annual Conference (see **Appendix 7**). These evaluations and the additional feedback provided by attendees help ACCESS monitor the effectiveness of our learning materials and training approaches:

- 100% of respondents agreed that the conference fulfilled their primary reason for attending
- 95.7% of respondents were satisfied with the conference speakers
- 95.6% of respondents were satisfied with the conference topics
- 95.6% of respondents would recommend this conference to a friend or colleague

(Write-In Comments) Strengths of the conference:

- All terrific!
- Every presenter was amazing. Thank you so much
- All the Ambassadors are amazing!
- This was great to hear, the work coming from peers and their experiences as Ambassadors
- Excellent presentations
- The County Spotlight presenters were awesome!
- I loved hearing how different counties are utilizing Peers within their systems of care. I am happy to learn how Peers are beginning to be advanced within county systems as a legitimate profession. This is so very awesome!
- The keynote speakers were awesome!
- Very informative and I learned a ton of new things regarding the National Peer Certification.
- The keynote speakers were fantastic. They really inspired me and I learned so much.

(10) Advocacy, Leadership, and Learning Series Webinars

Advocacy Webinars: These quarterly webinars provide mental health policy updates from a client/consumer 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 community planning process. Stakeholders can give feedback on important policy issues and help the ACCESS program focus its state-level advocacy activities. The webinars offer a great venue for clients/consumers, advocates, peer support workers, and other community stakeholders to receive input and views of those on the ground regarding important mental health advocacy and peer employment issues.

Target Audience: Clients/Consumers, General Public, Others who work with and on behalf of clients/consumers, Peer support workers, Peer-run agencies and programs, Other stakeholder groups

Leadership Webinars: These quarterly webinars provide an opportunity to collaborate with county-designated client/consumer 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/consumers throughout the state. Legislative and policy analysis will be provided, and participants will identify opportunities for local- and state-level public advocacy. County MH leadership and other local- and state-level policy makers will receive practical tips and resources to help facilitate effective participation of stakeholders in the community planning process. Participants can also give feedback on important policy issues affecting their communities and help the ACCESS program focus its state-level advocacy activities.

Target Audience: Local policy makers, State policy makers, Providers

Learning Series Webinars: These webinars 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. These webinars offer opportunities for individuals to share ideas and get their questions answered in a friendly, supportive, and nonjudgmental environment.

Target Audience: Clients/consumers, Local policy makers, State policy makers, Providers, General public, Others who work with and on behalf of clients/consumers

ACCESS conducted the following webinars this program year:

- **(10/15/19) Advocacy Webinar: MHSOAC Client Stakeholder RFP.** This webinar provided Ambassadors with an overview of the upcoming MHSOAC Client/Consumer Stakeholder RFP, with the purpose of developing a shared plan to advocate for Ambassador interests in the RFP development process.
- **(10/8/19) Learning Series Webinar:** This learning webinar purpose was to present California Stakeholder concerns and conduct an interview with Dr. Tom Insel, Governor Newsom's Special Adviser on Mental Health Policy.
- **(11/18/19) Leadership Webinar: CalMHSA Update on the HELP@HAND Project.** The objective of this webinar was to provide stakeholders the background on the statewide innovation project Help@Hand Project (formerly known as the Tech Suite), share projects lessons learned and respond to frequently asked questions.
- **(1/29/20) Advocacy Webinar: ACCESS Ambassador Quarterly Webinar.** The purpose of this webinar was to increase the Ambassador's advocacy toolbox and to learn how to avoid certain pitfalls when advocating and communicating.

- **(1/30/20) Learning Series Webinar: Social Determinants of Health 101.** This learning series provided participants with a review of the social determinants of health and how the SDOH relate to chronic stress, adverse childhood experiences, as well as how the SDOH correlate to health disparities.
- **(1/23/20) Leadership Webinar: What Happened?** This leadership webinar explored the three factors that have hindered the MHSA's intent of transforming the PMHS which are: Fragmented Oversight Authority, Phased Implementation, and The Great Recession.
- **(4/17/20) Advocacy Webinar:** This advocacy webinar was a shared learning opportunity created to learn from clients about the advocacy challenges they are facing in a new virtual meeting environment, and to share with them updates to open meeting laws and suggestions for continuing advocacy during the stay-at-home order.
- **(6/12/20) Leadership Webinar: Recovery-Oriented Outcomes and Measurements.** This leadership webinar provided participants an opportunity to learn about the 2019 state of recovery-oriented services, the client and leadership perspective, as well as the pitfalls we make in obtaining recovery-oriented services.
- **(6/12/20) Learning Series Webinar: Staying Connected.** This learning series webinar was designed to encourage advocacy efforts in spite of COVID-19 and covered: current brown act requirements, MHSA client-driven policy and stakeholder involvement, transparency, networking & connecting, and the digital divide.
- **(7/31/20) Learning Series Webinar: National Certified Peer Specialist.** For this learning series webinar ACCESS welcomed Kelly Davis, Director of Peer Advocacy, Supports, and Services with Mental Health America who walked participants through this exciting opportunity for California Peer supporters, as it is an opportunity for individuals to obtain an advanced national credential for peer providers.

eLearning Modules

Because ACCESS delivers a limited number of in-person trainings each year, ACCESS develops eLearning modules from each of its core trainings and other educational content, all of which are available for free online at <http://www.accesscalifornia.org/>. The year ACCESS created the additional eLearning modules:

- **(2/1/20) Peer Support 101:** Peer Support 101 introduces peer support concepts to facilitate understanding of how peer support works, core principles and values of peer support, appropriate and inappropriate duties for peer workers, and proficiencies for peer providers. In this training, we address the following topics: • Definitions of "Peer" and "Peer Support", What Peer Support Workers Do and Don't Do, Basic Values of Peer Support, Core Competencies for Peer Support Workers, Challenges to Integrating Peer Support, Peer Certification
- **(5/1/20) Surviving and Thriving:** This e-learning module covers how to get and keep a peer position in California's PMHS. This module focuses on professionalism in the peer support field, and teaches participants how to explore the types of peer positions that are right for them, examine personal barriers to workplace success, behave professionally in a workplace setting, function as part of a team, and understand workplace expectations so they are prepared to succeed at their new job on day one. Module components include: How working supports wellness, finding the right peer position for you, applying and interviewing, the onboarding and orientation process, becoming a great employee/volunteer, and overcoming barriers to workplace success
- **(5/20/20) Supporting Success:** This workshop focuses on proven methods of building a supportive work environment for your coworkers and yourself. Training Components include: The importance of social

support, psychological risk factors, challenges to developing a healthy work environment, and overcoming workplace challenges

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 2019-2020 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. Below you will find a sample of ACCESS provided TA, guidance, feedback, and support:

ENTITY/ORGANIZATION	SUPPORT PROVIDED
Modoc County	Provided feedback and guidance pertaining to questions around the MHSA & INN plans
American Psychological Association (APA) CA/Natl.	Support was provided around how strategies to advance the use of person-centered approaches to ensure individuals living with an SMI receive the support they need.
Santa Cruz	TA was provided along with ACCESS educational materials. Ongoing TA and training for the community and fellow board members was offered.
San Mateo	Education around ACCESS' position on AOT as well as ACCESS' position statement and articles that address concerns re. AOT
UCLA	Provided subject matter expertise on the Community Wellness Project
Placer	Provided all educational resources and opportunities that ACCESS and Cal Voices provide.
Los Angeles	2020 Mom The Blue Dot Project requested a panelist at their annual conference to inform attendees about MHSA & PMHS (request fulfilled).
Tri-Cities	Provided TA and resources around the MHSA's CPP and the involvement of youth
CBHPC	Provided a presentation of the Y2 SOCR at the Jan, 2020 CBHPC meeting
CA Senate	Requested a list of FAQ's pertaining to why CA needs a state peer certification. ACCESS created FAQ's for Senator Beall's office

ENTITY/ORGANIZATION	SUPPORT PROVIDED
Los Angeles	Provided information pertaining to the LAC BOS Agenda for 1/7/2020 related to the UsCC and addressed the fears around how this would impact the voice of the un/underserved communities.
Orange County	Provided ACCESS Position Paper and opportunities to meet with other concerned stakeholders at their collab mtg. scheduled for March 11, 2020.
Capital Public Radio	Requested more information on the WET and CFTN funding breakdown. Provided the breakdown as written in the WIC along with ACCESS program component handout.
State	Provided TA to the Build CA Wellness workgroup to develop an accessible site of digital MH resources for Californians Provided TA pertaining to content and design
Disability Rights California	Provided support with the California Memorial Projects 17 th annual Remembrance Day (remember individuals who lived and died in California State Institutions).
Sacramento	Provided the newly assigned Behavioral Health Director with the history of the client movement in Sacramento County
El Dorado	Provided training, educational materials and ongoing TA
CBHDA	Provided Michelle an overview of the work that ACCESS has done in CA counties and an overview of our Y1 & Y2 SOCR findings.
CalMHSA	Provided TA and support by recruiting two judges to review vendor applications and help select vendors that will demo their products and participate in site visits with the counties. Those who advance to this stage will have the opportunity to work with counties to submit proposals for a 3-month trial pilot. Upon a successful pilot, counties may elect to integrate the technology into the Help@Hand Product Portfolio of approved applications for further implementation across participating counties
NAMI California	Provided collaborative support with outreach UC Davis Center for Reducing Health Disparities/ Cultural Competence Training

2020 ACTIVITIES AND ACCOMPLISHMENTS: OUTREACH AND ENGAGEMENT

“No one would ever say that someone with a broken arm or a broken leg is less than a whole person, but people imply that all the time about people with mental illness.”

~Elyn R. Saks

Because ACCESS’ primary goal is to strengthen and expand consumer advocacy through individual and community empowerment, ACCESS provided targeted outreach, engagement and communications strategies directed to local clients/ consumers, family members, and members of underserved populations.

With the statewide shelter in place order imposed because of COVID-19, ACCESS’ outreach and engagement gained new importance. Clients were facing increased stress and were seeking information, knowledge and resources. In addition, advocacy activities were suddenly transformed into virtual meetings.

The goals of ACCESS’ outreach strategies in 2019-2020 were:

- Inform individuals of their rights as clients, families, and members of underserved communities
- Treat them as necessary and valued participants in local and state level stakeholder processes
- Respect their unique needs and empower them to take individual action in their communities
- Keep them informed about important mental health policy issues affecting them
- Keep them informed about policy changes resulting from the pandemic
- 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 and our ACCESS Ambassadors 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 and Stanislaus Counties). Due to the impacts of COVID-19, our Superior Region outreach events were conducted virtually.

COMMUNICATIONS ACTIVITIES

ACCESS Website

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. The ACCESS website is updated frequently, and includes our upcoming trainings, position papers, recent Ambassador advocacy successes, and a wide variety of advocacy resources, including advocacy tips, MHSA information and past webinars. Our website traffic has consistently increased since we began tracking visits this year.

Online Local and State Advocacy Directories

ACCESS maintains online local and state advocacy directories which are updated frequently. These directories identify state-level agencies who offer advocacy opportunities, and access points for local advocacy in each of the 59 local mental health agencies in California. Our State and Local Advocacy Directories identify:

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

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, mental health policy, ACCESS events, and other relevant information via email blasts, quarterly newsletters and social media posts. These updates increase awareness of local services, promote wellness and recovery, and provide information on advocacy, policy, and networking opportunities. In 2020, the pandemic caused increased stress and anxiety among Californians, especially consumers. In addition, due to the statewide stay at home order, more people were at home and in need of information. Cal Voices responded to the needs of consumers by increasing the frequency of our newsletters, sending out weekly comprehensive newsletters during the months of April, May and June.

While the standard average for Constant Contact clickthrough rates is approximately 7%, our average range is between 10-16% with over 5,000 subscribers. Our increasing community of subscribers is very active and interested to learn more about advocacy, policy, and Public Mental Health System trainings and news.

ACCESS maintains a Facebook profile, Instagram profile, a YouTube account and a Twitter profile, and has steadily grown our social media presence over the years.

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 conducts research on issues, drafts position statements, assists advocates with development of talking points, and provides informational handouts for distribution by stakeholders. Our Advocacy Helpline is available 24 hours a day for advocates to ask questions about effective advocacy. All messages are returned within 48 hours to ensure that individuals receive timely assistance with their issues.

Peer Voices of California

Late this year, ACCESS established a consumer advocacy coalition, called Peer Voices of California. This coalition has steadily grown in membership and now includes over 200 advocates. Peer advocates are informed directly of state level advocacy opportunities, and offered guidance on effective advocacy. This coalition will evolve to include regional volunteer advocacy leads to encourage broader dissemination of local advocacy opportunities and create regional advocacy networks.

2020 ACTIVITIES AND ACCOMPLISHMENTS: ACCESS AMBASSADORS

"My dark days made me strong. Or maybe I already was strong, and they made me prove it."

~ Emery Lord

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
- 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 2020 ACCESS AMBASSADORS?

For the 2019-2020 program year, Ambassadors came from all five MHSA Regions, representing the following California Counties: Alameda, Butte, Fresno, Humboldt, Los Angeles, Marin, Monterey, Sacramento, San Bernardino, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma, Stanislaus, and Ventura.

2020 SUPERIOR REGION AMBASSADORS

Andrea Wagner (State Ambassador): Butte County

Andrea Wagner has worked in Butte County Behavioral Health since 2015 and has been a strong and vocal advocate for the Peer Workforce in her County. Andrea believes strongly in what the Mental Health Services Act provides for California consumers, and has actively worked throughout the county to enhance and uplift the consumer and stakeholder voice.

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, they responded: *"Program and staffing cuts were foreshadowed in the upcoming budget but due to the attention we have put on peer support and all the proposed enhancements promised to the peer workforce, I am confident, after directly asking the administration, that peer positions will not be cut and are still going to grow in Butte County."*

Vernon Price (Regional Ambassador): Humboldt County

Vernon has been a long-term community advocate and activist for the homeless and mentally ill and Humboldt County. He has facilitated numerous "know your rights" classes and homeless voters registration drives. He was appointed by the Humboldt County Board of Supervisors to the housing trust fund Homeless solutions committee and was also appointed from the Humboldt County Board of Supervisors to the Behavioral Health Board along with participating in the adult and Senior adult subcommittees for Humboldt.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Vernon responded: *"Knowing that there are people and an institution that researches Mental Health Bill's and encourages us to be educated with the knowledge of these Bills so we can advocate."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Vernon responded: *"Humboldt County mental health administration has begun the process to have your around stakeholder participation work group meetings."*

2020 CENTRAL REGION AMBASSADORS

John Aguirre (State Ambassador): 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. John was an active state level advocate collaborating with various peer run organizations and stakeholder groups ensuring membership was reflective of the diversity of California.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, John responded: *"Affiliation with ACCESS gave local advocacy legitimacy. Advocates felt they weren't alone... It felt good to be part of a statewide team of professional advocates whose membership reflected the diversity of California, geographically and culturally."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, they responded: *"I advocated for a local health center to address the unique health concerns of LGBTQ+ community members, we now have the Rainbow Clinic, twice a month and are looking into including peer support, health navigators at the clinic."*

Clarene White (Regional Ambassador): 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. She has participated in increasing the community caregiver's awareness of Cal-Access (provides financial information supplied by state candidates, donors, lobbyists, and others), Fresno County Mental Health Board Meetings, and MHSA Innovation Funding opportunities.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Clarene responded: *"What I liked best about participating as an Ambassador was the opportunities to further hone my advocacy skills and being [a part] of a statewide effort to improve the lives of individuals and families affected by the minimal lack of access to mental health services."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Clarene responded: *"I worked with a Behavioral Health organization to develop program policy, staff, and board of director training, Q&A, and fact sheets resulting in increased awareness of Fresno County Mental Health Board meetings, MHA legislation, and identification community stakeholder service needs."*

Bill Floyd (State Ambassador): 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. Bill has consistently been an advocate for those unhoused, elevating their voices and their rights to be present when decisions are made regarding their services and opportunities to provide input when possible.

