ACCESS California

STATE OF THE COMMUNITY REPORT (2017-2018)

MAKING THE MHSA'S VISION FOR MEANINGFUL STAKEHOLDER INVOLVEMENT A REALITY

NORCAL MHA CLIENT/CONSUMER ADVOCACY PROGRAM | 16MHSOAC0029

ACCESS California — A PROGRAM OF NORCAL MHA

NorCal MHA — Mental Health America

Proposition 63 — Mental Health Services Act — California — Wellness · Recovery · Resilience

MHSOAC — Mental Health Services Oversight & Accountability Commission

ACCESS California
A PROGRAM OF NORCAL MHA

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Ombudsman and Advocacy Helpline

(707) 572 - HELP

www.accesscalifornia.org/helpline

Are you looking for advocacy opportunities in your local public mental health system?

Do you need support advocating?

Has a violation occurred in your local Community Program Planning Process?

Give our Advocacy Helpline a call! The Advocacy Helpline is a 24-hour message line. Our Outreach Team will call you back within two business days to assist you with your situation.

You can also email us at **access@norcalmha.org**.

ACCESS California is a program of NorCal MHA funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)

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ABOUT ACCESS CALIFORNIA

Founded in 1946, **Mental Health America of Northern California** (NorCal MHA) is the oldest, continuously-operating consumer advocacy agency in California. NorCal MHA 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 its programs, NorCal MHA works with individuals and families with mental health challenges to promote wellness and recovery, prevention, and improved access to services and supports.

NorCal MHA's 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. NorCal MHA strongly advocated 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 NorCal MHA to perform statewide advocacy on behalf of public mental health clients (MHSOAC, 2017a; MHSOAC, 2017b). NorCal MHA 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.

ACCESS' primary activities include:

- Maintaining a network of **subject matter experts** (public mental health 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;
- Drafting an **Annual State of the Community Report**, analyzing topics and trends of importance to public mental health clients in California, with a different annual focus/theme each year;
- Providing **training and education** to public mental health clients, their family members, and **on-call technical assistance** to public mental health policymakers and leaders of local and statewide public mental health agencies;
- Performing **outreach and engagement** to mental health clients and other stakeholders throughout California and providing information and messaging on important mental health policy issues; and
- Conducting ongoing **state- and local-level advocacy** to help effect and implement improvements to California's public mental health system.

This State of the Community Report reflects ACCESS' cumulative efforts and outcomes for the first year of its client/consumer stakeholder advocacy contract with the MHSOAC (September 1, 2017 – August 31, 2018).

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A copy of this report is available on ACCESS California's website at: www.accesscalifornia.org

ACKNOWLEDGEMENTS

Dawniell A. Zavala, Esq.
ACCESS Program Director

"Collaboration has no hierarchy. The Sun collaborates with soil to bring flowers on the earth." - Amit Ray, Enlightenment Step by Step

This State of the Community Report is dedicated to the clients receiving services in California's Public Mental Health System and to the ACCESS Ambassadors and other local advocates who represent the very best of stakeholder leadership throughout this state. Your feedback is driving our process, we honor you, and we will continue to ensure that all of our program activities are client driven and represent the authentic voices of clients in California.

First and foremost, we thank the Mental Health Services Oversight and Accountability Commission for awarding NorCal MHA the client stakeholder advocacy contract making the ACCESS California program possible, and for recognizing our agency as a statewide leader in public mental health policy and a prominent voice for clients throughout the state. We appreciate the MHSOAC staff (especially Angela Brand, Tom Orrock, and Lester Robancho) for their ongoing technical assistance and the unwavering support they have lent to the ACCESS team and to all the of MHSOAC stakeholder contractors.

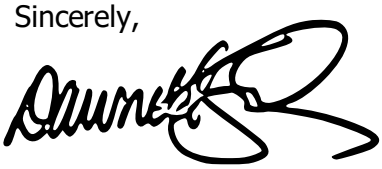
I am personally grateful for the invaluable contributions and support ACCESS California has received throughout our inaugural year from the wide range of individuals and organizations that stepped forward, committing time and resources to help advance ACCESS' mission to strengthen and expand local and statewide client advocacy through individual and community empowerment. These contributors include public mental health clients, local advocates, ACCESS Ambassadors, County mental health leadership, local- and state-level policy makers, and other interested community members. Specifically, we recognize the Los Angeles County Department of Mental Health and Placer County Mental Health Services for your invaluable partnerships with ACCESS over the past year, which not only raised the stature of our program, but demonstrated your deep commitment to elevating the voices of the clients, families, and other community stakeholders you serve.

My heartfelt gratitude goes to the ACCESS California team for their dedication to ACCESS' mission and values and to Andrea Crook for her unflappable enthusiasm and unshakable drive. By implementing

community-identified strategies to meet stakeholders' advocacy needs, promote client voices, and advance authentic system-stakeholder partnerships, the ACCESS team is driving truly transformative change in California's Public Mental Health System (and having fun while doing it).

Finally, I am indescribably thankful to NorCal MHA's Executive Director, Susan Gallagher MMPA, for her steadfast belief in the recovery model and for remaining a tireless proponent of the client voice at all levels within the Public Mental Health System. Never one to shirk her obligations or shy away from an important discussion, Susan is a true role model for all leaders of consumer-run mental health agencies. I am so proud to represent NorCal MHA and ACCESS California and am lucky to work for an organization that lives its principles. Because of Susan, NorCal MHA has become an agency that appreciates its employees' talents, encourages staff to find their voices, and provides endless opportunities for personal and professional development within the mental health field. Recovery is real and is happening all around us, every single day.

Sincerely,

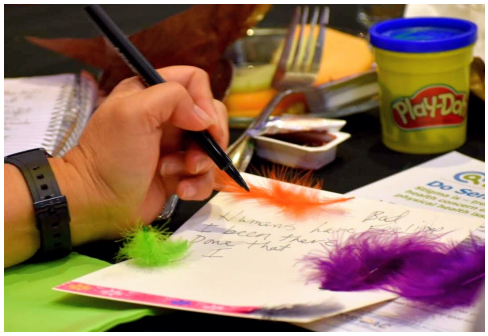


Dawniell A. Zavala, Esq.
Program Director, ACCESS California

ABSTRACT

Many state-level and local-level mental health issues overlap. Because of this, ACCESS California (ACCESS) has focused the following State of the Community Report on the mental health issues impacting clients receiving services in California's Public Mental Health System (PMHS) at both the state- and local-levels. In seeking this information, ACCESS has engaged with mental health clients and community stakeholders as well as mental health agencies and providers across California. As California is a collective of diverse communities, all with different priorities and needs, it is imperative to assess the status of public mental health services throughout the state from the stakeholders' perspective. After thoroughly reviewing related literature and surveying ACCESS participants, ACCESS has determined additional training is needed for both clients and PMHS leadership on the MHSA's mandates as they relate to the Community Program Planning Process (CPP) and meaningful stakeholder inclusion in important PMHS decision-making. Furthermore, MHSA expenditures, specifically those for the CPP, are insufficient and lack transparency. Other issues affecting mental health stakeholders include affordable and stable housing, income insecurity, criminal justice reform, transitioning out of the foster care system, and access to mental health care. This Report explores these issues as well as recommendations for future efforts.

DEFINITIONS



ACCESS California (ACCESS): NorCal MHA's 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.

Any Mental Illness (AMI): "A mental, behavioral, or emotional disorder; AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment" (National Institute of Mental Health, 2017). Also referred to as a mental health challenge.

Brown Act Open Meeting Law (Brown Act): An act codified in the California Government Code that: (a) Requires local public agencies to post notice and agenda, ensure citizen and professional involvement, hold public meetings and hearings, encourage community input at meetings, and treat documents as public; and (b) Prohibits public bodies subject to the Act from using communication methods, like email, to circumvent the Act.(Ralph M. Brown Act, 2018; California Government Code § 54050 et seq)..

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).

Capital Facilities and Technology Component (Cap Fac; CF/TN): A funding component of the MHSA for technological needs and capital facilities needed to provide mental health services in Counties' Adult and Children's Systems of Care. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing (WIC § 5847(b)(5)). From 2005 – 2008, Counties were required to use 10% of their total annual MHSA funding on CF/TN expenditures (WIC § 5892(a)(2)). 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)).

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).

Geographic Managed Care (GMC): The State contracts with a number of commercial managed care plans and pays for services on a capitated basis.

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 (Appendix Q).

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

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

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

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

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

Public Mental Health System (PMHS): Publicly-funded mental health programs/services and entities that are administered, in whole or in part, by the California Department of Health Care Services or a California County. It does not include programs and/or services administered, in whole or in part, by federal, state, County or private correctional entities or programs or services provided in correctional facilities (9 CCR § 3200.253).

Recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2014).

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

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

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

Stakeholder Bill of Rights (SBOR): A resource developed by ACCESS that enumerates six distinct rights of public mental health stakeholders and seeks to: (1) foster transparency, fiscal responsibility, and public accountability within California's Public Mental Health System; (2) protect the rights of mental health Stakeholders receiving services in California's Public Mental Health System; (3) strengthen, support, and expand grassroots, Stakeholder-led public mental health advocacy; (4) promote individual

and community empowerment; (5) increase meaningful Stakeholder participation and community inclusion, in public mental health planning and program design, service delivery, and evaluation; (6) facilitate collaboration and communication amongst Stakeholders, community members, Local Mental Health Agencies, State Mental Health Agencies, service providers, legislators, policy-makers, and other state and local entities that influence the Public Mental Health System; and (7) ensure effective and necessary improvements in public mental health policy, programming and services deliver (Appendix P).

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.

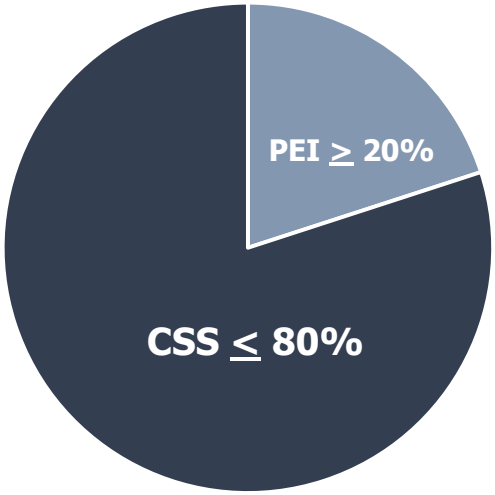
Transition Age Youth (TAY): Youth clients served in the PMHS who are between 16 and 25 years of age (9 CCR § 3200.280).

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)).

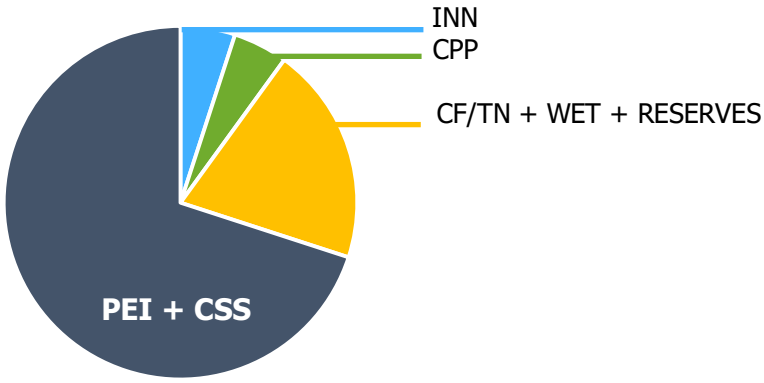
MHSA FUNDING AT A GLANCE

TOTAL COUNTY MHSA FUNDING



- PEI: shall be at least 20% of MHSA funds per WIC § 5892(a)(3)
- CSS: remainder of MHSA funds per WIC § 5892(a)(5)

OTHER MHSA FUNDING COMPONENTS



- INN: shall be exactly 5% of PEI + CSS funding per WIC § 5892(a)(6)
- CPP: shall be no more than 5% of total MHSA funding per WIC § 5892(c)
- CF/TN + WET + Prudent Reserve: may be up to 20% of five-year average per WIC § 5892(b)
- Remaining PEI + CSS Funding