Jessie Wright (Regional Ambassador): Sacramento County

Jessie believes in giving a voice to the voiceless and supporting consumers participating in changing the public mental health system. Jessie is a continuous advocate for breaking the stigma associated with mental health challenges and the elevation of peer support services and specialists throughout mental health services.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Jessie responded: *"ACCESS was always willing and glad to assist me in achieving the tasks that I sought to achieve. I was never left without contact from someone in the office any time that I had an inquiry. I could not have learned or achieved the level of advocacy I felt was meaningful without their overall assistance. I know without a shadow of doubt that my level of being more aware of mental health policy issues, meetings and ability to be vocal was not a presence in my life before ACCESS' empowerment training and information. I can truly say that I have learned to advocate for others, myself and encourage stakeholders and family members to get involved. I have a greater desire and drive to stay connected to my community."*

2020 BAY AREA REGION AMBASSADORS

Michael Lim (Regional Ambassador): San Mateo County

Michael Lim has been an active voice in the County of San Mateo throughout the year. He is a firm believer that meaningful peer support be utilized throughout all mental health services. Michael has been providing his advocacy skills and education to a variety of local-level advocacy committees (e.g.: Chinese Health Initiative, Suicide Prevention Subcommittee, Diversity and Equity Council, and the Mental Health Substance Abuse Recovery Commission), and has advocated for the unprecedented amount of stakeholder involvement the MHSA calls for on all levels, especially in the CPP.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Michael responded: *"Wouldn't have learned so much or be as effective without your help."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Michael responded: *"Recruited about 5 local stakeholders & NAMI-SMC to participate in various county meetings like Suicide Prevention, BOS, MH Commission, QIC, MHSA Planning, Diversity & Equity. Recruited 2 MH Commissioners to some of the above meetings too. Worked with NAMI-SMC to be the 1st CBO to transition all their peer support services onto Zoom [and] currently working NAMI-SMC to build their Advocacy offering."*

Lorraine Zeller (State Ambassador): 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", where participants receive training on advocacy and engagement in the mental health system. They then put their training into action by attending various Board and Commission meetings in their county, ensuring the consumer voice is at the table. Additionally, Lorraine has been a big voice and support for advancing stakeholders' education on the MHSA and advocating for transparency in the behavioral health system. She has established a reputation as a lead advocate in her county which has led to requests for policy support from the Board of Supervisors and CBO executives.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Lorraine responded: *"Continued building of meaningful, both personal and practical - to support advocacy efforts - relationships with ACCESS staff, ambassadors, and community leaders."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Lorraine responded: *"I worked with a group of advocates and COO of Valley Medical Center overseeing inpatient psych facility resulting in development of plans to bring peer support to the inpatient unit. I was asked by the Director of Consumer and Family Affairs to provide information and advice about peer training resulting in her strongly recommending that peer workers - especially interested in career advancement - attend the WISE-U training. I, and another peer advocate, were asked, by the Executive Director of the Behavioral Health Contractors Association and CEO of our largest mental health CBO to join leaders in support of expansion of the mobile crisis unit. We plan to build on this relationship to advocate for programs and services focused on prevention and recovery."*

Pamela Weston (State Ambassador): Monterey County

Pamela Weston has supported consumers within her county and statewide to use their voices and become actively engaged in all levels of mental health policy, planning, services, and oversight. She is a firm believer in the MHSA's motto "nothing about us without us" and the elevation and advancement of peers being utilized as the subject matter experts they are. Additionally, Pamela continuously fights for community-based services for youth and adults that are culturally specific and reflective of the diversity of each county. Culturally relevant training for service providers is something Pamela voices consistently along with the empowerment of peers throughout the mental health system.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Pamela responded: *"The information, support and opportunities provided and all the expertise provided by ACCESS to Speak truth to Power and raise the voices of our communities across the State"*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Pamela responded: *"Learning the background, language of the Proposition Requirements and the Community Planning Process with the General Guidelines has been significant in changing the priorities especially in how the County is doing engagement. Overall, this year I advocated for District specific and cultural relevant community-based services and support."*

Pamela Miles (State Ambassador): Alameda County

Pamela Miles is an advocate well versed in the needs of her community. She has promoted the benefits of trauma informed care training for those working in mental health and the consistent usage of peers to support wellness and recovery throughout the PMHS. Pamela additionally has become an active participant in her county's Quality Improvement Committee, supporting meaningful stakeholder engagement, accountability and transparency, and the empowerment and inclusion of peers. She has provided her experience and knowledge continuously with mental health legislation throughout the year.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Pamela responded: *"I was positive in advocating for youth and CPP engagement. I have become more outgoing in speaking at meetings."*

Richard Gallo (State Ambassador): Santa Cruz County

Richard Gallo has been a force in the consumer movement ensuring accountability on both the state and local level. Richard proudly supports Santa Cruz County with ensuring that consumers and family members are able to actively participate in the CPP and ongoing evaluation, development, and inception of programs and services funded by the MHSA. Richard has been a voice of the people and an advocate for peer elevation and empowerment throughout all mental health services in the state. Additionally, Richard actively advocates for the hard of hearing and disabled populations and ensures counties address ADA compliance and remove barriers for participation for those with disabilities.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Richard responded: *"ACCESS CA Staff provided valuable support and is compassionate about mental health services. Oversight Commission played politics with the second grant with bias and retaliation during the evaluation process while giving to another organization that only focuses on peer services."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Richard responded: *"reminding Oversight Commission on intent of the MHSA funding, mentioning Peer Support Services as part of grant proposal by other service providers that do not have it in their grant proposal. Working collaboratively with County MHAB as much as the management team plays politics just like some Counties and the Oversight Commission."*

Carol West (Regional Ambassador): Sonoma County

Carol West aids Sonoma County with the goals of empowering consumers, uplifting peers, and educating the community of the requirements and benefits of stakeholder engagement. This year Carol established the Sonoma County Peer Council and began her journey being appointed to the County's MHSA Steering Committee and the Mental Health Board. She not only promotes the implementation of peers on all levels but is a vocal advocate for creating meaningful ongoing CPPs in their county.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Carol responded: *"Loved all events but was sad we could not meet in person due to COVID 19 social distancing. ACCESS staff did an amazing amount of work to help us all transition to online methods of doing our advocacy work."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, they responded: *"I have advocated for a more robust CPP and we now have an active CPP work group looking to improve the number and frequency of opportunities for input to decision making in the mental health system in Sonoma County. I have enjoyed learning more about the interaction between Sonoma County law enforcement and people who have mental health challenges. I enjoyed learning about the MHSA and how it was essentially passed to empower people with lived experience and their families. Knowing our rights and the parts of the law that support our participation in decision making has been very enlightening and empowering."*

Jaime Yan Faurot (Regional Ambassador): Marin County

In Marin County Jaime has been consistently a voice for those in the unserved and underserved communities. She has skillfully utilized her lived experience as a way to connect with stakeholders and leadership, ensuring that adequate representation is present at tables where decisions are being made. Jaime is passionate about conducting outreach to diverse communities, educating them on the various disparities amongst mental health service provision, and empowering consumers/peers to use their voice to create meaningful change which is the

spirit of the MHSA. When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Jaime responded: *"Actually, to be able to be an ACCESS Ambassador this year has been a Major Highlight for me ever since I became disabled in 2012. For the longest time, I have been hiding myself behind closed doors because I kept on telling myself I am not good enough and nothing I do will ever matter, and soon enough it became my reality. It was not until I started going local leadership meetings and then becoming an ACCESS Ambassador that I realized that I have some worth and I can do something to make a difference not only in others' lives but also my very own. On top of that, it gave me a sense of purpose and a voice that I desperately needed."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, they responded: *"My advocacy success this Q4 was being able to witness the seeds of what I have sown come to fruition. The two distinctive instances are as follows : 1) Racism is now declared a top public health issue in Marin (as of 13 July 2020). For many years, i have been working on this issue....and trying to bring this issue to light....but each time I did I have been beaten down and drown in either an awkward silences or become shot down with blank stares. I even cited my first Xenophobic experience in 2011 I then went on speaking of it to all the community events /board meetings because i want it not be swept under the carpet because it was a big issue for me, being a person of BIPOC....2) Today as of 09/2/2020 , Marin CCAB finally has its Charter as well as Cultural Competency and Humility, Equity and Inclusion Framework policy being drafted. -To me this is a great deal because...this was the time we have these two incorporated into our county. Same time, it further accentuates the representation of diverse communities (BIPOC) to be heard and Not a One Size fits all. 3) More Diverse Peer Hires - With effective from this Sept 2020, the County will have 1 more Peer on board that is from the LatinX Community, and then another Peer Coordinator."*

2020 LOS ANGELES REGION AMBASSADORS

Pam Inaba (Regional Ambassador): Los Angeles County | Service Area 6: South

Pam Inaba is a longtime 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. Pam has made it her mission to support how she can improve the PMHS and access to care for those un/underserved in Los Angeles County. She is passionate about increasing peer support and encouraging people from all walks of life to lend their voice at ensuring consumers of mental health services receive quality, diverse care and support.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Pamela responded: *"As it has been every year, working with other Ambassadors was my favorite part of being an Ambassador. I worked with Johana, Amparo, and Bianca most of the time. These fantastic Ambassadors reminded me of the dedication that they have to the Program and each other. This continues to demonstrate the stellar job excellent advocates do to improve the public Mental Health system. And the fact that I am part of this group makes me extremely proud."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Pamela responded: *"I advocated for The Asian Pacific Planning and Policy Council to make available information on the 2020 possible election measures and candidates. Stakeholders need to obtain this information to assist in voting decision-making for this years' extremely important election. I was told this information is forthcoming as soon as possible."*

Tiffany Duvernay (State Level Ambassador): Los Angeles County | Service Area 6: South

Tiffany Duvernay has been an active advocate on both the local and state level this year. She has used the language of the statutes and regulations to her advantage when advocating and has established herself as a knowledgeable mental health advocate, especially for those unhoused and/or incarcerated. Tiffany encourages and empowers stakeholders to hold county and state leadership accountable, while creating supportive and trusting relationships. She is consistently engaged with her local SPA/SAAC Meetings and continuously sharing knowledge and educating others on what the MHSA mandates in order to embark upon the system transformation it was created to accomplish.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Tiffany responded: *"I enjoy collaborating with other advocates, learning the issues and progress being made in other Regions. I love Bootcamp!"*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Tiffany responded: *"I advocated in support of Cares First, Jails Last and contributed to the 114 recommendations adopted by the Los Angeles County Board of Supervisors March 10, 2020. I advocated for a year during the Alternatives to Incarceration Workgroups for people to receive mental health treatment instead of going to jail, or prison."*

Hector Ramirez (State Level Ambassador): Los Angeles County | Service Area 2: San Fernando

Hector Ramirez has been a force to be reckoned with during this year of the peer and within the focus on mental health advocacy empowerment. Hector has had a leading advocacy presence within both the county and the state level, supporting organizations and policy makers creating and revising legislation focused on reducing mental health disparities, especially for racial, ethnic, and LGBTQIA communities. Hector holds many titles including but not limited to being a long-term disability rights advocate, a member of the Mental Health Services Oversight and Accountability Commission's Cultural and Linguistic Competence Committee and the California Behavioral Health Planning Council.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Hector responded: *"This program really helped me better serve the folks in my family, my communities in LA County, my work for all the disabled folks in California. I learned that I am scared of meeting and working with new people and it takes time and trust for me to overcome this. Not sure why this happens or how long I have been doing this. I learned how to lean into my peers and trust others, and that has changed my life for the better. Now with COVID-19, I am able to cross apply my Mental Health advocacy skills in this pandemic to help my disabled, Latinx, Native American, and LGBTI2S communities. This training got me ready as I hit the floor running when this pandemic hit us all."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Hector responded: *"Helped underserved communities LA retain LACDMH funding for its UsCC programs, helped stakeholders in LA County to attend, participate, and advocate for the CPP, worked with stakeholders and CBOs in LA County to pass BOS motion to fund specific mental health initiatives for Latino, Disabled, and Black communities, helped community stakeholders and CBOs to pass BOS motion to fund 'Promotoras' (MHSA funded project) as a stand-alone program within the county, mentored 3 ACCESS Ambassadors go increase CPP awareness in LA County, to advocate for UsCC MHSA funding, and to engage with LA County BOS to increase MHSA stakeholder raining for LA County stakeholders."*

Amparo Ostojic (State Level Ambassador): Los Angeles County | Service Area 4: Metro

Amparo Ostojic is a motivated mental health advocate whose boots on the ground activism for consumers and their family members from underserved communities helps improve access to appropriate mental health services. Amparo has made strides year-round to support, educate, and advocate the Underserved Cultural Community subcommittees (UsCC; the Latino UsCC specifically) and the Service Area Advisory Committee for her area. She has worked closely with her LA Regional ACCESS Ambassadors to ensure that the voice of un/underserved populations are brought to the table of decisions being made on their behalf without their input.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Amparo responded: *"I learned how to become an effective advocate and stand up for members of my community. I'm very grateful for this life-changing opportunity."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Amparo responded: *"my team and I advocated to maintain the UsCC intact, this ensured that \$1.3 Million dollars were dedicated to the Underserved Cultural Subcommittees. Johana, Bianca, Hector, Pamela Inaba and I made this possible."*

Bianca Gallegos (Regional Ambassador): Los Angeles County | Service Area 6: South

Bianca Gallegos continues to be a vocal advocate on the local level for mental health consumers in LA County. Bianca is committed to reducing stigma and discrimination associated with mental health and focuses her efforts on addressing policy level issues which have created challenges with mental health services for consumers. She has worked closely with her LA Regional ACCESS Ambassadors throughout the county on various issues that are meaningful regarding mental health services and legislation.

Alicia Rhoden (Regional Ambassador): Los Angeles County | Service Area 6: South

Alicia Rhoden is passionate about empowering and encouraging community members, consumers, family members, and all other stakeholders to provide their input, education, and experiences at the various boards and commission meetings that oversee mental health services in LA County. Alicia is driven by supporting underserved and diverse populations with becoming empowered to find their voice as mental health advocates and drivers in their own recovery.

Thomas Smith (Regional Ambassador): Los Angeles County | Service Area 6: South

Thomas Smith focused heavily on ensuring that adequate mental health services are available and accessible for all, especially those formally incarcerated, living with trauma, and impacted by economic disadvantages. Thomas advocates and empowers these populations with tools needed to bring their stories and experiences to the tables where they are able to independently and collaboratively advocate for policy and systemic changes in mental health.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Thomas responded: *"What I liked best about participating is knowing that if there were any road blocks, or barriers in which I would have encountered that I had an entire ACCESS support team in Sacramento available to me."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Thomas responded: *"After participating in and voting during Alternative to Incarceration Workgroups for approximately one year for people to be intercepted and to not be sent to jail for mental health challenges, I*

advocated during public comment at a Board of Supervisors hearing for them to adopt 114 recommendations. The recommendations were adopted."