INTRODUCTION

History of California's Mental Health Services Act

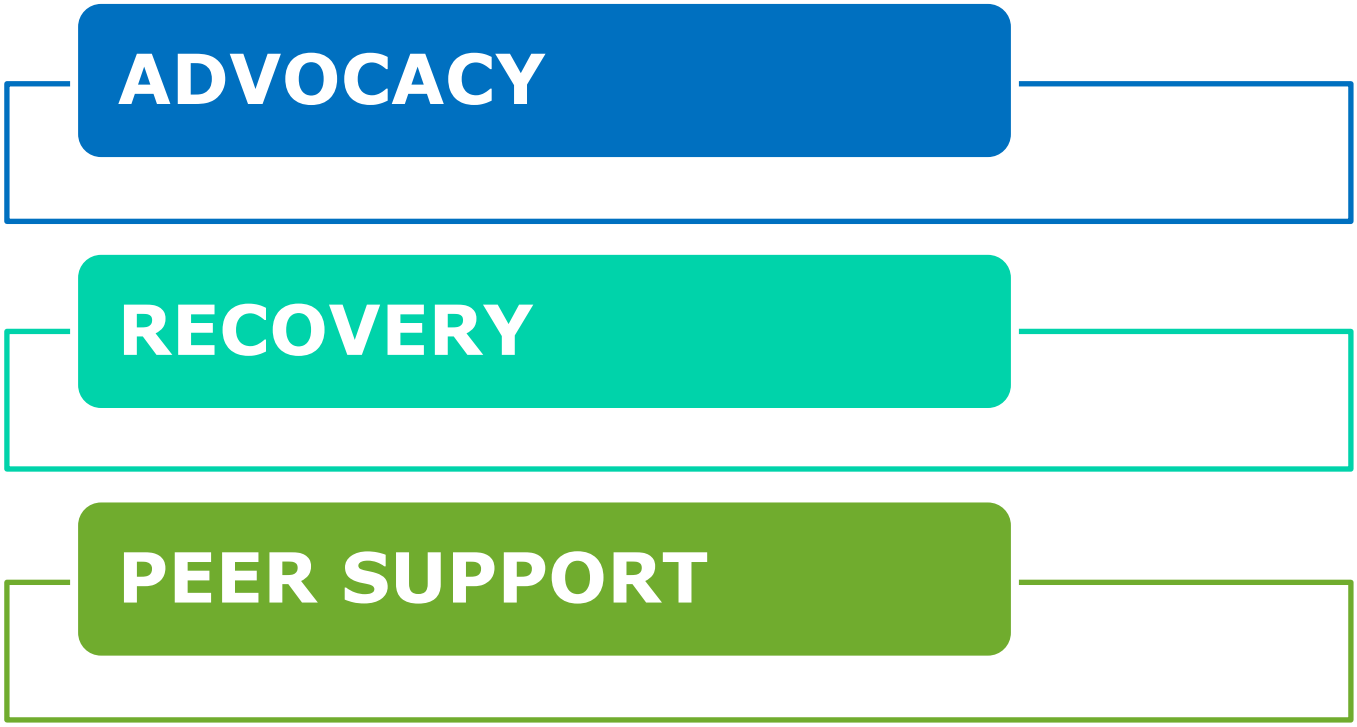
In 2004, the voters of California sent an unequivocal message to public mental health agencies throughout the state: the public mental health system was broken, too many people were falling through the cracks and suffering needlessly, and something drastic needed to be done to reverse course. Upon the MHSA's passage over a decade ago, client/consumer communities across the state rejoiced at the prospect of a truly client-driven mental health system that is responsive to the needs of the people it serves and fully accountable to the public. The MHSA was intended to transform the public mental health system, not only through the generation of new revenue to fund the expansion of services, but also by requiring **unprecedented levels of stakeholder input and involvement at all levels of program planning, development, and oversight**.

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

To achieve the level of system transformation envisioned by the Act, the MHSA requires Counties to implement a broadly inclusive Community Program Planning Process (CPP) to identify local-level needs, define MHSA funding priorities, and guide the creation, implementation, oversight, and evaluation of MHSA-funded programs, and any changes or updates thereto. Through the CPP, Counties must bring together mental health consumers, their family members, representatives of traditionally un-, under-, and inappropriately-served populations, and other local stakeholders to develop a shared vision for MHSA

programming and spending based on the unique needs of individual communities and the stated interests of consumers being served in their local mental health systems.

Despite these mandates, the collective client stakeholder voice both in local communities and across the state has waned since the early days of the MHSA. To address the widening disconnect between the MHSA's vision for stakeholder involvement and the realities for clients on the ground, ACCESS has structured all of its program activities around three core values, which also happen to be our annual programming themes:



These themes continue to emerge as areas of importance to clients in the PMHS. The ability to receive services that reflect clients' expressed recovery goals is critical and often overlooked in service delivery, despite the client driven mandates of the MHSA. Many of the clients have spoken with over the year would like to have a more active voice not only in program planning and development, but also in the trajectory of their own mental health services and supports. Nearly all of the clients interviewed expressed a desire for more evidenced based peer support services. Each of these themes is examined more fully in the following section of this Report.

ANNUAL THEMES

Year One (2017-2018): Advocacy

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.

Year Two (2018-2019): Recovery

In California, the MHSA mandates adoption of a recovery-oriented system of care. Evidence reveals that peer support programs have positive impacts on people in their recovery while also providing valuable advocacy support to the public mental health service system. The MHSAOAC client stakeholder project provides a unique opportunity to move the ball forward in the recovery movement by elevating diverse,

client advocacy efforts towards the establishment of consistent recovery outcome measures throughout California's public mental health system.

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

Recovery means the infusion of recovery principles in all aspects of services delivery in the PMHS. It means honoring client voice and choice and the creation of individualized services to meet clients' unique needs. Recovery involves shared decision making between client and services providers and insists that all treatment approaches be fully informed and voluntary. Recovery oriented systems require ongoing recovery-based training and support for mental health professionals and the tracking, reporting, and analysis of recovery outcomes in all mental health programs.

Year Three (2019-2020): Peer Support

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.

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 MHSA Workforce Education and Training funds (WET), aimed at increasing the peer workforce in California, has failed to move the needle in this critical area.

Despite the MHSA's mandate to employ individuals with lived experience throughout the PMHS (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.

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.

YEAR ONE: ADVOCACY

This year, the ACCESS program's annual theme is Meaningful Stakeholder Participation in California's Public Mental Health System.

ACCESS aims to expand meaningful stakeholder involvement in public mental health systems planning, development, implementation, oversight, evaluation, and improvement, as originally envisioned by the MHSA when it was passed back in 2004. To accomplish this, ACCESS is actively training, educating, and engaging 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 MSHA's statutory and regulatory mandates as they relate to Community Collaboration, the Community Program Planning 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. All of our program activities in Year One have been organized around this primary theme. A summary of these accomplishments is provided below.

Year One Highlights and Achievements

- **(1) Stakeholder Bill of Rights**
- **(1) Local Advocacy Toolkit**
- **(5) Regional Stakeholder Focus Groups:** Superior Region, Modoc County; Bay Area Region, San Francisco County; Central Region, San Joaquin County; Los Angeles Region, Los Angeles County, Culver City, Service Area 5; Southern Region, Riverside County
- **(6) Regional PMHS Leadership Round Tables:** Superior Region, Modoc County; Bay Area Region, San Francisco County; Central Region, San Joaquin County; Los Angeles Region, Los Angeles County, Los Angeles, Service Area 4; Los Angeles Region, Los Angeles County, Culver City, Service Area 5; Southern Region, Riverside County

- **(6) In-Person Leadership Trainings:** Superior Region, Modoc County; Bay Area Region, San Francisco County; Central Region, San Joaquin County; Los Angeles Region, Los Angeles County, El Monte, Service Area 3; Los Angeles Region, Los Angeles County, Los Angeles, Service Area 4; Southern Region, Riverside County

- **(8) Community Empowerment Workshops:** Superior Region, Modoc County; Superior Region, Humboldt County; Bay Area Region, San Francisco County; Central Region, Placer County; Central Region, Stanislaus County; Los Angeles Region, Los Angeles County, San Gabriel Valley, Service Area 3; Los Angeles Region, Los Angeles County, El Monte, Service Area 3; Southern Region, Riverside County

- **(6) Informational Webinars:** 2/15/18 Advocacy Webinar; 3/7/18 Learning Series Webinar; 4/12/18 Leadership Webinar; 5/3/18 Advocacy Webinar; 6/6/18 Learning Series Webinar; 8/9/18 Leadership Webinar

- **(2) Online eLearning Modules:** MHSA 101; Local Advocacy 101

- **(1) ACCESS Ambassador Boot Camp:** 2/21/18 – 2/23/18 in Sacramento, CA

- **(1) Statewide Advocacy Conference:** 8/24/18 in Sacramento, CA

- **(1) State of the Community Report:** This State of the Community Report provides current and key findings related to the involvement of clients in their local community planning processes throughout California, and highlights other client needs related to California's PMHS and the implementation of the Mental Health Services Act. According to the data collected throughout the year and chronicled in this Report, meaningful client involvement in the CPP is weak throughout the state, and needs systemic support from advocacy groups, the MHSAOC, Mental Health Boards and Commissions, Boards of Supervisors, and a collective investment in elevating the voices of consumers in the both planning for the PMHS and their own services. Underpinning the Report are current aspirations for robust and meaningful client involvement in the CPP, as well as future goals for the involvement of clients in the PMHS, and recommended administrative and legislative remedies to address significant gaps the MHSA relating to stakeholder advocacy and involvement in MHSA planning and oversight.