Jolissa Hebard (Regional Ambassador): Los Angeles County | Service Area 8: South Bay

Jolissa Hebard has been a mental health advocate for Los Angeles County by educating stakeholders, promoting advocacy, and aiding in the efforts to end mental health stigma. This year Jolissa worked towards establishing a working, meaningful relationship with county leadership, by way of continuously attending regularly scheduled meetings and being a voice of the people. By doing so she developed a relationship with her local LADMH representatives and other stakeholders in the area.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Jolissa responded: *"PEER CERTIFICATION! SB 803 and we are making great progress with the 9-8-8 national number. Even with the issues that CV19 presented we were able to move forward with this much needed legislation."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Jolissa responded: *"increased networking with other peers, nonprofits, and community groups. Due to my work within the Ambassador program, I have met and had a chance to interact and get to know a multitude of people and groups that are working diligently to change the world of mental health. These connections only further my ability to spread awareness, increase advocacy and end stigma."*

Johana Lozano (Regional Ambassador): Los Angeles County | Service Area 7: East

Johana Lozano is passionate about speaking up for those marginalized, un/underserved, or unable to speak up due to fear, trauma, lack of trust, or simply unknowing that they can speak up and create change. Johana has been an active advocate on the local level, consistently supporting her community and leadership with better understanding of the MHSA, the rights of mental health consumers, and ways to effectively advocate and network.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Johana responded: *"Had it not been for COVID, everything would be "very effective" all things considered, ACCESS did an outstanding job!... I created a strong network to assist the community in mobilizing to prevent defunding stakeholder engagement in LADMH. Honestly, I felt more empowered this year. The new ambassadors were professional and their motivation kept me advocating. The ACCESS staff had a plan from the start. They went above and beyond with supporting us LA region ambassadors."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Johana responded *"I de-escalated 2 misunderstandings within DMH leadership resulting in their respective departments to work together and retain stakeholder reimbursement for activities. I recruited the youth (13 - 28 yr old) to participate in stakeholder engagement in SPA 3. I helped organize people in leadership roles to become advocates for MHSA in their workspace."*

2020 SOUTHERN REGION AMBASSADORS

Vickie Mack (State Level Ambassador): San Bernardino County

Vickie Mack is a well-known advocate in San Bernardino County and is consistently educating the community and county leadership of the mandate and value of stakeholder engagement in all aspects of MHSA funding and

services. She continues to work towards ensuring that the various, diverse voices and experiences are afforded the opportunity to bring their voices to the table where decisions are being made about their lives.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Vickie responded: *"ACCESS staff was very flexible and accommodating while still maintaining the standards that produced quality work from ambassadors... The State of the Community Reports were very comprehensive and contained information of great importance to mental health stakeholders, consumers and family members."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Vickie responded: *"My increased knowledge and engagement has made me feel empowered as a mental health advocate because I have been up-to-date on the relevant and timely issues concerning California mental health issues and policies."*

Jacob McDuffee (Regional Ambassador): Santa Barbara County

Jacob McDuffee has been an active advocate in Santa Barbara County enthusiastically working towards increasing community engagement and knowledge regarding peer services as an evidence-based practice, and elevating the voices of the youth. Jacob has invested in creating meaningful relationships throughout the county with fellow advocates, county leadership, consumers, family members, amongst other stakeholders.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Jacob responded: *"It is my honor and privilege to be serving as a Y3 Ambassador to the Southern Region, Wouldn't Change a thing... If I could advocate on behalf of ACCESS forever, I would!"*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Jacob responded: *"I was able to form and maintain close personal and professional relationships with a number of Commissioners and high-level decision makers in the county. In so doing I helped to get the ACCESS California name out there and actually helped institute some change in the way our Commission and county approach and engage our community's partnership and stakeholders."*

Pete Lafollette (State Level Ambassador): Ventura County

Pete Lafollette has been a strong advocate for both Ventura County and across the state for decades. This year, he's ensuring that mental health stakeholders are aware of opportunities to participate in transformative change. Pete is active locally and statewide, always keeping his fellow peers abreast of the constantly changing mental health landscape in California.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Pete responded: *"Cal Voices staff are very smart, effective, and FUN!... Always appreciate the patience, expertise and levity demonstrated by Cal Voices staff. My effectiveness level was lessened by the pandemic and lack of real time meetings."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Pete responded: *"Much as I loathe social media as the sole source of communicating, I continue to learn and practice it and am trying to increase local network outcomes."*

Chuck Hughes (Regional Ambassador): Santa Barbara County

Chuck Hughes, an avid advocate for peer services, has been highly active in Santa Barbara's Peer Action Team which is the county's consumer and family member action team, with a mission to increase and improve recovery by way of implementing peers throughout the PMHS. Chuck is vocal about ensuring stakeholder engagement is appropriately sought and utilized within all aspects of MHSA funded programs and is consistently looking to strengthen the county's consumer network as a main source of input of services, programming, and evaluation.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Chuck responded: *"My advocacy has resulted in the development of a new advocacy and training program being written into our county's 3 year plan. We are in the process of developing a Pool of Consumer Champions similar to the one in Alameda County. I have also been instrumental in developing a meaningful consumer and family member action team web page on our department website."*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Chuck responded: *"Being an ACCESS Ambassador has weaponized me with legal codes. So I can confidently confront my county's Behavioral Health administrators to effect positive system change. As well as hold them accountable to MHSA."*

Arnetta Brown (Regional Ambassador): San Bernardino County

Arnetta Brown advocates for consumers formerly incarcerated and experiencing homelessness. Arnetta does not shy away from speaking up for those who have been marginalized or feel powerless regarding the services they receive (or need to receive) within the PMHS. Additionally, she is passionate about the MHSA's mission to reduce and eradicate the stigma placed on consumers and elevate the voices of those with lived experience.

When asked to provide feedback regarding their experiences as an Ambassador this year on their Annual Reflection assignment, Arnetta responded: *"I truly appreciate the amount of valuable information that flows through Access & how much participation all the staff provides to their Ambassadors"*

Regarding positive advocacy outcomes that have resulted from their participation as an Ambassador this year, Arnetta responded: *"I worked with several programs to implement ways to refer our mental health clients to adequate housing and services clients are in need of & now San Bernardino County has implemented a full service partnership for multi Counties initiatives. This is a move in the right direction."*

WHAT HAVE THE 2019-2020 ACCESS AMBASSADORS ACCOMPLISHED?

This program year ACCESS Ambassadors provided training, education, resources, technical assistance, and advocacy in all 5 MHSA Regions of the State. Ambassadors in every Region have reported 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 have been successful advancing their county's peer workforce through continued advocacy in support of expanded peer support services. County administration committed to expanding and creating a career ladder and hiring more peers, despite the anticipated budget cuts coming due to COVID. Additionally, the county mental health administration established the process to have year-round stakeholder participation work group meetings.

CENTRAL REGION OUTCOMES AND ACCOMPLISHMENTS

Central regional ambassadors advocated on the local level yearlong to address the unique health concerns of the LGBTQ+ Community members and successfully established a “Rainbow Clinic”. The clinic is moving forward with including peer support and health navigators onsite. Additionally, Central region ambassadors heavily advocated for the rights and inclusion of those unhoused to be at the table of decision-making meetings throughout the county. During COVID-19, Central region ambassadors were successful with meeting with Stanislaus PEI Manager to strategize implementing new priorities in COVID-19 climate and established a plan on how to get ongoing consumer input.

BAY AREA REGION OUTCOMES AND ACCOMPLISHMENTS

Bay Area ambassadors have continued to be active throughout the region with educating county leadership, various boards and committees, community members, consumers, family members, and other stakeholders on the mission and vision of the MHSA and ways to advocate for programs and services funded by the MHSA are upholding its statutes and regulations. Bay Area Ambassadors have attended 87 local-level advocacy meetings all while focusing heavily on being involved in their county’s 3-year planning processes, providing feedback and guidance on meaningful CPP processes, and becoming more present on MHSA steering committees, boards & commissions, quality and improvement committees, and peer driven advisory groups. These ambassadors collectively have consistently advised decision making bodies of the MHSA’s General Standards and that they should be reflected in all of the plan developments, implementations, reviewal processes, updates, and evaluations.

LOS ANGELES REGION OUTCOMES AND ACCOMPLISHMENTS

Los Angeles ambassadors continue to nurture trustworthy relationships with consumers, community members and leaders, community-based organizations, and the LA Department of Mental Health leadership, resulting in a strengthening of the local community planning process. The LA Ambassadors can be tied to successful prevention of the Underserved Cultural Community subcommittees (UsCC) in LA County being absorbed by the Service Area Advisory Committees. Collectively they helped community stakeholders and Community Based Organizations to pass Board of Supervisors motion to fund “Promotoras” (an MHSA funded project) as a stand-alone program within the county. Additionally, they advocated to maintain the UsCC intact, this ensured that \$1.3 Million dollars were dedicated to the Underserved Cultural Community Subcommittees. Lastly but definitely not the least LA Ambassadors united to provide recommendations on the need for immense stakeholder engagement regarding LADMH’s 3-Year MHSA Plan for 2020-2021 due to COVID-19 which were adopted and are set to resume community engagement early next year with hopes of reaching more people for input.

SOUTHERN REGION OUTCOMES AND ACCOMPLISHMENTS

Southern region Ambassadors engaged heavily in ongoing local-level advocacy meetings such as Mental Health Board Meetings, MSHA Community Program Planning Meetings, and MHSA Steering Committee/Advisory Board Meetings, totaling 42 meetings for the year. Ambassadors have been an essential resource for ACCESS regarding networking with Southern Region Counties to ensure that stakeholders were able to attend meaningful training opportunities such as the Community Empowerment Workshop and the MHSA Leadership Training. Southern Region Ambassadors were vocal and determined to increase the Community Program Planning Processes for their counties and were successful in seeing an increase in stakeholder engagement this year.

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

The Ambassador Boot Camp is designed to provide ACCESS Ambassadors with the basic tools necessary for them to perform their roles as Local-Level mental health subject matter experts and State-Level advocates. This boot camp consisted of a combination of training modules for both the Local-Level and State-Level Ambassadors. Local-level boot camp topics included the following topics, e.g.: Understanding the role of an ambassador, MHSA 101, local level advocacy 101, fundamentals of public speaking, statewide advocacy 101, duties and activities, etc.

State-Level Ambassador boot camp topics focused on the same topics as the Local-Level boot camp. However, for those embarking on their 2nd or 3rd years as ACCESS Ambassadors, ACCESS provided a more intensive training opportunity, including the following topics, e.g.: the role of a state-level ambassador, MHSA 201 (included AB 34/2034, County Plans and Updates, the Seven Funding Components, County MHSA Four Funding Requirements, etc.), Statewide Advocacy 201(checks and balances, State PMHS decision making processes/branches), other funding sources for county/local MHS, and Legislative Updates (Local-level and state level legislation ACCESS is watching/engaged with and legislative priorities).

Every topic addressed in boot camp Ambassadors were trained on within the consistent framework of representing higher ideals and shared values and protecting the rights of others. Ambassadors were additionally trained on how to evaluate innovation plans, how to craft a public statement, local decision-making body regulations, state level decision making processes, and other vitally important components to effective mental health advocacy.

The boot camp consisted of 28 ambassadors from all 5 MHSA regions for a total of 3 full days of training for local-level Ambassadors and 4 full days of training for state-level ambassadors. Ambassadors were provided training and educational material to support their advocacy and networking efforts in the community along with flyers and informative mental health programmatic and funding overviews for community distribution. Additionally, ambassadors were provided opportunities to converse and bond with their regional team members in order to create a network of support for the ongoing efforts of community building and advocacy strengthening in their region.

AMBASSADOR BOOT CAMP EVALUATION

The 28 Ambassadors in attendance completed a post-Boot Camp evaluation providing ACCESS with useful feedback on which aspects of the Boot Camp they liked best and least, sharing what they learned, how it impacted them, and offering suggestions on ways to improve the training in future years:

- 95% said that Boot Camp met their needs/expectations
- 97% said that they were either "very" or "mostly satisfied" with the training content
- 90% said that they were either "very" or "mostly satisfied" with the training material
- 100% said that they were either "very" or "mostly satisfied" with the hotel accommodations

- 100% said that they were either “very” or “mostly satisfied” with the program staff
- 97% of our ambassadors felt as though our annual boot camp, which armed them with effective advocacy tools, MHSA education, legislative updates, and public speaking training was either “very” or “somewhat” effective
 - Direct ambassador feedback:

"The best thing about the Ambassador Boot Camp is to know that there is actually an organization (Cal Voices) that backs us up in our plight to improve mental health....and I am not alone on this quest. There is a whole room of like-minded folks who want to come together and be the difference we want to see in this corner of the world we are in."

Did attending the Boot Camp increase your advocacy skills and confidence as a public speaker?

- 90% said they agreed that Boot Camp increased their advocacy skills and confidence in public speaking

How well did the Ambassador Boot Camp prepare you to perform the following advocacy-related activities?

- 100% said that Boot Camp prepared them to be able to evaluate whether a mental health policy or program complies with the MHSA's General Standards and Community Program Planning requirements “very well” to “pretty well”
- 92% said that Boot Camp prepared them to explain how decisions are made in their local mental health system to other community stakeholders “very well” to “pretty well”
- 95% said that Boot Camp prepared them to explain important requirements of the MHSA to other community stakeholders “very well” to “pretty well”
- 97% said that Boot Camp successfully helped them to deliver an effective position statement at a public meeting “very well” to “pretty well”
- 93% of ambassadors reported that Boot Camp supported their ability to participate in their local mental health system’s MHSA Community Program Planning Process “pretty well” to “very well”

What are some things you learned at the Boot Camp that you didn't know before?

Direct Ambassador Feedback:

- *I had no knowledge of CalAIM and implications of changes being considered to MHSA. I learned that MHSA was largely based on the success of AB 34 and 2034. And the fact that counties sometimes actually draft their MHSA plans and then pretend to engage the community ... this fact was driven home*
- *I couldn't believe our state was considering making changes to the MHSA instead of mandating adherence to everything in the MHSA. We can enforce oversight and accountability instead of making changes. Counties need to spend MHSA funds properly and state law doesn't require oversight and accountability.*
- *The extent to which counties including my own have excluded clients from the Community Planning Process. I was made aware of resources intended for training peer /consumer advocates for leadership positions*
- *How the state is willing to support the local voice!!! And not just support those voices but BACK those voices!!!*
- *I have learned that there are so many ways I can advocate as an ambassador. At the same time, didn't realize the roles of an Ambassador are also all of this:- ...Facilitate small group discussions with community stakeholders about a mental health policy issue. ...Network with other community stakeholders to develop,*

support, or oppose a mental health policy issue. (which i do not know i Can Do...which is so Powerful and Engaging)...to bring about a Collective Action!!

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

Direct Ambassador Feedback:

- *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.*
- *Reinforce CPP at all planning, monitoring, and approving levels with the County. Reinforce the intent of MHSA at the State level both with the California Department of Health Care Services and MHSOAC*
- *Advocate with more confidence*
- *Follow the money more closely. Teach other peers the importance of fiscal oversight*
- *Really focus on the CPP*
- *It's already happening. More awareness, facts and passion as I advocate. I'd like to train other advocates*
- *Advocate for more MHSA training for stakeholders for meaningful engagement*
- *I will continue to be more involved in community meetings*
- *I will use tact when speaking up and engaging with stakeholders and the entities that control the money, and I will speak up*
- *When speaking up I will tactfully tailor my speech to demonstrate how the entire community is impacted when quality of life is neglected for people with lived experience*
- *More promotion of implementation of MHSA principles*
- *I will make sure I keep a finger on the pulse of the peer community. I learned it is a privilege to represent my peers before decision makers and I will use this responsibility in the highest regard and with the utmost respect. I also learned the value of collaboration.*

What did you like best about the Ambassador Boot Camp?