TARGET POPULATIONS

I. Clients of California's Public Mental Health System

The MHSA defines a "client" as: "An individual of any age who is receiving or has received mental health services," and "includes those who refer to themselves as clients, consumers, survivors, patients, or ex patients" (9 CCR § 3200.040). For the purposes of this program, ACCESS considers "clients" to be adult mental health clients served in the PMHS including those with Severe Mental Illness (SMI), and those being served in Prevention and Early Intervention (PEI) and publicly-funded Geographic Managed Care (GMC) programs, with particular emphasis on engaging individuals from unserved and underserved communities.

II. Intersecting Identities: Unserved and Underserved Communities

ACCESS recognizes that not everyone who has a mental health condition in California will have received mental health services, particularly for those representing underserved racial/ethnic and LGBTQ communities in California. As a result of inherent disparities, these communities have often been unserved or underserved in our public mental health system, but nevertheless have individuals identifying as living with or in recovery from a mental health and/or substance use disorder. Therefore, for the purposes of this program, ACCESS recognizes any individual who self-identifies as having lived experience with a mental health condition, a co-occurring disorder, and/or is living in recovery from a mental health condition as a client.

California is the nation's most racially diverse state, hosting the largest number of Asian and Latino residents, and the second highest number of residents identifying as black or American Indian (United States National Institute of Mental Health, 2001). Given the endless number of subgroups and variations, we recognize the importance culture brings to bear as an important aspect of what an individual brings to the mental health setting. Most often, culture plays a role on how and when people seek help or whether they seek help at all. It also influences how people interpret mental health in terms of meanings and the context of mental health disorders, diagnoses and terminology, and how they are communicated.

Culture also influences how someone may choose to advocate for their mental health needs, both individually and as part of a larger community.

As important as racial and cultural distinctions are, so are gender identity and sexual orientation in mental health service settings. Demographic data collection for LGBTQ people across the lifespan, and across cultures/ethnicities is lacking at both the state and local levels (Mikalson, Pardo, and Green, 2012). California's mental health workforce does not adequately reflect the cultures, sexual orientation, and gender identity of the communities it serves (9 CCR § 3300(b)(4)), nor the knowledge necessary to provide culturally appropriate mental health services. The lack of culturally competent recovery-oriented services for people of color, underserved communities, and LGBTQ populations may lead to multiple harms and disparities contributing to negative mental health outcomes.

Equally important is the recognition that both the medical model itself and the staff working within it have their own cultures, which impact the way the mental health system engages its participants and provides services/supports. The public mental health system (PMHS) in California is embedded in Western medicine, which places a huge emphasis on diagnostics, medications, and scientific inquiry. Therefore, in California we have a perfect conflict of westernized medical model mental health care being delivered to people from various cultural/ethnic/racial norms that remains in contrast to a traditional service system. As a result, cultural misunderstandings, bias, and a fragmented mental health system in California often create barriers for individuals from underserved communities when accessing care.

Nearly every psychological theory taught in colleges and practiced in clinics in the US was derived by psychologists and psychiatrists who shared a White Eurocentric culture. ALL mainstream intelligence and personality tests administered in public schools, detention centers, prisons, courts, the military, jobs, and clinics, were designed by white practitioners. Psychological tests and diagnostic systems have been constructed and norms have been developed and standardized primarily on middle class, White persons of Euro-American origins. Therefore, these tools should not be considered to produce fully accurate results when used with people of color, persons of different cultures, or persons living in poverty. The Diagnostic and Statistical Manual (DSM) uses diagnostic criteria based on Euro-American and Eurocentric symptoms, syndromes, and disorders. The resulting diagnoses lack accuracy and constitute bias in the absence of a cultural formulation (Vahia, 2013).

Even in a state as diverse as California, people of color and those identifying as LGBTQ have been inappropriately pathologized by being erroneously diagnosed with a mental illness based upon a psychologist or psychiatrist's lack of understanding of the situations and contexts in which a person has

lived. There are racism and discriminatory behaviors and reactions that a person may display that are not pathological mental illnesses, but logical responses from living with and experiencing chronic racism or discrimination. Often social control is maintained through the use and development of psychological tests that can marginalize, oppress, and pathologize persons from non-dominant groups. The need for safe, appropriate services that incorporate cultural humility is an essential component of California's PMHS. Finally, diverse client stakeholders are grossly underrepresented in the local and statewide Community Planning Processes related to MHSA.

III. Public Mental Health System Leadership

ACCESS also considers mental health leadership as a secondary target population. County departments and agencies, mental health providers, and local- and state-level policy makers make up this target population.

IV. Participant Demographics

Please refer to Tables 1-9 for a complete breakdown of the demographic results highlighted below.

- **Geographic Regions**

As of this writing, 941 surveys and evaluations have been completed in full (1181 including partial completions), with data pooled to reflect the following results. At least 52 California Counties were represented in survey results, with the most represented areas being Los Angeles County (21.8%), Sacramento County (19.3%), and Stanislaus County (8.8%).

- **Race/Ethnicity**

In general, California is a very diverse state. This is reflected in survey responses, as participants were majority minority. 49% of respondents identified as Caucasian/White/European (non-Hispanic), 19.6% identified as Latinx/Hispanic, 13.2% as African American/Black/African, 8.9% as Asian, 6.8% as American Indian/Native American/Alaskan Native, 1.6% as Pacific Islander, and .9% as Middle Eastern.

- **Gender Identity and Sexual Orientation**

In regards to gender, 70.8% of respondents identified as female, 25.9% as male, 0.9% as androgynous, 0.7% as male/transman/FTM, 0.6% as female/transwoman/MTF, 0.1% as questioning their gender, and 1.1% as something else ("other"). When asked about sexual orientation, 79.8% of respondents identified

as heterosexual/straight, 7.6% as bisexual/pansexual, 4.1% as lesbian, 3.1% as gay, 2.1% as queer, 1.5% as questioning their sexuality, and 1.8 as something else ("other").