Direct Ambassador Feedback:

- *Knowledgeable staff 😊👍*
- *The family-like atmosphere*
- *The small intimate setting. The openness of all staff*
- *The way the trainers modeled the behavior they desire from us*
- *I liked that I was able to focus on the task at hand. The Boot Camp was very organized in terms of learning materials and handouts. The class was small and comfortable, not crowded with people sitting on top of each other.*
- *Fellowship, support, encouragement*
- *All of it*
- *The connection built among Ambassadors and learning how much we have to offer*
- *I enjoyed being with others who are similarly committed to mental health equity and justice*
- *The best thing about the Ambassador Boot Camp is to know that there is actually an organization (Cal Voices) that backs us up for our Plight for Mental Health....and i am not alone on this quest. There is a whole room of like-minded folks who wants to be to come together and be the difference we want to see in this corner of the world we are in*
- *Training on the CPP*

COMMUNITY EMPOWERMENT WORKSHOP EVALUATION

Several (17) Ambassadors assisted ACCESS in completing our Regional Community Empowerment Workshops. Those who attended were asked to evaluate and provide feedback on this activity. Ambassadors who completed the evaluation said the Community Empowerment Workshop:

- 100% of our ambassadors reported that attending the ACCESS Community Empowerment Workshop for their region was either “very” or “somewhat” effective

What did you like best about the Community Empowerment Workshop?

Direct Ambassador Feedback:

- *Connecting and networking with other peers involved in advocacy work. Learning and refreshing advocacy skills*
- *Participants were enthusiastic and engaged*
- *Exercise on "Kill the Company"*
- *Relevant information, networking*
- *This was my 4th time attending one and I felt like even now I learn the material a little more each time. I liked that the MHSA standards are broken down for people to really understand what could be complicated normally*
- *Refresh of Advocacy techniques*
- *Public speaking preparation*
- *Always like how motivated participants get after attending. The presentation was very smooth*
- *I liked the participation that our county had in the workshop. A great free flow and exchange of ideas. Great questions and answers and every participant was extremely respectful*

OVERALL PROGRAM EVALUATION AND ANNUAL REFLECTIONS

Ambassadors were provided an Annual Reflection Assignment to complete at the end of the 2019-2020 fiscal year providing insight on their successes and challenges within their roles as state and regional ACCESS representation which included but was not limited to; their county’s reception of their expertise as a mental health advocate, their ability to contribute and participate in meaningful meetings where legislative change takes place and policy and oversight of county PMHS services are evaluated and discussed, and overall engagement and collaboration with community members in order to educate and empower stakeholders on their value within their mental health system. The feedback provided below is directly from these reflection assignments given to ACCESS Ambassadors between 07/2020 and 08/2020.

ACCESS California has effectively executed their 3rd year of the Ambassador program which trains, empowers, and educates subject matter experts to advocate on the local level, collaborate with other advocates, consumers, and stakeholders for mental health advocacy, education, and engagement county and/or statewide, and ongoing evaluation and assurance that the usage of MHSA funds are appropriately aligned with the mission and vision of the Act. Through our ACCESS Ambassador Annual Reflection Assignment, we’ve learned that:

- 100% of our ambassadors felt as though our quarterly advocacy webinars have been either “very” or “somewhat” effective.
- 93% of our ambassadors identified state-level activities promoted and supported to attend by ACCESS were either “very” or “somewhat” effective

- 100% of our ambassadors stated that ACCESS' advocacy messaging, strategies, and methods were either "very" or "somewhat" effective.
- 100% of ambassadors identified the coaching they received as either "very" or "somewhat" effective.

Other data identified via the ACCESS Ambassador Annual Reflection Assignment:

100% of ACCESS Ambassadors rated their level of agreement with the following statements related to their Ambassador experience this year as either "strongly agree" or "agree":

- ACCESS clearly explained the duties and expectations of Ambassadors
- ACCESS made it easy for me to complete my assigned Ambassador activities
- ACCESS keeps its Ambassadors informed about important mental health policy issues
- ACCESS did a good job of explaining its positions on important mental health policy issues
- ACCESS increased my knowledge of the MHSA's general standards and community program planning requirements
- ACCESS empowered me to speak up, ask questions, and share my opinions about mental health policy issues
- ACCESS helped me to better represent the interests of clients/consumers in my community (not just my own)
- Participation in the ACCESS program has made me a more effective mental health advocate
- ACCESS was flexible and supportive of COVID-19 changes established regarding my ability to participate in regional and/or state-level activities

When asked **how satisfied were you with your experience this year as an ACCESS Ambassador**, 100% reported that they were either "very satisfied" or "satisfied"

When asked **what Ambassadors liked best about participating in the Ambassador program this year** some of the responses were:

Direct Ambassador Feedback:

- *The connections I made with other advocates throughout the state and the support and understanding we provided each other plus the support of the ACCESS staff*
- *Knowing that there are people and an institution that researches Mental Health Bill's and encourages us to be educated with the knowledge of these Bills so we can advocate*
- *The information, support, and opportunities provided and all the expertise provided by ACCESS to Speak truth to Power and raise the voices of our communities across the State*
- *Learning how to become an effective advocate and stand up for members of my community*
- *What I liked best about participating is knowing that if there were any road blocks, or barriers in which I would have encountered that I had an entire ACCESS support team in Sacramento available to me*

When asked **"In what ways can we improve the Ambassador experience next year? Please be specific"**, Ambassadors responded:

- *If possible, find funding to continue this awesome program*
- *Keep the program going and train the next generation of peer advocates*

- *Send Ambassadors the Reports Required for the specified Quarter*
- *You guys really do a great job and I know you're probably very busy but perhaps you could provide a little more structure and guidance and support for less engaged ambassadors*
- *Distribute survey data that is county specific to us. It will help us to be more specific on where we should focus our actions on. It'll also give us the data to make our case on issues, instead of having it so easily dismissed because the data is state-wide and that it may not be relevant in our county. That not only makes us look like diminished, but it also accentuate the power differential to potential advocates for fear of being so easily dismissed*
- *Find a way to resurrect ACCESS!*
- *It would have been good to have strategic talking points that we could all advocate for at various meetings in our Region...especially at Mental Health Commission meetings*
- *Thank you for going out of your way to ensure that we were fully able to participate in activities and outreach. Thank you for alerts, emails and reminders*
- *More bonding activities but that's it. Also talking to all ambassadors regarding ambassador conflicts*
- *Maybe develop a phone text-tree app so we all weigh in and reach out more often*
- *Closed caption or CART, and a vaccine for COVID-19*
- *Nothing, Stay as it is*

2020 ACTIVITIES AND ACCOMPLISHMENTS: MENTAL HEALTH POLICY UPDATE

“Mental health is often missing from public health debates even though it’s critical to wellbeing.”

~Diane Abbott

ACCESS’ legislative and public policy team monitors legislation and state-level 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 promote 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.

In 2020, the COVID-19 pandemic resulted in stay-at-home orders, risks of exposure for individuals in congregate care settings, reduced county funding for PMHS services, and a greater need for PMHS services. These impacts necessitated sudden changes to our policy focus in early 2020. In addition to our key focus areas, we also began to focus on policy activities aimed at protecting PMHS consumers in congregate settings from exposure to the virus, and protecting funding for PMHS programs and services.

Our Year 3 policy activities had the following goals:

- Support the voice and meaningful participation of clients/consumers in local and state mental health advocacy activities;
- Ensure effective and necessary improvements in local policy, programming and services delivery; and
- Increase community inclusion, transparency, and public accountability within local mental health systems
- Ensure that COVID-19 is tracked within congregate care environments
- Ensure that state budget cuts do not negatively impact PMHS clients and consumers

Our legislative and policy efforts have proven to be integral to effectuating system-wide change, while simultaneously educating and empowering our constituency to become involved in state and local policy making.

MHSA Coalition

In March, ACCESS convened a meeting of our State Ambassadors and leaders from key statewide mental health advocacy organizations to discuss proposed changes to the MHSA, and determine areas of agreement among advocates. This meeting resulted in formation of a broad coalition of organizations who drafted a set of Guiding Principles which identified underpinning elements of the MHSA that the coalition believes must be preserved, regardless of any future updates to the Act. California’s plans to update the MHSA have been put on hold temporarily due to the pandemic.

(25) Legislative Advocacy Letters

ACCESS tracks federal and state legislation impacting clients/consumers and services in California’s PMHS, and submitted 25 legislative advocacy letters to lawmakers and committees in support of or opposition to legislation. In addition, ACCESS signed on to several coalition letters in support and opposition to legislation and policies.

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.

(7) State Administration Advocacy Letters

In addition to monitoring legislation, ACCESS tracks policy issues of immediate concern to consumers, and educates state administration directly on those issues. This year ACCESS sent 7 advocacy letters to members of the Administration. These letters addressed changes to the MHSA, consumer representation on state advisory boards, and consumer needs during COVID-19.

(16) In-Person/Virtual Legislative Meetings

ACCESS held 16 in-person and virtual meetings with legislators and legislative staff to discuss the consumer perspective on 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.

(3) Position Statements

This year, ACCESS completed three position statements. These position statements examined the state's proposed MHSA Refresh, changes to the Medi-Cal program, and the Help@Hand Innovation project.

(5) Legislative Hearings

ACCESS was invited to provide testimony at a legislative hearing that explored updates to the MHSA. ACCESS spoke from the consumer perspective and suggested that if the MHSA is effectively enforced, access to services would improve. The hearing was well attended by consumers from throughout California who supported ACCESS' message during public comment. ACCESS also offered public comment at a legislative hearing which examined potential solutions to California's increasing numbers of homeless individuals. In addition, ACCESS attended three legislative bill hearings to voice support/opposition for pending legislation and also offered opportunities for Ambassadors and the public to attend these events.

2020 Activities and Accomplishments: Mental Health Policy Update

ACCESS' public policy team monitors legislation and state policy issues that have the potential to impact PMHS clients and/or California's PMHS. We focus on policies that support and empower peers and increase the peer workforce, ensuring that the vision and General Standards of the MHSA are upheld, increasing client-driven and community-based services, and increasing involvement of consumers in PMHS decision-making.

In 2020, our focus was expanded to include issues related to the COVID-19 pandemic, and its effects on PMHS clients in California. COVID-19 issues included protection of consumers residing in congregate environments, declining county revenues due to the sudden economic recession, and the increased need for services and programs due to the social effects of the pandemic.

2020 LEGISLATIVE ISSUES AND UPDATES

Due to the statewide stay at home order, and COVID-19 exposures within the Capitol building, COVID-19 impacted the 2020 legislative session by limiting the number of bills to only those bills related to COVID-19.

Once again, achieving peer support certification was a legislative goal in California. SB 803 (Beall) was California's fourth attempt at this effort. Prior attempts to pass statewide peer certification were either pulled by the bill author or vetoed by the Governor. This year, SB 803 was changed from prior years to allow DHCS to delegate some of their responsibilities to an entity that represents counties. In addition, SB 803 (Beall) does not create a statewide certification program, but it allows each county to develop a county certification program. The bill was signed into law on September 18, 2020.

Another bill of concern to PMHS clients was SB 665 (Umberg), which would have amended the MHSA to allow MHSA funds to be utilized to provide services to clients in jail. While ACCESS California strongly supports the provision of necessary, effective and appropriate services to all PMHS consumers, the Mental Health Services Act was designed to provide community-based services with a goal of preventing criminal justice involvement, and is therefore not the proper funding stream for these services. A broad coalition of groups representing counties, providers, consumers and families opposed the bill, and it was ultimately held in the Assembly Appropriations Committee.

Efforts to increase involuntary commitment were once again prominent in this Legislative Session. Several bills were introduced to expand the definition of gravely disabled, with the ultimate goal of increasing the number of individuals subject to involuntary treatment. None of these bills succeeded. AB 1976 (Eggman), would expand Assisted Outpatient Treatment, also known as Laura's Law. Where Laura's Law is currently optional for counties, AB 1976 would mandate that counties participate in Laura's Law unless they opt out by resolution. As of this writing, the bill is moving forward.

Other bills of note this year include AB 2112 (Ramos), which will create a state office of suicide prevention, SB 855 (Wiener), which will expand California's parity law, and AB 2265 (Quirk-Silva), which clarifies that MHSA funds can be used to treat co-occurring substance use disorders when they occur alongside a mental health condition. All of these bills were signed into law by Governor Newsom.

OTHER MENTAL HEALTH POLICY ISSUES IN 2020

The COVID-19 pandemic created unique policy issues this year. Statewide stay-at-home orders resulted in extended closures of the State Capitol, which limited the number of bills that were permitted to move forward. The pandemic also caused unprecedented challenges for mental health consumers living in congregate facilities, which can include homeless shelters, inpatient facilities, board and care homes, and crowded housing. ACCESS actively advocated for increased COVID-19 tracking within congregate facilities, and increased efforts to ensure that educational materials and personal protective equipment was made available to these individuals.

In late 2019, ACCESS became aware of state efforts to make significant changes to the MHSA. These changes were supported by the Governor, but were being led by the Steinberg Institute, and conducted without any public involvement. The goals of these changes were primarily to decrease criminal justice involvement and reduce homelessness. While these are worthwhile goals, ACCESS believes that the Act is written to accomplish these goals but it has never been properly enforced. In response to our concerns about these proposed changes

and the lack of stakeholder involvement in the process, ACCESS convened a coalition of mental health organizations. This coalition united around the key pieces of the Act that must be preserved regardless of any changes that are implemented.

In 2019, the Department of Health Care Services (DHCS) began to work on Medi-Cal Reform. DHCS released their reform proposal, called CalAIM (California Advancing and Innovating Medi-Cal), was released on October 29, 2019, and proposed sweeping changes to Medi-Cal. The goal of CalAIM was to improve the quality of life and health outcomes of our population by implementing a broad delivery system, program and payment reform across Medi-Cal. ACCESS was involved in this process, and advocated for the needs of public mental health consumers at stakeholder meetings until the project was put on hold due to COVID-19.

PART II. ANNUAL THEME 2020: PEER SUPPORT IN CALIFORNIA'S PMHS

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 certainty 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 training and support, 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:

- To identify if medication is a prerequisite for obtaining Peer Support Services.
- To Identify if the Core Competencies for Peer Support Workers are being upheld.
- To determine if State Agencies are collecting outcome data from the Counties it oversees for Peer Support Services provided, what data collection tools are being utilized, how the State Agencies are sharing and/or publicizing the Peer Support Outcome Data it collects, and to determine how the State Mental Health Agencies currently utilize Peer Support Service Outcome Data to inform its MHSA evaluations, funding, programming, and/or policy decisions.
- To identify if/how Counties are imbedding Peer Support Positions within their MHSA funded programs.
- To determine if Counties and Local Mental Health Systems are collecting outcome data for Peer Support Services provided from the MHSA programs it oversees, what data collection tools are being utilized, how the Counties and Local Mental Health Agencies currently utilize Peer Support Service Outcome Data to inform its MHSA evaluations, funding, programming, and/or policy decisions.

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.

PEER SUPPORT IN CALIFORNIA'S PMHS: AN OVERVIEW OF THE ISSUES

"We know that mental illness is not something that happens to other people. It touches us all. Why then is mental illness met with so much misunderstanding and fear?"

~Tipper Gore

Despite the MHS's mandate to employ individuals with lived experience throughout the PMHS (9 CCR § 3610(b)), consumers are starkly underrepresented amongst the staff of County mental health departments and their contracts 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 and 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.

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 (Sheedy, 2009). 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.

The MHS requires Counties to utilize MHS funding to establish peer support and family education support services or expand these services to meet the needs and preferences of clients and/or family members (9 CCR § 3610(d)). 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.

The rate of unemployment for clients in California PMHS is staggering, with only 8.3 percent of PMHS clients employed in the labor force (SAMHSA, 2016), leaving an abysmal 91.7 percent unemployed. The national average for employment of people with mental health disorders is 21.5 percent, making California fifth in the nation in the unemployment of mental health clients. Even the availability of MHS Workforce Education and Training funds (WET), aimed at increasing the peer workforce in California, has failed to move the needle in this critical area.

Peer support means Counties maintain fidelity to the evidence-based model of shared lived experience in all peer positions. It means the incorporation and expansion of peer support in all programs and services within the PMHS. Further, peer support includes substantial investment in peer positions to provide essential training in

peer core competencies, living wages and commensurate employment benefits, ongoing professional development, and opportunities for career advancement in the PMHS.

What is Peer Support?

Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both. This mutuality is often called “peerness” between a peer support worker and person in or seeking recovery promotes connection and inspires hope. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships.²³ By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self--determined lives for themselves.

What Does a Peer Support Worker Do?

A peer support worker is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths--based support and are “experientially credentialed” by their own recovery journey.²⁴ Peer support workers may be referred to by different names depending upon the setting in which they practice. Common titles include: peer specialists, peer recovery coaches, peer advocates, peer partner specialist and peer recovery support specialists.

Peer support workers can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with other members of the treatment team. The peer support worker’s role is to assist people with finding and following their own recovery paths, without judgment, expectation, rules, or requirements. Peer support workers practice in a range of settings, including peer-run organizations, recovery community centers, recovery residences, drug courts and other criminal justice settings, hospital emergency departments, child welfare agencies, homeless shelters, and behavioral health and primary care settings. In addition to providing the many types of assistance encompassed in the peer support role, they conduct a variety of outreach and engagement activities.

Peer Support Workers:

- Inspire hope that people can and do recover;
- Walk with people on their recovery journey;
- Dispel myths about what it means to have a mental health condition;
- Provide self-help education and link people to tools and resources; and
- Support people in identifying their goals, hopes, and dreams, and creating a roadmap for getting there.²⁵

How Does Peer Support Help?

The role of a peer support worker complements, but does not duplicate or replace the roles of therapists, case managers, and other members of a treatment team. Peer support workers bring their own personal knowledge of what it is like to live and thrive with mental health conditions and substance use disorders. They support

²³ Mead & McNeil, 2006

²⁴ Davidson, et al., 1999

²⁵ Retrieved from: SAMHSA.gov

people's progress towards recovery and self-determined lives by sharing vital experiential information and real examples of the power of recovery. The sense of mutuality created through thoughtful sharing of experience is influential in modeling recovery and offering hope.²⁶

Research shows that peer support is effective for supporting recovery from behavioral health conditions. Benefits include but are not limited to:

- Increased self-esteem and confidence²⁷
- Increased sense of control and ability to bring about changes in their lives²⁸
- Raised empowerment scores²⁹
- Increased sense that treatment is responsive and inclusive of needs³⁰
- Increased sense of hope and inspiration³¹
- Increased empathy and acceptance (camaraderie)³²
- Increased engagement in self-care and wellness³³
- Increased social support and social functioning³⁴
- Decreased psychotic symptoms³⁵
- Reduced hospital admission rates and longer community tenure³⁶
- Decreased substance use and depression³⁷

Core Competencies for Peer Workers in Behavioral Health Services

What is a peer worker?

The role of the peer support worker has been defined as “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations.” Peer support has been described as “a system of giving and receiving help” based on key principles that include “shared responsibility, and mutual agreement of what is helpful.” Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

²⁶ Davidson, Bellamy, Guy, & Miller, 2012

²⁷ Davidson, et al., 1999. Salzer 2002

²⁸ Davidson, et al., 2012

²⁹ Davidson, et al., 1999; Dumont & Jones, 2002; Orchoka, Nelson, Janzen & Trainor, 2006; Resnick & Rosenheck, 2008

³⁰ Davidson, et al., 2012

³¹ Davidson, et al., 2006; Ratzlaff, McDiarmid, Marty, & Rapp, 2006

³² Coastwortha Puspokey, Forchuk, & Warda Griffin, 2006; Davidson, et al., 1999

³³ Davidson, et al., 2012

³⁴ Kurtz, 1991; Nelson, Ochocka, Janzen & Trainor, 2006; Ochocka et al., 2006; Trainor, Shepherd, Boydell, Leff & Crawford, 1997; Yanos, Primavera & Knight, 2001

³⁵ Davidson et al., 2012

³⁶ Chinman, Weingarten, Stayner & Davidson, 2001; Davidson, et al., 2012; Forchuk, Martin, Chan & Jenson, 2005; Min, Whitecraft, Rothbard, Salzer, 2007

³⁷ Davidson, et al., 2012

As mentioned previously, the development of additional Core Competencies may be needed to guide the provision of peer support services to specific groups who also share common experiences such as family members. The shared experience of being in recovery from a mental or substance use disorder or being a family member of a person with a behavioral health condition is the foundation on which the peer recovery support relationship is built in the behavioral health arena.

What is recovery?

SAMHSA developed the following working definition of recovery by engaging key stakeholders in the mental health consumer and substance use disorder recovery communities:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Throughout the competencies, the term “recovery” refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According to the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include “professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches.” SAMHSA has identified four major dimensions that support a life in recovery:

1. **Health**—Learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one’s physical and emotional wellbeing;
2. **Home**—A stable and safe place to live;
3. **Purpose**—Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and, increased ability to lead a self-directed life; and meaningful engagement in society; and
4. **Community**—Relationships and social networks that provide support, friendship, love, and hope
5. Peer workers help people in all of these domains.

WHAT ARE CORE COMPETENCIES?

Core Competencies are the capacity to easily perform a role or function. They are often described as clusters of the knowledge, skills, and attitudes a person needs to have in order to successfully perform a role or job or as the ability to integrate the necessary knowledge, skills, and attitudes. Training, mentoring, and supervision can help people develop the competencies needed to perform a role or job. This will be the first integrated guidance on competencies for peer workers with mental health and substance use lived experience.

Why do we need to identify Core Competencies for peer workers?

Peer workers and peer recovery support services have become increasingly central to people’s efforts to live with or recover from mental health and substance use disorders. Community-based organizations led by people who have lived experience of mental health conditions and/or who are in recovery from substance use disorders are playing a growing role in helping people find recovery in the community. Both the mental health consumer and the substance use disorder recovery communities have recognized the need for Core Competencies and both communities actively participated in the development of these peer recovery support worker competencies.

Potential Uses of Core Competencies

Core Competencies have the potential to guide delivery and promote best practices in peer support. They can be used to inform peer training programs, assist in developing standards for certification, and inform job descriptions. Supervisors will be able to use competencies to appraise peer workers' job performance and peers will be able to assess their own work performance and set goals for continued development of these competencies.

Core Competencies are not intended to create a barrier for people wishing to enter the peer workforce. Rather they are intended to provide guidance for the development of initial and on-going training designed to support peer workers' entry into this important work and continued skill development.

Core Competencies, Principles and Values

Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individual has identified to the peer worker.

VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

OVERVIEW

In 2015, SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to Core Competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition. SAMHSA—via its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project—convened diverse stakeholders from the mental health consumer and substance use disorder recovery movements to achieve this goal. SAMHSA in conjunction with subject matter experts conducted research to identify Core Competencies for peer workers in behavioral health. SAMHSA later posted the draft competencies developed with these stakeholders online for comment. This additional input helped refine the Core Competencies and this document represents the final product of that process.

As our understanding of peer support grows and the contexts in which peer recovery support services are provided evolve, the Core Competencies must evolve over time. Therefore, updates to these competencies may occur periodically in the future.

Core Competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use conditions and delivered by or to adults, young adults, family members and youth. The competencies may also apply to other forms of peer support provided by other roles known as peer specialists, recovery coaches, parent support providers or youth specialists. These are not a complete set of competencies for every context in which peer workers provide services and support. They can serve as the foundation upon which additional competencies for specific settings that practice peer support and/or for specific groups could be developed in the future. For example, it may be helpful to identify additional competencies beyond those identified here that may be required to provide peer support services in specific settings such as clinical, school, or correctional settings. Similarly, there may be a need to identify additional Core Competencies needed to provide peer support services to specific groups, such as families, veterans, people in medication-assisted recovery from a SUD, senior citizens, or members of specific ethnic, racial, or gender-orientation groups.

SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services

Category I: Engages peers in collaborative and caring relationships: This category of competencies emphasized peer workers' ability to initiate and develop on-going relationships with people who have behavioral health condition and/or family members. These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

1. Initiates contact with peers
2. Listens to peers with careful attention to the content and emotion being communicated
3. Reaches out to engage peers across the whole continuum of the recovery process
4. Demonstrates genuine acceptance and respect
5. Demonstrates understanding of peers' experiences and feelings

Category II: Provides support: The competencies in this category are critical for the peer worker to be able to provide the mutual support people living with behavioral health conditions may want.

1. Validates peers' experiences and feelings
2. Encourages the exploration and pursuit of community roles
3. Conveys hope to peers about their own recovery
4. Celebrates peers' efforts and accomplishments
5. Provides concrete assistance to help peers accomplish tasks and goals

Category III: Shares lived experiences of recovery: These competencies are unique to peer support, as most roles in behavioral health services do not emphasize or even prohibit the sharing of lived experiences. Peer workers need to be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a person living with behavioral health conditions. Family peer support worker likewise share their personal experiences of self-care and supporting a family-member who is living with behavioral health conditions.

1. Relates their own recovery stories, and with permission, the recovery stories of others to inspire hope
2. Discusses ongoing personal efforts to enhance health, wellness, and recovery
3. Recognizes when to share experiences and when to listen

4. Describes personal recovery practices and helps peers discover recovery practices that work for them

Category IV: Personalizes peer support: These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer worker operationalizes the notion that there are multiple pathways to recovery.

1. Understands his/her own personal values and culture and how these may contribute to biases, judgments and beliefs
2. Appreciates and respects the cultural and spiritual beliefs and practices of peers and their families
3. Recognizes and responds to the complexities and uniqueness of each peer's process of recovery
4. Tailors services and support to meet the preferences and unique needs of peers and their families

Category V: Supports recovery planning: These competencies enable peer workers to support other peers to take charge of their lives. Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health.

1. Assists and supports peers to set goals and to dream of future possibilities
2. Proposes strategies to help a peer accomplish tasks or goals
2. Supports peers to use decision-making strategies when choosing services and supports
3. Helps peers to function as a member of their treatment/recovery support team
4. Researches and identifies credible information and options from various resources

Category VI: Links to resources, services, and supports: These competencies assist peer workers to help other peers acquire the resources, services, and supports they need to enhance their recovery. Peer workers apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer workers have knowledge of resources within their communities as well as on-line resources.

1. Develops and maintains up-to-date information about community resources and services
2. Assists peers to investigate, select, and use needed and desired resources and services
3. Helps peers to find and use health services and supports
4. Accompanies peers to community activities and appointments when requested
5. Participates in community activities with peers when requested

Category VII: Provides information about skills related to health, wellness, and recovery: These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. These competencies recognize that peer workers have knowledge, skills and experiences to offer others in recovery and that the recovery process often involves learning and growth.

1. Educates peers about health, wellness, recovery and recovery supports
2. Participates with peers in discovery or co-learning to enhance recovery experiences
2. Coaches peers about how to access treatment and services and navigate systems of care
3. Coaches peers in desired skills and strategies
4. Educates family members and other supportive individuals about recovery and recovery supports
5. Uses approaches that match the preferences and needs of peers

Category VIII: Helps peers to manage crises: These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. Peer workers may have to manage situations, in which there is intense distress and work to ensure the safety and well-being of themselves and other peers.

1. Recognizes signs of distress and threats to safety among peers and in their environments
2. Provides reassurance to peers in distress
3. Strives to create safe spaces when meeting with peers
4. Takes- action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers
5. Assists peers in developing advance directives and other crisis prevention tools

Category IX: Values communication: These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. These competencies suggest language and processes used to communicate and reflect the value of respect.

1. Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others
2. Uses active listening skills
3. Clarifies their understanding of information when in doubt of the meaning
4. Conveys their point of view when working with colleagues
4. Documents information as required by program policies and procedures
6. Follows laws and rules concerning confidentiality and respects others' rights for privacy

Category X: Supports collaboration and teamwork: These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. These competencies involve not only interpersonal skills but also organizational skills.

1. Works together with other colleagues to enhance the provision of services and supports
2. Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers
3. Coordinates efforts with health care providers to enhance the health and wellness of peers
4. Coordinates efforts with peers' family members and other natural supports
5. Partners with community members and organizations to strengthen opportunities for peers
6. Strives to resolve conflicts in relationships with peers and others in their support network

Category XI: Promotes leadership and advocacy: These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. They also guide peer workers on how to advocate for the legal and human rights of other peers.

1. Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected
2. Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family
3. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
4. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families

5. Educates colleagues about the process of recovery and the use of recovery support services
6. Actively participates in efforts to improve the organization
7. Maintains a positive reputation in peer/professional communities

Category XII: Promotes growth and development: These competencies describe how peer workers become more reflective and competent in their practice. The competencies recommend specific actions that may serve to increase peer workers' success and satisfaction in their current roles and contribute to career advancement.

1. Recognizes the limits of their knowledge and seeks assistance from others when needed
2. Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)
3. Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support
4. Seeks opportunities to increase knowledge and skills of peer support³⁸

³⁸ Retrieved from:

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

PEER SUPPORT IN CALIFORNIA'S PMHS: A DISCUSSION OF THE METHODOLOGY

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 surveys that we disseminated both digitally and physically, each of which were designed to capture different data points:

- 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 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;
- Relied on our Regional ACCESS Ambassadors to help generate local interest in and responses to our data collection tools; and
- Raffle 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 disseminated our surveys at:

- Five Regional Stakeholder Focus Groups
- Five Regional Leadership Roundtables
- Seven Regional Community Empowerment Workshops
- Eight Regional Leadership Trainings
- One Annual Conference

RESEARCH STRATEGIES

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

- The origins of Peer Support Services in the Behavioral Healthcare Workforce
- The efficacy of and scientific support behind Peer Support Services
- Models and methods for the creation of the Peer Support Workforce
- Best practices for peer support, recovery-based and client-driven services delivery

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. 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.

PEER SUPPORT 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, 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.