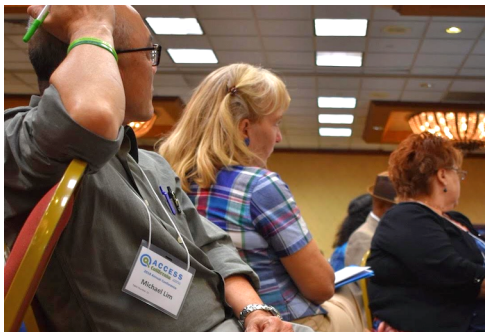
- **Age**

Most respondents (68.2%) identified as being between the ages of 40 and 64, though other age groups were represented as follows: 18-24 (5.3%), 25-39 (17.4%), 65+ (9.1%).

- **Other Demographic Indicators**

78.7% of respondents statewide identified as a client, 31.1% reported currently receiving services in the PMHS, and 29.4% reported previously receiving such services. Additionally, 56.5% of respondents self-identified as having a disability. 5.9% of respondents identified as being a military veteran. In addition to these demographics, ACCESS surveys found that 48.9% of clients surveyed work in the PMHS, and 21.3% volunteer in the PMHS.

METHODS



To accurately assess the mental health issues and needs affecting the target populations, a variety of surveys and evaluations were disseminated to clients statewide. In order to reach as many clients as possible, surveys were available in paper format, online format, in-person, and over the phone. For the purposes of this report, data collection began on October 19, 2017 and ended on August 20, 2018. Surveys can be found in Appendices A-G, and survey reports can be found in Appendices H-N. Results reflect data pooled from responses to the following:

1. Initial Stakeholder Feedback Surveys

On an annual basis, client stakeholders (persons who are either currently receiving or have previously received public mental health services) are provided with an initial survey that examines the types of local and state-level mental health needs and issues that are most important to clients throughout California. Those who complete the survey are entered to win two $100 Amazon gift cards. The raffle utilizes a random number generator to determine winners.

2. Annual Client Stakeholder Surveys

On an annual basis, PMHS clients and other community stakeholders were provided with a survey to gauge general levels of understanding and involvement in the MHSA's CPP. Questions also examined mental health needs and barriers to services from the client perspective. The survey takes approximately ten minutes to complete. Persons who completed the survey were entered into a raffle using a random number generator for a chance to win gift cards of varying values (one $100 Amazon gift card and two $20 Target gift cards). The survey takes about ten minutes to complete, and asks questions related to the stakeholders' familiarity and involvement with their respective local agencies. For the purposes of this program "local agency" is defined as the local County- or city-run mental or behavioral health department that provides public mental health services.

3. Annual County and Provider Surveys

On an annual basis, local mental health agencies and providers are given a survey that examines the frequency of stakeholder involvement in MHSA planning sessions throughout California. Those who complete the survey are entered to win gift cards of varying values (one $100 Amazon gift card and 2 $20 Target gift cards). The raffle utilizes a random number generator to determine winners. The survey takes about ten minutes to complete. For the purposes of this program, those invited to complete the survey include:

- Local Mental Health Agency Leadership
- Local Mental Health Provider Agency Leadership
- Local MHSA Coordinators & Program Planners
- Designated Consumer Advocates & Liaisons

4. Stakeholder Satisfaction and Participation Barriers Surveys

Towards the end of each fiscal year, community members statewide are invited to provide feedback on ACCESS activities, as well as on barriers to participating in their County's local CPP process. The survey takes approximately ten minutes to complete, and those who complete the survey are entered in a raffle to win one of fifteen $20 Target gift cards.

5. ACCESS Ambassador Boot Camp Training Evaluations

The ACCESS Ambassador Boot camp is an annual three-day workshop in which attendees are provided with a program overview and trained on the following:

- ACCESS Ambassador Expectations
- Fundamentals of Public Speaking
- MHSA 101
- Local Advocacy 101
- Statewide Advocacy 101

By the completion of the workshop, attendees will have observed an Oversight and Accountability Commission (OAC) meeting and toured the state capitol. Evaluations examine attendee's confidence at effectively articulating policy positions and mental health needs through local- and state-level processes.

6. Leadership Training Evaluations

Leadership Trainings provide an opportunity to collaborate with County-designated i.e. client advocates/liaisons, mental health board/commissioners, County behavioral/mental health leadership, clients who identify as community leaders, and both County and contract provider leadership 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 the clients throughout the state. Legislative and policy analysis is provided, and participants identify opportunities for local- and state-level public advocacy. County mental health leadership and other local- and state-level policy makers receive practical tips and resources to help facilitate the effective participation of stakeholders in the community planning process. Evaluations allow participants the opportunity to provide feedback on important policy issues affecting their communities and help ACCESS to evaluate state-level advocacy activities.

7. Community Empowerment Workshop Evaluations

Community Empowerment Workshops are held in each of the five MHSA regions and provide vital support to ACCESS Ambassadors on the ground by assisting them in training community stakeholders to participate in public meetings and effectively advocate for their mental health needs. The workshop consists of a full day of training which educates community members about the local community planning process and helps them craft their own public statements. Participants attend a local mental health meeting where ACCESS staff and Ambassadors will support those wishing to publicly advocate for services and policies that will positively impact clients. Evaluations examine attendees' thoughts and feelings regarding the level of support they receive, as well as outcomes of advocating for their needs.

8. Advocacy Helpline Information Requests

This helpline establishes a dedicated phone line and email account for clients, other stakeholders, and the general public who need help navigating ACCESS online statewide advocacy directories, or who need assistance advocating for their needs on the state level. The use of this helpline promotes and facilitates interaction between stakeholders and state-level policy leaders, legislative staff, and state agencies and entities. It is also a way to increase stakeholder participation in activities of the MHSOAC including Commission meetings, committees, policy projects and panels. ACCESS supports the participation of clients in state-level mental health policy discussions and state-level public advocacy activities.

The Advocacy Helpline provides callers with information on local, statewide, and federal mental health laws and policies. Dedicated staff help callers figure out which meetings and public hearings are

happening in their area and who to contact to for more information. Callers can be connected with ACCESS Ambassadors nearby who can provide advocacy coaching and tips, offer informational resources, and accompaniment to public meetings to help advocate for the mental health issues important to them. Logs of callers' requests are kept to help track the needs of the community.

9. Ombudsman Complaints & Resolutions

The Ombudsman provides callers with information on local, statewide, and federal mental health laws and policies. Dedicated staff help callers figure out which meetings and public hearings are happening in their area and who to contact to for more information. Callers can be connected with ACCESS Ambassadors nearby who can provide advocacy coaching and tips, offer informational resources, and accompaniment to public meetings to help advocate for the mental health issues important to them. Call logs of complaints and resolutions are kept to track consumer/client experiences with and efficacy of MHSA planning processes. This also serves to highlight the unmet needs of the community.

10. Leadership Roundtable Activity Summaries

One Leadership Roundtable is conducted in each of the five MHSA regions on an annual basis. Here, ACCESS staff, key policy makers (including local County and provider leadership), designated client liaisons, members of local mental health boards, and MHSA steering committees discuss the local- and state-level challenges facing public mental health agencies and service providers. Summaries of roundtable activities outline challenges, strategies, and pressing issues related to client care, access to services, and improved system outcomes.

11. Regional Stakeholder Focus Group Activity Summaries

Each year, ACCESS hosts one focus group in each of the five MHSA regions for clients, advocates, and other community stakeholders. Locations within the region are changed each year in order to ensure greater penetration of data collection. These focus groups allow ACCESS staff to make personal connections with clients across the state, providing a deeper understanding of local- and state-level mental health needs. Summaries focus on any data that might have been missed by other survey methods, including feedback on program activities and personal anecdotes. In addition to these measures, a thorough literature review was conducted regarding rates of mental illness and related factors.

THE STATE OF THE MHSA IN 2018

ACCESS began this year with the theory that Counties may not be sufficiently engaging stakeholders in the MHSA's Community Program Planning Process and other important MHSA-related decision-making. Based on the results of our annual surveys and our extensive interactions with County leadership, public mental health clients, ACCESS Ambassadors, and other advocates throughout the state, this hypothesis has borne out.

To test our premise, ACCESS developed annual data collection tools for clients and Counties to gauge each group's understanding of the MHSA's inclusion requirements and measure levels of stakeholder involvement in the CPP across the state. The data collected through these surveys and from feedback at our trainings and workshops demonstrates most California Counties are not upholding the MHSA's vision for meaningful stakeholder inclusion and involvement in the MHSA planning process. Stakeholders feel increasingly marginalized and perceive few opportunities to meaningfully participate in important decisions about the public mental health policies and services that directly affect them. Far too many local mental health boards, MHSA steering committees, and other stakeholder advisory bodies in the PMHS function as mere formalities, effectively rubberstamping whatever proposals are brought before them by the agencies they are meant to guide and oversee, without significant discussion or thoughtful deliberation about what they are being asked to approve. This is not necessarily because Counties are adverse to meaningful stakeholder involvement. Rather, significant barriers to inclusion exist on the County level that are not adequately addressed through the current system of oversight and accountability. Recommendations to overcome such barriers are discussed at length later in this Report.

The statutory and regulatory provisions governing stakeholder involvement in the PMHS, especially as it relates to MHSA planning and oversight, are examined in detail herein, along with commentary and analysis of how these provisions are actually applied by public mental health agencies in California. All of the statistics cited throughout this section were derived from the data collected in ACCESS' annual client stakeholder and county/provider surveys, included with this Report in Appendices I and J.

I. Representation on Local Mental Health Boards

What is it?

The California Welfare and Institutions Code, in legislation predating the MHSA, requires each local mental health agency to establish a local mental health board consisting of 10-15 members appointed by the County Board of Supervisors or other governing body responsible for overseeing the local mental health agency (WIC § 5604(a)(1)).

Local mental health boards must do all of the following:

- Review and evaluate the community's mental health needs, services, facilities, and special problems.
- Review any County agreements entered into pursuant to Section 5650.
- Advise the governing body and the local mental health director as to any aspect of the local mental health program.
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- Submit an annual report to the governing body on the needs and performance of the County's mental health system.
- Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
- Review and comment on the County's performance outcome data and communicate its findings to the California Behavioral Health Planning Council (WIC § 5604.2(a)).

What is it supposed to look like?

Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the County (WIC § 5604(a)(1)). Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers (WIC § 5604(a)(2)). Different composition requirements apply to Counties with

fewer than 80,000 residents, affecting roughly 20 of California's 58 Counties (WIC §§ 5604(a)(1), 5604(a)(3); Demographics by Cubit, 2017).

How does it actually look in the PMHS today?

A review of local mental health board rosters in California Counties suggests a majority of Counties are not adhering to the 50+% recommendation as stated in WIC § 5604(a)(2) (Sacramento County Mental Health Services, 2010). Many ACCESS participants have expressed concerns regarding their perception that mental health board seats are primarily filled with family members, as opposed to a more balanced mix of family members and clients, meaning the compositions of these boards are fewer than 20% consumers.

II. Meaningful Stakeholder Involvement in the MHSA Planning Process

What is it?

> Each [MHSA] three-year program and expenditure plan **and update** shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the [MHSA Community Program Planning] process that includes **meaningful stakeholder involvement** on **mental health policy**, **program planning**, and **implementation**, **monitoring**, **quality improvement**, **evaluation**, and **budget allocations**" (WIC § 5848(a)).

The MHSA requires Counties to utilize this "Community Program Planning" process to develop their MHSA Three-Year Program and Expenditure Plans, **and annual updates to such plans** in partnership with stakeholders to:

- Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act.
- Analyze the mental health needs in the community.
- Identify and re-evaluate priorities and strategies to meet those mental health needs (9 CCR § 3200.070).

What is it supposed to look like?

Several regulations provide clarification and guidance on the intended scope and breadth of the CPP:

9 CCR § 3300

The County shall provide for a Community Program Planning Process (CPP) as the basis for developing the MHSA Three-Year Program and Expenditure Plans **and updates** (9 CCR § 3300(a)).

To ensure that the Community Program Planning Process is adequately staffed, the County shall designate positions and/or units responsible for:

- The overall Community Program Planning Process.
- Coordination and management of the Community Program Planning Process.
- Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.
    - Stakeholder participation shall include representatives of unserved and/or underserved populations and family members of unserved/underserved populations.
- Ensuring that stakeholders that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity have the opportunity to participate in the Community Program Planning Process.
- Outreach to clients with serious mental illness and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate (9 CCR § 3300(b)).

The Community Program Planning Process (CPP) shall, at a minimum, include:

- Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
- Participation of stakeholders (as defined in 9 CCR § 3200.270).
- Training.
    - Training shall be provided as needed to County staff designated responsible for any of the functions listed in 3300(b) that will enable staff to establish and sustain a Community Program Planning Process.
    - Training shall be offered, as needed, to those stakeholders, clients, and when appropriate the client's family, who are participating in the Community Program Planning Process (9 CCR § 3300(c)).

Beginning with Fiscal Year 2006-07, or in fiscal years when there are no funds dedicated for the Community Program Planning Process, the County may use up to five (5) percent of its Planning Estimate, as calculated by the Department for that fiscal year, for the Community Program Planning Process (9 CCR § 3300(d)).

9 CCR § 3310

The County shall **update** Three-Year Program and Expenditure Plans at least annually (9 CCR § 3310(c)).

The County shall develop the Three-Year Program and Expenditure Plans **and updates** in collaboration with stakeholders, through the Community Program Planning Process, as specified in Section 3300.

- County programs and/or services shall only be funded if the Community Program Planning Process set forth in these regulations was followed (9 CCR § 3310(d)).

The Three-Year Program and Expenditure Plans **and updates** shall include a statement explaining how the requirements of Section 3300 were met (9 CCR § 3310(e)).

How does it actually look in the PMHS today?

The MHSA requires Counties to implement a broadly inclusive CPP to identify local-level needs, define MHSA funding priorities, and guide the creation, implementation, oversight, and evaluation of MHSA-funded programs, **and any changes or updates thereto**. Through the CPP, Counties must bring together mental health consumers, their family members, representatives of traditionally un-, under-, and inappropriately-served populations, and other local stakeholders to develop a shared vision for MHSA programming and spending based on the unique needs of individual communities and the stated interests of consumers being served in their local mental health systems.