ANNUAL CLIENT AND LEADERSHIP SURVEY

SURVEY COMPONENTS

This survey contained three 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 Peer Support Services for adult mental health clients in their Local Mental Health Systems. (602 responses)
2. A section for State Mental Health Agency Leadership to determine how oversight agencies are ensuring Counties/Local Mental Health Systems integrate Peer Support Services into adult mental health programs. (57 responses)
3. A section for Local Mental Health System Leadership and Peer Providers to gauge levels of integration of Peer Support Services in adult mental health services. (198 responses)

Based on the respondent's current role within the PMHS, they may have been asked to complete one or more of these sections where their feedback will be most valuable. Additionally, this survey collected demographic data from respondents so ACCESS may assess how well we are engaging with various underserved populations. The demographics questions were optional.

KEY QUESTIONS: ANNUAL CLIENT AND LEADERSHIP SURVEY

The three 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. Important roles of a Peer Supporters.
2. If medication is a prerequisite to obtaining Peer Support Services.
3. To Identify if the Core Competencies for Peer Workers are being upheld.
4. To determine if State Mental Health Agencies are collecting outcome data from the Counties it oversees for Peer Support Services provided, what data collection tools are being utilized, how the State Agencies are sharing and/or publicizing the Peer Support Outcome Data it collects, and to determine how the State Mental Health Agencies currently utilizes Peer Support Service Outcome Data to inform its MHSA evaluations, funding, programming, and/or policy decisions.
5. To identify if/how Counties are imbedding Peer Support Positions within their MHSA funded programs.
6. To determine if Counties and local Mental Health Systems are collecting outcome data for Peer Support Services provided from the MHSA programs it oversees, what data collection tools are being utilized, how the Counties and Local Mental Health Agencies are sharing and/or publicizing the Peer Support Outcome

Data it collects, and to determine how the Counties and Local Mental Health Agencies currently utilizes Peer Support Service Outcome Data to inform its MHSA evaluations, funding, programming, and/or policy decisions.

RESPONDENT DEMOGRAPHICS

Members of Peer Communities

- 50.7% identified as an adult client or consumer
- 14.3% identified as a family member
- 1.3% identified as a transition aged youth (TAY)
- 6.7% identified as a parent/caregiver of a child/youth

Employment/Services in the PMHS

- 63.2% of respondents currently work in the PMHS
- 8.8% have previously worked in the PMHS
 - 54.9% of those worked in the PMHS less than two years ago

Other Demographic Data

- 30.7% of respondents identified as an ethnic minority
- 25.2% identify as LGBTQ+
- 41.6% identify as having a disability
- 6.1% identified as former foster youth
- 23.1% identify as an older adult
- 68.4% of those that identified as a client or TAY are current or previous PMHS clients
- 68.3% of those that identified as an adult family member have a family member that currently or previously received PMHS
- 4.9% of respondents identified. As a military veteran
- 22.9% have experienced homelessness
- 13% had past contact with the criminal justice system (including formerly incarcerated)
- 19.8% identified as having a co-occurring condition
- 5.5% identified as an immigrant or refugee
- 19.1% identified as having a dual disability

KEY FINDINGS: ANNUAL CLIENT AND LEADERSHIP SURVEY

1. Important Roles of Peer Supporters

Clients/Consumers and TAY

We provided a list of factors that are/were important to those who serve in the role of a Peer Supporter. What is Peer Support? Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health condition, substance use disorders, or both. This mutuality—often called “peerness”—between a peer support worker and person in or seeking recovery promotes

connection and inspires hope. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships (Mead & McNeil, 2006). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.

The top ten Peer Support factors clients/consumers and TAY identified as important to their personal recovery are:

1. Inspires hope that people can and do recovery
2. Increases personal empowerment
3. Provide people with tools and resources
4. Increases sense of hope and inspiration
5. Increases people's self-esteem and confidence
6. Walk with people on their recovery journey
7. Increased a sense of control and ability to bring about changes in their lives
8. Increased engagement in self-care and wellness
9. Increased social support and social functioning
10. Support people in identifying their goals, hopes and dreams; and creating a road map to get there

Notably, the one factor on the list that respondents least identified as important in the role of a Peer Supporter (and the only factor that fewer than 50% of respondents selected was:

- Decreased psychotic symptoms

Family Members of Adult Clients/Consumers

We provided the same list of Peer Support factors to respondents identifying as family members of adult clients/consumers. We then asked respondents, if known, which of these factors were important to their adult family member in achieving or maintaining their recovery.

The top ten factors that family members identified as important to their adult loved one's recovery were ...

1. Provide people with tools and resources
2. Increased sense of hope and inspiration
3. Increased people's self-esteem and confidence
4. Inspires hope that people can and do recover
5. Increased social support and social functioning
6. Increased engagement in self-care and wellness | Provides self-help education
7. Increases personal empowerment
8. Support people in identifying their goals, hopes and dreams; and creating a roadmap to get there
9. Increased empathy and acceptance (camaraderie)
10. Walk with people on their recovery journeys

*#6 was a tie

The three factors on the list that respondents least identified as important in the role of a Peer Supporter (and the only factors that fewer than 50%) of respondents selected were:

- Decreased psychotic symptoms
- Decreased substance use and depression
- Increased sense that treatment is responsive and inclusive of needs

*the last two bullets were a tie

Core Competencies for Peer Workers

We asked the consumers and TAY who have received Peer Support services in the PMHS to rate their experiences with their current or most recent service provider, to gauge the extent to which Peer Providers are upholding the necessary competencies identified by SAMHSA.

The factors listed were developed from SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services.

CLIENTS ASSESSMENT OF PEER WORKERS	AGREE	DISAGREE/ NOT SURE
My Peer Worker initiates contact with me	78%	22%
My Peer Worker listens to me with careful attention to the content and emotion being communicated	90%	10%
My Peer Worker reaches out to engage me across the whole continuum of the recovery process	80%	20%
My Peer Worker demonstrates genuine acceptance and respect	92%	8%
My Peer Worker demonstrates understanding of my experiences and feelings	92%	8%
My Peer Worker validates my experiences and feelings	90%	10%
My Peer Worker encourages the exploration and pursuit of community roles	81%	19%
My Peer Worker conveys hope to me about my own recovery	91%	9%
My Peer Worker celebrates my efforts and accomplishments	91%	9%
My Peer Worker provides concrete assistance to help me	84%	16%
My Peer Worker relates their own recovery stories, and with permission, the recovery stories of others to inspire hope	88%	12%
My Peer Worker discusses ongoing personal efforts to enhance health, wellness, and recovery	84%	16%
My Peer Worker recognizes when to share experiences and when to listen	86%	14%
My Peer Worker describes personal recovery practices and helps me discover recovery practices that work for me	85%	15%
My Peer Worker understands my personal values and culture and how these may contribute to biases, judgments and beliefs	84%	16%

CLIENTS ASSESSMENT OF PEER WORKERS	AGREE	DISAGREE/ NOT SURE
My Peer Worker appreciates and respects the cultural and spiritual beliefs and practices of me and my family	86%	14%
My Peer Worker recognizes and responds to the complexities and uniqueness of my process of recovery	86%	14%
My Peer Worker tailors' services and support to meet the preferences and support of me and my family	77%	23%
My Peer Worker assists and supports me to set goals and to dream of future possibilities	85%	15%
My Peer Worker proposes strategies to help me accomplish tasks or goals	86%	14%
My Peer Worker supports me to use decision making strategies when choosing services and supports	83%	17%
My Peer Worker helps me to function as a member of my treatment/recovery support team	83%	17%
My Peer Worker researches and identifies credible information and options from various resources	78%	22%
My Peer Worker develops and maintains up to date information about community resources and supports	82%	18%
My Peer Worker accompanies me to community activities and appointments when requested	53%	47%
My Peer Worker participates in community activities with me	55%	55%
My Peer Worker educates me about health, wellness, recovery	84%	16%
My Peer Worker participates with me in discovery or co-learning to enhance recovery experiences	78%	22%
My Peer Worker coaches me about how to access treatment	79%	21%
My Peer Worker coaches me in desired skills and strategies	77%	23%
My Peer Worker educates my family members and other supportive individuals about recovery and recovery supports	46%	54%
My Peer Worker uses approaches that match the preferences and needs of me	81%	19%
My Peer Worker recognizes signs of distress and threats to my safety and in my environments	81%	19%
My Peer Worker provides reassurance to me if/when I am in distress	88%	12%
My Peer Worker strives to create safe spaces when meeting with me	87%	13%
My Peer Worker takes -action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of mine	82%	18%

CLIENTS ASSESSMENT OF PEER WORKERS	AGREE	DISAGREE/ NOT SURE
My Peer Worker assists me in developing an advanced directive and other crisis prevention tools	65%	35%

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 Peer Support services or get referred to new services?

- YES: 20%
- NO: 62%
- NOT SURE: 18%

We asked 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 Peer service to gauge the extent to which Peer Providers are upholding the necessary competencies identified by SAMHSA.

The factors listed were developed from SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services.

FAMILY MEMBERS' ASSESSMENT OF PEER WORKER	AGREE	DISAGREE/ NOT SURE
The Peer Provider reaches out to engage my family member across the whole continuum of the recovery process	59%	41%
The Peer Provider encourages the exploration and pursuit of community role	66%	34%
The Peer Provider provides concrete assistance to help my family member accomplish tasks and goals	71%	29%
The Peer Provider discusses ongoing personal efforts to enhance health, wellness, and recovery	67%	33%
The Peer Provider appreciates and respects the cultural and spiritual beliefs and practices of my family	66%	34%
The Peer Provider recognizes and responds to the complexities and uniqueness of my family members process of recovery	64%	36%
The Peer Provider proposes strategies to help my family to accomplish tasks and goals	66%	34%
The Peer Provider supports my family member to use decision making strategies when choosing services and supports	67%	33%
The Peer Provider participates and/or accompanies my family member to community activities and appointments when requested	59%	41%
The Peer Provider educates my family member about health, wellness, recovery and recovery supports	65%	35%

FAMILY MEMBERS' ASSESSMENT OF PEER WORKER	AGREE	DISAGREE/ NOT SURE
The Peer Provider shows my family member about how to access treatment and services and navigate systems of care	64%	36%
The Peer Provider educates me and other support people in my family members life about recovery and recovery supports	57%	43%
The Peer Provider assists my family member in developing advance directives and other crisis prevention tools	50%	50%

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: 30%
- NO: 42%
- NOT SURE: 27%

State Agency Leadership

We asked respondents representing state mental health agencies: How is your State mental Health Agency collecting Outcome data from the Counties it oversees for Peer Support Services Provided? Check all that apply.

STATE AGENCY LEADERSHIP DATA COLLECTION SOURCES	AGREE
Not Sure & N/A- My State Mental Health Agency doesn't collect Peer Provider Outcome Data from the Counties it oversees	47%
County MHSA Three Year Program and Expenditure Plans	25%
Annual Updates to County MHSA Three Year Program and Expenditure Plans	25%
County Client and Service Information System Data Reports	22%
County Quarterly Progress Reports	20%
County Full Service Partnership Performance Outcome Data Reports	17%
County Consumer Perception Semi-Annual Survey Reports	6%
County Three-Year Prevention and Early Intervention	14%
County Annual Innovative Project Reports	14%
County Final Innovative Project Reports	11%

State Agency Leadership Continued:

We asked State Agency Leadership: Is your State Mental Health Agency using any specific data collection tool(s) to monitor and measure clients' Peer Support Services Outcomes? Check all that apply.

STATE AGENCY LEADERSHIP DATA COLLECTION TOOLS	AGREE
Yes, we use [a] data collection tool(s) that we developed	19%
Yes, we use [a] data collection tool(s) developed by a third party	8%
No, we don't collect Peer Provider Outcomes data	16%
Not Sure	62%

We asked State Agency Leadership: How is your State Mental Health Agency sharing or publicizing the Peer Support Service Outcomes data it collects? Check all that apply.

STATE AGENCY LEADERSHIP PUBLICATION OF OUTCOME DATA	AGREE
Internal Agency Meeting	14%
Internal Agency Trainings	11%
Stakeholder Trainings	11%
Public Trainings/Conferences	14%
Public Webinars	14%
Email Blasts	19%
Website Post	28%
Social Media Posts	8%
Stakeholder Planning Meetings	14%
Public Board, Commission, or Committee Meetings	28%
N/A – My State Mental Health Agency doesn't collect Peer	14%
N/A – My State Mental Health Agency doesn't share the Peer	3%
Not Sure	42%

We asked State Agency Leadership: How is your State Mental Health Agency currently using Peer Support Service Outcomes data to inform its MHSA evaluation, funding, programming, and/or policy decisions? Check all that apply.

STATE AGENCY LEADERSHIP USE OF OUTCOME DATA	AGREE
Peer Support Service Outcomes data are used to expand MHSA funding for effective programs	23%
Peer Support Service Outcomes data are used to decrease or eliminate MHSA funding for ineffective programs	9%
Peer Support Service Outcomes data are used to clarify or refine the scopes of work for MHSA-funded programs	14%
Peer Support Service Outcomes data are used to define goals and objectives for MHSA-funded programs	14%
Peer Support Service Outcomes data are used to determine additional training and/or support needs within MHSA-funded programs	14%
Peer Support Service Outcomes data are used to define goals and objectives for MHSA-funded programs	20%
Peer Support Service Outcomes data are used to evaluate the effectiveness of MHSA-funded programs	14%
Peer Support Service Outcomes data are used to shape internal organizational policies, procedures, practices, and standards for services delivery	14%
N/A – My State Mental Health Agency doesn't collect Meaningful Peer Support Service data	14%
N/A – My State Mental Health Agency doesn't use Peer Support Service Outcome data in MHSA evaluation, funding, programming, and/or policy decisions	3%
Not Sure	51%

We asked State Agency Leadership: How is your State Mental Health Agency tracking the cost savings? ([EBP research shows that utilizing peer support services saves \\$\\$](#))

We received the following write-in responses:

- Not Sure
- To my knowledge they do not track the cost savings
- Not that I am aware of at this moment
- Internally
- It does not track cost savings
- Computer
- Assessing how we use the funds and the areas that are missed that will need financial support
- I have no idea
- N/A

We asked State Agency Leadership: Is your State Mental Health Agency ensuring that the counties are complying with the [WIC](#) & [CCR](#) ?

We received the following write-in responses:

- Yes
- I hope so
- Hopefully
- Not sure
- Unknown
- We have no county oversight role
- I have made multiple requests but I am not aware of any efforts to ensure compliance with WIC, CCR, or ADA or any other state and disability laws
- Yes, it requires that the MHP develop a plan of correction. If the dept. determines that action needs to be taken the dept. will issue MHP with a written notice of non-compliance and the corrections that need to be made.
- They don't, there is no central governing authority
- Not that I am aware of at this moment
- N/A

The following populations were asked to complete the Local System Leadership and Peer Provider Survey:

- People who work for a County/Local Mental Health System in an executive leadership, management, professional, or evaluation role
- People who work for a Local Mental Health Advocacy Organization in an executive leadership, management, or high-level advocacy role
- People who work for a Local Services Provider in an executive leadership, management, or professional role
- People who serve on a Local PMHS Policy-Making/Oversight Body

We asked Local System Leadership: Are Peer Support Positions included in your MHSA plan? In other words, are MHSA funded programs creating peer support positions and hiring individuals with lived experience of recovery from a mental illness?

- Yes, always: 55%
- Yes, sometimes: 32%
- No, never: 2%
- Not sure: 11%

We asked Local System Leadership: If no, why?

We received the following (relevant) write-in responses:

- Unknown. The county plan does not include this for the LGBTQ+ people, declines meaningful involvement with the LGBTQ+ community, declines consultation with the local non-profits
- N/A
- We have had many requests over the years, but have had no direct update on these items

- This depends on the usage of transitional funding under the MHSA as well as community partnership planning funds. When transitional funding is being used in conjunction with innovation plans, peer support specialists end up falling by the wayside
- No authority from the state to do so-nothing binding
- Many of these individuals report increased stress and difficulty in their work assignments due to lack of necessary ADA accommodations needed for them to do their job. The county and the department does not have a clear and informed approach to providing people with psychiatric disabilities with the necessary accommodations for them to be successful and stay safe at their workplace
- Peer Support positions are often written into the MHSA plan, but are often not filled or ignored by agencies
- Last fiscal year, nearly all Consumer and Family Member operated programs were eliminated from the budget. They were able to continue operating due to bridge funding by the Board of Supervisors. In the next fiscal year, funding has been restored to all programs through MHSA
- Through contracts, but very lacking of the County hiring benefited positions, some extra help though.
- Have not hired in sometime due to working on changing/updating job description which is time consuming due to bureaucracy
- Funding and lack of Peer Support Certification in CA
- They are in each of our plans, but not in all programs
- N/A
- There is not a plan at this time. I was involved in creating paid peer positions. The agency was consolidating and reorganizing.

We asked Local System Leadership: How many Peer Positions?

- 0-5: 31%
- 5-10: 20%
- 10-20: 19%
- 20+: 29%

We asked Local System Leadership: What is the employment status of the peer positions?

- Full-Time: 75%
- Part-Time: 59%
- Volunteer: 30%

We asked Local System Leadership: Are Peers given a living wage with health benefits?

- Yes: 52%
- No: 26%
- I don't know: 26%

We asked Local System Leadership: Are Peers offered opportunities for continuous learning, professional development, career advancement?

- Yes: 72%
- No: 12%
- I don't know: 18%

We asked Local System Leadership: Is lived experience with a mental health condition required?

- Yes: 68%
- No: 19%
- I don't know: 15%

We asked Local System Leadership: Do the Peers lived experience with mental health match the population(s) served?

- Yes: 68%
- No: 8%
- I don't know: 26%

We asked Local System Leadership: Do Peers reflect the diversity of the communities served?

- Yes: 73%
- No: 12%
- I don't know: 15%

We asked Local System Leadership: Are Peers supervised/managed by other peer professionals to promote career ladders for peers and to ensure performance expectations and practice guidelines reflect fidelity to the evidence base and core principles of peer support?

- Yes: 55%
- No: 25%
- I don't know: 20%

We asked Local System Leadership: What training and ongoing education do peers receive to develop and enhance SAMHSA's 12 Core Competencies for Peer Support Workers and to ensure fidelity to the evidence-based peer support model?

We received the following (relevant) write in responses below:

- Wellness Recovery Action Plan (WRAP)
- Mental Health First Aid
- Wise U
- ACCESS
- Cal Voices
- Not Sure
- Unknown
- None, that I am aware of
- Intentional Peer Support
- Online trainings
- There is no Peer Training program
- All Peers get trained annually on core competencies. We use in person and eLearning platforms
- BHRS
- NAMI
- SAMHSA
- Relias training platform

- RI Consulting Peer Empowerment Training
- Goodwill/Peer Employment and Training Program
- OSHPD Peer Support Training
- CAMHPRO Peer Support Trainings/Webinars
- Motivational Interviewing
- Trauma Informed Care
- I don't know

We asked Local System Leadership: What training and ongoing education do supervisors, clinicians, etc. who work with peers receive to help peers develop and enhance Core Competencies and ensure fidelity to the evidence-based peer support model and prevent co-optation and marginalization of peers?

We received the following (relevant) write in responses below:

- Currently no ongoing training
- Online
- Not sure
- None
- None stated in the plan
- None that I am aware of
- Unknown
- No training has been offered to supervisors, clinicians, or colleagues on the meaning, model, or evidence -base of peer support
- I am not sure
- WISE
- A full range of trainings are offered to both sets of workers and the trainings overlap
- eLearning
- Little to none
- All managers and supervisors obtain ongoing education by the Peer Empowerment Manager
- Supervising Peer Workforce
- All trainings required by the State. Inclusion of peer advocates in the clinical setting and case discussion. Open learning environment.
- Cultural Competence Training
- SAMHSA
- I have never heard of any

Success of Peer Support Workers

We asked Local System Leadership: If your County/Local Mental Health System provides PEER SUPPORT Services to adult mental health clients, how would you rate your organization's ability to ensure success in these core competencies for Peer Providers?

The following 11 Core Competencies Identified by SAMHSA for Peer Support Workers in the Behavioral Health System are:

SUCCESS OF PEER SUPPORT SERVICES	EFFECTIVE	INEFFECTIVE/ NOT SURE
59.6% of respondents stated that they do not know any of this information.		
A recovery-oriented work culture that values the unique contributions of peers	78%	22%
Dedicated and influential workplace leaders committed to peer-provided services;	80%	20%
Supportive managers and supervisors willing to coach peer staff;	75%	25%
High-quality ongoing training and individual mentoring for peers;	71%	29%
Adequate oversight, evaluation, and feedback for peer positions;	68%	32%
Clearly-defined peer roles and genuine opportunities for career advancement;	66%	34%
Collaborative working relationships amongst all staff, peer and non-peer;	81%	19%
Workplace infrastructure that supports continuity and growth of peer programs;	71%	29%
Regular opportunities for peer employees to interact with one another;	77%	23%
Flexible workplace policies and procedures;	69%	31%
An open learning environment.	79%	21%

*59.6% of respondents stated that they do not know any of this information.

We asked Local System Leadership: If your County/Local Mental Health System provides PEER SUPPORT Services to adult mental health clients, how would you rate your organization's ability to ensure success in these core competencies for peer providers? (You may explain your responses or provide additional details in the comments box below.)

We received the following (relevant) write-in responses:

- Peer folks are always welcome
- Many of our peer workers are reporting high levels of harassment and discrimination in their workplace by management and county leadership. Many of the peers report not getting requested ADA disability accommodations for them to do their work, get training, and participate equitably alongside their fellow coworkers.
- We have a long way to go. Peer was scolded for informing therapist that a client was suicidal ("Not your job.")
- Peer was gossiped about because colleagues found out what meds they took.
- Peer providers have the same written job description, but duties vary widely. Some peer providers have no access to peer colleagues or support to ensure their work is true to the peer model.

- In my experience, peers in the workplace in a clinical environment are not valued.
- I am a contracted provider and often try to support clients in obtaining peer employment, however roles for peers are not full time positions and do not appear to have consistent support and mentorship, leading to inconsistent, unsuccessful peer development and advocacy.
- Our company developed a clinical system centered on Recovery
- Overall, we do a good job. We need to improve training options for our peer support specialist.
- Some Personnel are more difficult to collaborate with than others.
- There is periodic role confusion amongst peers and with other staff
- I witnessed higher level peers being spoken over and talked down to... without reason. I heard of non-peer being hired in peer positions... to save face. I heard of peers not being adequately trained
- Attitude of peer services being disposable as per budget cuts and lack of understanding of many of the value of peer services.
- Room for improvement in all areas.
- There is openness and support amongst leadership and staff. Policy, procedures etc. are not yet in place
- Peer run centers are extremely effective. Peers are hired as drivers and in some other positions. There are not enough career opportunities, and the lack of Peer Certification in California has been stated as a problem in hiring.
- Our supervisory team really works to support and develop peer positions in our county
- Open & supportive.
- I would say the CBOs in our county are much more effective than the county ... but having said that, there is much room for improvement for all.
- Peers are more of a token
- I notice some difficulties between peer staff and clinicians.

Effectiveness of Peer Support Services

We asked Local System Leadership: If your County/Local Mental Health System provides PEER SUPPORT Services to adult mental health clients, how effective are these services in supporting collaboration and teamwork, promoting leadership and advocacy, and promoting growth and development?

EFFECTIVENESS OF PEER SUPPORT SERVICES	EFFECTIVE	INEFFECTIVE/ NOT SURE
51.9% of respondents stated they do not know any of this information		
Peer Employee works together with other colleagues to enhance the provision of services and supports	82%	18%
Peer Employee assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of clients	75%	25%
Peer Employee coordinates efforts with health care providers to enhance the health and wellness of clients	79%	21%
Peer Employee coordinates efforts with clients' family members and other natural supports	72%	28%

EFFECTIVENESS OF PEER SUPPORT SERVICES	EFFECTIVE	INEFFECTIVE/ NOT SURE
Peer Employee partners with community members and organizations to strengthen opportunities for peers	80%	20%
Peer Employee strives to resolve conflicts in relationships with clients and others in their support network	75%	25%
Peer Employee uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that client's rights are respected	77%	23%
Peer Employee advocates for the needs and desires of clients in treatment team meetings, community services, living situations, and with family	82%	18%
Peer Employee uses knowledge of legal resources and advocacy organization to build an advocacy plan	70%	30%
Peer Employee participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families	78%	22%
Peer Employee educates colleagues about the process of recovery and the use of recovery support services	80%	20%
Peer Employee actively participates in efforts to improve the organization	77%	23%
Peer Employee maintains a positive reputation in peer/professional communities	83%	17%
Peer Employee recognizes the limits of their knowledge and seeks assistance from others when needed	80%	20%
Peer Employee uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)	73%	27%
Peer Employee reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support	74%	26%
Peer Employee seeks opportunities to increase knowledge and skills of peer support	80%	20%

We asked Local System Leadership: If your County/Local Mental Health System provides PEER SUPPORT Services to adult mental health clients, how effective are these services in supporting collaboration and team work, promoting leadership and advocacy, and promoting growth and development?

We received the following (relevant) write in responses.

- Peer employees have no knowledge of their rights, therefore cannot extend that knowledge to clients. Peer employees are denied continuing education by county/contracted staff who are supervising them due to what would be a shortage if the peer worker took time off for training.
- Peer employees report need for support and education to better enhance the mentioned services with little to no response from management with cases of retaliation and harassment for doing so.

- we are limited to how much information we can share in our particular center.
- consistent oversight does not appear to be effective and there is no clear progressive growth flows identified for Peers in employment.
- not all peers have the leadership to be reminded of the peer values often.
- we have seen some great peer support.
- There is still a lot of stigma in the PMHS and peer employees are still seen as a jobs program, not as adding value to mental health services and recovery. There is a lot of lip service given to Peer Services, but in general the peer employees are not encouraged to provide peer services and instead are used to do case management at best and girl Friday tasks at worst.
- Room for improvement in all areas.
- Overall our Peers work well with the community and encourage consumers to become peers as well.
- I do not directly work with Peer staff.
- The training and infrastructure are there, but again, opportunities for career positions are lacking. I would say the employees that are there are amazing, but we need more.
- Generally, everyone who requests more knowledge is provided an opportunity. Though not all peers desire to increase knowledge other than staff meetings.
- There are some very effective peer employees and volunteers, but in general, more training is needed to prepare and inform others. More peer employment is also needed.
- I did not interact enough with the small peer led program to see results.
- I do not directly supervise Peer Employees so I am not able to answer these particular questions

Local System Leadership | Assessment of Peer Support Outcomes

We asked Local System Leadership: When assessing the Meaningful PEER SUPPORT Outcomes listed in the previous question, how important is the opinion or perspective of each participant listed below? In other words, whose opinion counts the most in evaluating a client's progress towards their peer support outcomes?

Order of identified importance:

1. The Client's Opinion
2. The Client's Family Member's Opinion
3. The Peer Support Worker's Opinion
4. The Psychiatrist's or Medical Staff's Opinion
5. Not Sure
6. The Clinician's or Clinical Staff's Opinion
7. The Case Manager's or Service Coordinator's Opinion
8. The Social Worker's Opinion

Local System Leadership | Data Collection Tools

We asked Local System Leadership: Is your County/Local Mental Health System using any specific data collection tool(s) to monitor and measure clients' meaningful recovery outcomes based on clients who are receiving Peer Support Services in comparison to those who are not receiving Peer Support Services? Check all that apply.

- Yes: 32%
- No/Not Sure: 68%

We asked Local System Leadership: How is your County/Local Mental Health System reporting on the Peer Support Services Outcomes data it collects? Check all that apply.

LOCAL SYSTEM LEADERSHIP REPORTING OF OUTCOME DATE	%
County MHSA Three Year Program and Expenditure Plans	33%
Annual Updates to County MHSA Three Year Program and Expenditure Plans	26%
County Client and Service Information System Data Reports	12%
County Quarterly Progress Reports	13%
County Full Service Partnership Performance Outcome Data	19%
County Consumer Perception Semi-Annual Survey Reports	15%
County Three-Year Prevention and Early Intervention	12%
County Annual Innovative Project Reports	10%
County Final Innovative Project Reports	9%
Other	4%
N/A – My County/Local Mental Health System doesn't collect Peer Support Service Outcomes data	7%
N/A – My County/Local Mental Health System doesn't report the Peer Support Service Outcomes data it collects	2%
Not Sure	50%

We asked Local System Leadership: How is your County/Local Mental Health System sharing or publicizing the Peer Support Outcomes data it collects? Check all that apply.

LOCAL SYSTEM LEADERSHIP SHARING OF OUTCOME DATA	%
Internal System Meetings	16%
Internal System Trainings	8%
MHSA Stakeholder Training	18%
Public Trainings/Conferences	14%
Public Webinars	4%
Email Blasts	10%
Website Posts	7%

LOCAL SYSTEM LEADERSHIP SHARING OF OUTCOME DATA	%
Social Media Posts	4%
MHSA Community Program Planning Process/Stakeholder Planning Meetings	24%
Local Mental Health Board Meetings	22%
County Board of Supervisors Meetings	13%
Other	6%
N/A – My County/Local Mental Health System doesn't collect Peer Support Service Outcomes data	7%
N/A – My County/Local Mental Health System doesn't share the Peer Support Service Outcomes data it collects	2%
Not Sure	53%

We asked Local System Leadership: How is your County/Local Mental Health System currently using the Peer Support Outcomes data it collects to inform MHSA funding and programming decisions? Check all that apply.

LOCAL SYSTEM LEADERSHIP UTILIZATION OF OUTCOME DATA	%
Peer Support Outcomes data are used to evaluate the effectiveness of MHSA-funded programs that utilize peer providers	24%
Peer Support Outcomes data are used to develop standards for services delivery	15%
Peer Support Outcomes data are used to determine gaps in services and local MHSA programming priorities	18%
Peer Support Outcomes data are used to identify opportunities and methods to improve services for adult mental health clients	18%
Peer Support Outcomes data are used to expand MHSA funding for effective programs	18%
Peer Support Outcomes data are used to decrease or eliminate MHSA funding for ineffective programs	7%
Peer Support Outcomes data are used to clarify or refine the scopes of work for MHSA-funded programs	8%
Peer Support Outcomes data are used to define goals and objectives for MHSA-funded programs	16%
Peer Support Outcomes data are used to determine additional training or support needs within MHSA-funded programs who utilize peer providers	10%
Other	2%
N/A – My County/Local Mental Health System doesn't collect Peer Support Outcomes data	7%

LOCAL SYSTEM LEADERSHIP UTILIZATION OF OUTCOME DATA	%
N/A – My County/Local Mental Health System doesn't use Peer Support Outcomes data in MHSA funding and/or programming decisions	2%
Not Sure	61%

CONCLUSION AND OBSERVATIONS: ANNUAL CLIENT AND LEADERSHIP SURVEY

The MHSA requires Counties to utilize MHSA funding to establish peer support and family education support services or expand these services to meet the needs and preferences of clients and/or family members (9 CCR § 3610(d)). 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.