The overwhelming majority of stakeholders surveyed (67.9%) feel that their ability to participate in the CPP is hindered due to lack of information and promotion of CPP meetings and events. Of those, 45.5% (30.9% of total responses) said this lack of information prevents them from participating at all in these sessions. Over 49% of participants surveyed reported inconvenient meeting times impacting their ability to fully participate in their local CPP. More than 53% of stakeholders surveyed report not knowing how frequently their local MHSA CPP committee meets. Unfortunately, approximately 35% of leadership surveyed report not knowing what types of outreach and engagement strategies their local agency utilized, if any, while other leadership respondents surveyed reported the most utilized outreach efforts

include on-site provision of flyers and fact sheets (endorsed by 51.5% of leadership) and snacks (endorsed by 45.4% of leadership).

Clients have expressed a need for increased communication and transparency from County leadership regarding the CPP. More than 43% of stakeholders surveyed report not knowing if their County provides trainings on the MHSA planning process. Confusion around the CPP is not limited to stakeholders. Among local agency leadership surveyed, 27.6% were unsure if their local agency hosted a standing stakeholder committee on a regular basis. Although 51.9% of local agency leadership surveyed reported hosting such trainings, 27.6% were unsure how frequently the trainings occurred.

Many client advocates across the state report that programs identified through their CPP do not come to fruition, particularly those that are peer focused and recovery oriented (Sacramento County Mental Health Services, 2010). Only 27.1% of ACCESS stakeholders surveyed report changes to MHSA funded programs coming to stakeholders for review and approval prior to finalization. Sadly, a full 43.5% of leadership surveyed report being unsure of how local agencies ensure stakeholders remain actively involved in ongoing oversight of MHSA plans and programs. Another 16.9% of leadership surveyed say changes to MHSA plans and programs (i.e., the **updates** contemplated in WIC § 5848(a) and 9 CCR §§ 3200.070, 3300(a), 3310) are not subject to stakeholder review at all.

Clients also noted that Counties should take more consumer input into consideration during the CPP. Certainly, stakeholder presence appears muted at MHSA CPP sessions. Even though 55.8% of stakeholders surveyed report having attended a local Mental Health Board meeting, only 32.2% report having attended a MHSA CPP meeting. Additionally, 81.5% of stakeholders surveyed do not identify as being members of either their local Mental Health Board or MHSA CPP committee. Having stakeholders serve as board and committee members is crucial for the inclusion of stakeholder input. See Appendix I for further detail on stakeholder responses regarding involvement with mental health boards and the CPP.

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

This is evident from the MHSOAC's online fiscal transparency tool, which reveals how Counties are spending MHSA funds. Upon review of data collected directly from this tool, it is indisputable that most

Counties are spending little to no money on their local CPP. Tables 10-13 compare the MHSA funds Counties have received, interest earned on these funds, the funds available for CPP use (defined as 5% of the County's annual MHSA budget), and the actual CPP expenditures reported by Counties to the MHSOAC for fiscal years 2013/2014 through 2016/2017. A cursory analysis makes clear that Counties earn more interest on unspent MHSA funds each year than they are spending on the CPP.

The average spent by Counties on their local CPP was just $89,152.46 in 2013/2014, $79,494.47 in 2014/2015, $94,008.73 in 2015/2016, and $68,014.93 in 2016/2017. However, this average is not representative of the amounts actually spent by most Counties. In fiscal year 2013/2014, only five of the 59 counties reported spending any funds on planning at all. This trend is true for all years examined: four of 59 for 2014/2015, five of 59 for 2015/2016, and 15 of 59 for 2016/2017. In essence, the mode of total funds spent on CPP was $0 for each of the fiscal years examined.

Without investment in the CPP, including effective outreach to community members and regular trainings to give client stakeholders the necessary background to provide informed decisions, the MHSA's provisions mandating meaningful stakeholder involvement remain impotent, rendering systems transformation an unfulfilled promise.

III. The MHSA's General Standards

Programs and services funded by the MHSA must meet certain standards throughout the planning, implementation, and evaluation processes. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the County's MHSA Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery. Per the California Code of Regulations (9 CCR § 3320), Counties shall adopt the following six standards in **planning**, **implementing**, and **evaluating** all programs and/or services provided with MHSA funds:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

What follows is an examination of the MHSA General Standards with emphasis on stakeholder perspective and involvement, using survey data from ACCESS participants.

1. Community Collaboration

What is it?

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 (WIC §§ 5830(a)(3), 5866; 9 CCR § 3200.060).

What is it supposed to look like?

Community collaboration is meant to include diverse representatives from the community throughout all of the program planning, implementation, and evaluation processes. Community feedback is expected to be valued and included to the same extent that leadership and contractor feedback is valued and included. Community members should not be tokenized, nor should their role be seen as a rubber stamp. As explained by The Western and Pacific Child Welfare Implementation Center (WPIC) and The Los Angeles Department of Children and Family Services (2013), "Meaningful stakeholder engagement is not just an end in itself, nice to have, or a good way to manage crises. It is an essential and mutually beneficial strategic function that results in better-informed and more effective policies, projects, programs, and services."

How does it actually look in the PMHS today?

See the previous section discussing the MHSA's Community Program Planning Process. Upon examination of stakeholders' and PMHS leadership's general lack of awareness regarding the CPP processes Counties are employing it is difficult to argue that local mental health agencies' MHSA program planning and oversight actually reflects "a shared vision and goals" developed in partnership with clients and other community stakeholders.

2. Cultural Competence

What is it?

According to Georgetown University Health Policy Institute (2004), cultural competence is the ability to effectively deliver "services that meet the social, cultural, and linguistic needs of" [clients]. For MHSA program and service planning, this means that such services and programs meet the social, cultural, and

linguistic needs of community members at all stages of the planning, implementation, and evaluation processes.

What is it supposed to look like?

The MHSA requires Counties to demonstrate cultural competence by incorporating and working to achieve nine specific goals into all aspects of policy-making, program design, administration and service delivery. Each system and program are assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals (9 CCR § 3200.100). The MHSA's nine goals to achieve cultural competence are:

- Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.
- Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
- Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.
- An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.
- An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.
- An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.
- Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.
- Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.
- Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic,

cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community (WIC §§ 5813.5(d)(3), 5868(b), 5878.1(a); 9 CCR § 3200.100).

Furthermore, the MHSA requires Counties to preside over a local community planning process that ensures clients, including those that reflect diversity of the demographics of the County, have an opportunity to participate (9 CCR § 3300(b)(4)). Client representatives should include representatives of unserved and/or underserved populations. As such, Counties must conduct outreach to clients with serious mental illness and/or serious emotional disturbance to ensure the opportunity to participate in the planning, implementation, and evaluation processes of MHSA programs and services.

How does it actually look in the PMHS today?