Despite the MHSA's mandate to employ individuals with lived experience throughout the PMHS (9 CCR § 3610(b)), consumers are starkly underrepresented amongst the staff of County mental health departments and their contracts CBOs.

Investing in the capacity building of peers in California's PMHS not only promotes inclusivity but also evidence-based practices. Peer support is an evidence-based practice proven to reduce costs by preventing the need for more crisis intervention care and sustaining longer periods of recovery (www.samhsa.gov, 2016). Peer support is a core principle of Recovery-Oriented Services that aims to direct behavioral health clients toward community resources and practices and away from expensive institutions and emergency rooms. Peer Providers have the lived-experience to establish relationships with clients as equals and share stories of experiences that support an individual's journey to recovery.

Peer support means Counties maintain fidelity to the evidence-based model of shared lived experience in all peer positions. It means the incorporation and expansion of peer support in all programs and services within the PMHS. Further, peer support includes substantial investment in peer positions to provide essential training in peer core competencies, living wages and commensurate employment benefits, ongoing professional development, and opportunities for career advancement in the PMHS.

Observations: Peer Support in California's Public Mental Health System

Of the 1,007 respondents:

- 51% of respondents identified as an adult client or consumer
- 63% of respondents currently work in the PMHS

Please note: Participants were allowed to opt out of answering questions throughout the survey. Of the 448 clients and family members who answered the question, *have you or your family member ever received Peer Support Services* 139 (31%) of respondents stated they have never received Peer Support.

Clients and Family members identified the top ten Peer Support factors that are important to their and/or their family members recovery. Of the top threeresponses, both clients and family members identified Peer Support as important to individual's recovery as Peer Supporters provide people with tools and resources to achieve recovery.

Fifty-seven of the respondents identified as having a leadership position within a State Agency, and 44 of the respondents agreed to complete the State Agency Leadership Survey. Of the 44 State Agency leadership responses 78% of respondents stated that they **do not** collect Peer Provider Outcome data.

The following State Agencies participated in the State Agency leadership Survey:

- State Department of Healthcare Services (DHCS)
- Mental Health Services and Oversight Accountability Commission (MHSOAC)
- Office of Statewide health Planning and Development (OSHPD)
- California Behavioral Health Planning Council (CBHPC)
- California Mental Health Services Authority (CalMHSA)

266 of the respondents identified as part of their Local System Leadership. Of the Local System Leadership responses 68% of respondents stated that they do not and/or were unsure if their PMHS collects meaningful recovery outcomes based on clients who are receiving Peer Support Services in comparison to those who are not receiving Peer Support Services.

SATISFACTION AND BARRIERS SURVEY

The Annual Satisfaction and Barriers Survey is an opportunity to hear from Stakeholders that have participated in ACCESS sponsored training and events and learn what activities were the most meaningful, and to learn how we may approve upon activities in the future. Additionally, it is an opportunity for us to revisit the Community Program Planning Process and to identify areas that inhibit our stakeholders to meaningfully participate in the CPPP.

ACCESS disseminated the Annual Satisfaction and Barriers Survey between July 1, 2020 – August 15, 2020 and gathered 75 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.

Of the Annual Satisfaction and Barriers Survey respondents, when asked what impacts their ability to participate in the MHSA Community Program Planning Sessions:

- 53% reported that a lack of understanding of the MHSA requirements and standards impacts their ability to participate.
- 43% reported that stigma impacts their ability to participate.
- 45% reported the lack of information/advertising (I was unaware of these meetings, or did not know what it was for.) impacted their ability to participate.
- 40% reported that the lack of transportation impacts their ability to participate.
- 58% reported the meeting times impact their ability to participate.
- 45% of respondents reported that the meeting location impacts their ability to participate.

CONCLUSIONS: STAKEHOLDER INCLUSION AND FEEDBACK SURVEY | SATISFACTION AND BARRIERS 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.

PART III: BREAKING NEWS AND WISE

BREAKING NEWS

THE IMPACT OF COVID-19 ON PEER SUPPORT SPECIALISTS:

Researchers at Boston University's Center for Psychiatric Rehabilitation, in collaboration with the National Association of Peer Supporters (NAPS), conducted a survey of US-based Peer Support Specialists from May 18, 2020-June 22, 2020 in order to assess the impact of the novel coronavirus/COVID-19 on the peer support workforce, including job tasks, challenges and supports. A total of 1,280 peer support specialists (paid and volunteer) qualified for, consented and responded to the online survey. Individuals from all 50 states responded.

The research uncovered that Peer support specialists may be filling gaps in mental health service needs and delivery that have resulted from the pandemic, including those that clinical staff may not be able or willing to address. Based on survey responses, it appears that peer support specialists, and the organizations in which they work, demonstrated flexibility and creativity in addressing unplanned needs and were not constrained by existing job descriptions.

Lessons learned from the peer support workforce during this pandemic should influence future service delivery; for example, remote or virtual support has allowed some individuals to engage in services who were previously unable, such as those with transportation barriers or discomfort with in-person interactions. Implications for these findings include the need to continue to fund this vital part of the mental health workforce and support peer specialists through the pandemic. Given the information gathered about the unexpected benefits arising from the pandemic, we should systematically examine these creative adaptations to ensure the continuation of flexible, creative, and responsive mental health peer support services while preserving the integrity and values of peer support.

The key findings were as follows:

1. **JOB LOSS/ECONOMIC IMPACT:** All respondents had been employed for pay or volunteering in peer support positions prior to COVID-19 (as of February 2020), including 67% who were employed full time at that time. At the time of survey response (May/ June 2020), 6.2% reported no current paid or volunteer peer position, and 8.5% reported having lost a job/ being laid off due to COVID-19. Furthermore, 7.3% reported losing some or all benefits due to COVID-19, and 13.4% reported having to take a pay cut. Despite these factors, the majority of respondents believed that the coronavirus crisis had impacted their personal financial situation less than most others.
2. **CHANGES TO TASKS:** The majority of peer support specialists (72.5%) reported being engaged in new job tasks due to COVID-19 and related changes, including tasks specific to the pandemic, including: technology, community resources, and other non-peer related tasks. Conversely, respondents reported engaging less frequently in many standard peer support-related tasks, particularly in terms of providing individual support and group facilitation. A sizable portion (44.8%) of respondents stated that the number of individuals they were supporting had increased as a result of the pandemic, while 29.1% reported a decrease.

3. **INDIVIDUALS SUPPORTED:** Many peer support specialists (57.1%) indicated that more individuals were reaching out for support since the pandemic began. Respondents reported that the individuals they support are experiencing significant additional challenges since the pandemic, including increased isolation (91.5%), mental health symptoms (86.4%), substance use issues (67%), food shortages (63.5%), housing instability (60.1%), possibility of job loss (59.4%), and interpersonal/ family violence (38.3%).
4. **SUPPORT AND POSITIVE IMPACTS:** Respondents also reported that they themselves are experiencing a variety of new and additional challenges related to their peer specialist roles, especially feelings of isolation (73%) and communication challenges (69.7%). Despite the above factors, most respondents reported feeling “satisfied” or “very satisfied” with the amount of support that they are receiving during this crisis from their organizations (68.1%), supervisors (74.5%), and coworkers (74.5%). Furthermore, almost three quarters of respondents reported positive impacts/benefits resulting from the pandemic, including benefits to peer specialists, service recipients and the field as a whole. For example, benefits included being able to learn and apply new technology, provide tangible supports such as food and housing assistance to those they support, connect and engage more readily with some peers, and exercise creativity in their roles. They can now support geographically diverse individuals, and noted an increased awareness of the mental health and peer services more broadly.

To read the full report click [here](#).

H.R.8206-PEER ACT of 2020:

New bipartisan legislation introduced in the House of Representatives by Representatives Judy Chu (D-CA) and Adrian Smith (R-NE) to provide Medicare coverage of peer support services for individuals with mental illness and/or substance use disorders who are being treated in primary care and receiving integrated behavioral health services. The bill clarifies that nothing in the Medicare statute prohibits peer support specialists from providing services billed as part of integrated behavioral health. It specifies that peer support specialists’ services may be billed under the collaborative care and other behavioral health integration codes in Medicare.

Peer support specialists are people with lived experience of a mental illness or substance use disorder who have completed specialized training and are certified to deliver support services under appropriate state or national certification standards. Peer support specialists assist individuals in achieving their recovery goals by furnishing emotional, informational, and other support services to individuals who have been diagnosed with a mental illness (including dementia) or a substance use disorder.

This legislation recognizes the unique role of peer support specialists. They complement therapists, case managers, and physicians as part of a coordinated team. Peer support promotes recovery by helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities. Under this proposed legislation peer support specialists may be included as part of an integrated behavioral health team that includes a primary care doctor, a consulting psychiatrist, a care manager and others.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes peer support as an effective, evidence-based practice. According to SAMHSA, the proven benefits of peer support include reduced hospital admission rates, increased social support and social functioning, and decreased hospitalizations per year and saved an average of \$2,138 per Medicaid-enrolled month in Medicaid substance use and depression. A 2018 analysis showed that providers with peer services had 2.9 fewer expenditures. As of January 2017, 43 states allow Medicaid to be billed for peer support services.

The Veterans' Administration has recognized the value of peer support specialists to serve Veterans with mental health and substance use conditions. For example, a 2012 White House Executive Order to improve Mental Health access for Veterans included a directive to hire additional Peer Support Specialists.

The COVID-19 crisis is exacerbating a pre-existing behavioral health workforce shortage that is particularly acute in rural areas and communities of color. This policy change represents an opportunity to develop a peer workforce that reflects the communities to be served and understands their unique mental health needs by expanding access to recovery services in primary care.

To get updates on the PEERS Act of 2020 visit <https://www.congress.gov/bill/116th-congress/house-bill/8206/text> or click [here](#).

ACCESS believes that peer support specialists play a unique and critical role in health care and communities. With distress among Americans continuing to increase in response to the coronavirus pandemic, the peer support specialist workforce has the potential to fill massive gaps in resources. The philosophy of peer support, rooted in empowerment, mutuality, connection, and inclusion, is needed now more than ever.

Despite the clear need, limitations to peer support services remain. With states projecting budget shortfalls due to the pandemic's economic impact, it is still unclear how this will impact mental health budgets and resources at the state and local levels in the coming years. At the state level, we are continuing to work to ensure access to and investment in mental health and peer support services.

To support the needed investment in the peer support workforce at the federal level, ACCESS has been working alongside our colleagues to enact policies that give more people access to the life-changing power of peer support. Currently, we are focused on the following bills:

- H.R. 7780. "The Virtual Community Support Act of 2020," sponsored by Rep. Joseph Kennedy and Rep. Tony Cardenas. This bill would create a new program for peer-led community-based organizations to provide peer support services virtually during and after COVID-19.
- H.R. 8016. "Peer Assisted Relief Through Empathetic Resources and Supports (PARTNERS) Act. This bill would create a National Warm Line staff with peer support professionals for anyone experiencing mental health distress.
- H.R. 8206. "Promoting Effective and Empowering Recovery Services in Medicare Act of 2020" or the "PEERS Medicare Act of 2020," a bipartisan bill sponsored by Rep. Judy Chu and Rep. Adrian Smith. This bill seeks to provide Medicare coverage of peer support services for individuals with mental illness and/or substance use disorders who are being treated in primary care and receiving integrated behavioral health services. The bill includes the first definition of peer support specialists in the Medicare program and specifies that nothing in the Medicare statute prohibits peer support specialists from providing services billed as part of integrated behavioral health services.

WISE PROGRAM (WORKFORCE INTEGRATION SUPPORT AND EDUCATION)

WISE U is an 11-day interactive peer training course that Cal Voices' (Formerly NorCal MHA) WISE Program offers quarterly. WISE U is designed to increase the peer workforce and aid in the development of peer support services already within substance-use disorder and mental health service settings.

The primary goal is to assist WISE U participants with placement into a full-time or part-time, paid or volunteer peer position in the public mental health field.

Following the 11-day peer training course, each successful applicant is matched with a WISE U Career Mentor who will work with them to create their individualized career plan to help gain or maintain peer employment.

Cal Voices, in partnership with its national affiliate Mental Health America (NMHA), provides access to NMHA's **National Certified Peer Specialist (NCPS)**³⁹ program, the only nationally- recognized peer credential in the United States. The NCPS was developed to **exceed** the individual statewide standards used in public behavioral health systems around the country. Cal Voices worked closely with NMHA in the development of its NCPS program, providing subject matter expertise and feedback on the NCPS core competencies and exam content. NMHA recognizes WISE U's 77-hour Peer Training Academy and 40-hour Advanced Certification Academy as approved training programs and Cal Voices as an authorized testing center, meaning we are currently the only organization in California permitted to both train peers for the NCPS exam **and** administer the exam to qualified peers.

³⁹ National MHA's informational booklet about its new NCPS credential program is available online here:
<https://flcertificationboard.org/wp-content/uploads/NCPS-Standards-and-Requirements-Tables-February-2019.pdf>

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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 **A**dvancing **C**lient and **C**ommunity **E**mpowerment through **S**ustainable **S**olutions, 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

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.

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)).

LIST OF APPENDICES

APPENDIX 1: ANNUAL CLIENT AND LEADERSHIP SURVEY REPORT

OVERVIEW: The Annual Client and Leadership Survey is for clients, community stakeholders, and Public Mental Health System (PMHS) leadership, to provide feedback regarding the availability and integration of Peer Support Services within the public mental health system.

The survey was circulated between April 30, 2019 – August 28, 2020, and received 628 responses.

FULL REPORT: https://reporting.alchemer.com/r/267733_5f72c4c39b6b09.70395408

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 28, 2020 - September 16, 2020, and received 97 responses.

FULL REPORT: https://reporting.alchemer.com/r/267733_5f691fbfb5c6f1.25054479

APPENDIX 3: YEAR 3 AMBASSADOR BOOT CAMP EVALUATION SURVEY REPORT

DESCRIPTION: This survey assesses the efficacy of our Ambassador Boot Camp and assists ACCESS with continually improving the program. Responses were collected from 30 ACCESS Ambassadors between November 8, 2019 – February 29, 2020.

REGIONAL AMBASSADOR REPORT: https://reporting.alchemer.com/r/267733_5fc5440cc745c3.93287005

STATE AMBASSADOR REPORT: https://reporting.alchemer.com/r/267733_5fc545df2a0ba7.71968286

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 November 15, 2019 – February 29, 2020.

REGIONAL AMBASSADOR REPORT: https://reporting.alchemer.com/r/267733_5fc54a9c97e583.29868130

STATE AMBASSADOR REPORT: https://reporting.alchemer.com/r/267733_5fc54cf0aa0156.54751039

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 60 evaluation responses between September 1, 2019 – March 13, 2020.

FULL REPORT: https://reporting.alchemer.com/r/267733_5ec8592712bbd7.35093808

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 60 Workshop evaluations between September 1, 2019 – March 13, 2020.

FULL REPORT: https://reporting.alchemer.com/r/267733_5f5169a8b75e48.74598955

APPENDIX 7: ANNUAL CONFERENCE EVALUATION REPORT

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

FULL REPORT: https://reporting.alchemer.com/r/267733_5f865b3c202977.92875073

APPENDIX 9: ANNUAL CONFERENCE EVALUATION REPORT

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

FULL REPORT: https://reporting.alchemer.com/r/267733_5f865b3c202977.92875073