Lack of information is not the only barrier to participation reported by stakeholders. Other barriers listed by stakeholders include lack of cultural competency, negative perception of system(s), and lack of transportation. These barriers demonstrate a lack of not only cultural competence, but of cultural humility as well. By failing to consider how the culture of the medical model might create barriers such as stigma, and by neglecting the impact of factors such as meeting times and locations (creating a lack of access), organizers of the MHSA CPP sessions are failing to empathize with the client perspective. If clients are unable to attend MHSA CPP sessions because of a lack of cultural competency/humility, it is fair to assume any resulting programs developed potentially lack cultural competency/humility as well.

3. Client Driven

What is it?

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 (WIC §§ 5813.5(d)(2)(3), 5830(a)(2) and 5866; 9 CCR §3200.050).

What is it supposed to look like?

For the MHSA, "client driven" means that clients are able to define primary outcome goals for MHSA-funded services and programs. Client outcome goals might be significantly different than that of leadership, clinicians, and contractors, but that does not invalidate client input. This input should be sought throughout the planning, implementation, and evaluation processes.

SAMHSA's 2012 Working Definition of Recovery includes "person driven" as a guiding principle of recovery. According to SAMHSA, "person driven" means:

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

How does it actually look in the PMHS today?

When surveyed, 49.4% of ACCESS participants reported stigma being a barrier to participating in MHSA processes, which significantly impacts the client-driven nature of MHSA-funded services. ACCESS' focus in Year Two is Recovery Oriented Systems, Services, and Outcomes. We plan to expand our data collection efforts related to these subjects in our second program year to better evaluate Counties' integration of recovery tools and outcomes measurements in all MHSA-funded programs and services.

4. Family Driven

What is it?

Families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes (WIC §§ 5822(h), 5840(b)(1), 5868(b)(2) 5878.1; 9 CCR §3200.120).

What is it supposed to look like?

This standard is not referring to family members or caregivers of **adults** with mental health challenges. Rather, "family driven" under the MHSA means the inclusion of the perspectives of parents and caregivers of children and youth served in the PMHS's Children's System of Care. Thus, family members of adult clients are not a primary driving factor in services and supports provided in the Adult System of Care.

How does it actually look in the PMHS today?

Many ACCESS participants have voiced concerns regarding how "family driven" is implemented. Some are concerned because the term "family" is being used to describe family members of adult clients instead of family members of child clients, thus removing representation of the adult client voice. Similarly, family members of child clients are concerned because when the term "family" is used in this way, child clients (and their families) do not get needed representation. See Appendices I and K for stakeholder comments regarding the influence of families in policy decisions.

5. Wellness, Recovery, and Resilience Focused

What is it?

Planning for MHSA-funded services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: (1) to promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination; and (2) to promote consumer-operated services as a way to support recovery (WIC § 5813.5(d)).

What is it supposed to look like?

SAMHSA's 2012 Working Definition of Recovery defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." This definition includes four major dimensions and ten guiding principles, each of which are listed below.

Four Major Dimensions of 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.

Ten Guiding Principles of Recovery

- Hope
- Person-Driven
- Many Pathways
- Holistic
- Peer Support
- Relational
- Culture
- Addresses Trauma
- Strengths/Responsibility
- Respect

How does it actually look in the PMHS today?

Currently, goals for services and programs still tend to be measured via the medical model. This means that outcome goals typically focus on medication compliance, number of kept provider appointments, and other similar goals. These goals do not always reflect those of the clients. Client perspectives on services and programs can be found in Appendix H.

The MHSA requires Counties to provide peer support services as part of the CSS programming component (9 CCR § 3610(b)). Per Mental Health America (MHA) and the Center for Peer Support (2018), several studies comparing peer staff and non-peer staff providing conventional mental health services have detected consistent differences between the two. Peer-delivered services generate superior outcomes in terms of engaging "difficult to reach" individuals, reduce rates of hospitalization and days spent as inpatient, and decrease substance use among persons with co-occurring substance use disorders. Individuals assigned peer recovery mentors do significantly better in number of hospitalizations and number of days spent in hospitals than control groups with no peer support (Davidson, L. et al, 2012). Other studies indicate that peer support improves symptoms of depression more than care as usual (Pfeiffer et al, 2011). Moreover, peer support is generally cost-effective and cost saving.

Nevertheless, peer support appears to remain an underutilized resource in the PMHS. ACCESS' focus in Year Two is Recovery Oriented Systems, Services, and Outcomes. We plan to expand our data collection efforts related to these subjects in our second program year to better evaluate Counties' integration of recovery tools and outcomes measurements in all MHSA-funded programs and services. This research will necessarily include an examination of the current rates of peer employment in the PMHS.

6. Integrated Services Experience

What is it?

The client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner (WIC §§ 5878.1(a), 5802, 5806(b), 5813.5(d)(4); 9 CCR § 3200.190).

What is it supposed to look like?

This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come.

How does it actually look in the PMHS today?

Because licensed mental health providers and crisis care facilities are not distributed evenly throughout the state (discussed in more detail later), accessing services and transitioning from crisis care to general medical care can be difficult, if not impossible. This is especially true for those who live in rural areas and the elderly, as many lack transportation to these services. For more details on barriers to an integrated service experience, please see Appendix I.

IMPORTANT ISSUES IN 2018

In addition to analyzing the state of the MHSA in 2018, ACCESS examined other issues currently relevant to public mental health clients. Such issues include: (1) transparency in MHSA spending and the threat of funding reversion; (2) stable and affordable housing; (3) income insecurity; (4) criminal justice reform; (5) former foster youth; (6) access to basic mental health care; and (7) access to crisis mental health care.

I. Transparency in MHSA Spending and the Threat of Funding Reversion

The California State Auditor's February 2018 Report entitled "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding" examined Counties' unspent MHSA funds and the broken process of reversion of Counties' impermissible accumulation of MHSA fund balances. The Auditor's main finding was highly critical of Counties and the DHCS:

> The MHSA intended for local mental health agencies to provide services for the mentally ill, not amass unspent funds. Nonetheless, [DHCS] has not ensured that local mental health agencies revert their unspent MHSA funds to the [Mental Health Services] Fund for the State to reallocate to other local mental health agencies. … [S]tate law requires local mental health agencies to revert unspent MHSA funds within certain time frames. … Nonetheless, [DHCS] has not developed a methodology for the local mental health agencies to revert unspent funds (California State Auditor, 2018, p. 11).

As a result, "[t]he cumulative reserves of all 59 local mental health agencies equaled 47 percent of their total prior-year Community Support [CSS] funds" (California State Auditor, 2018). Indeed, local mental health agencies have "continue[d] to amass excess reserves instead of using these funds to provide additional mental health services." Compounding this problem is the fact that MHSA reserves "continue to earn interest, … for which the local mental health agencies [also] lack spending guidance" (California State Auditor, 2018).

While the reversion threat of MHSA funds has existed since the inception of MHSA, Counties for the most part have historically ignored and been spared these consequences until the recent passage of AB 114.

Among other things, this law, enacted in July 2017, requires any MHSA funds subject to reversion on or after July 1, 2017, to be reallocated to other counties, and requires DHCS to annually publish an online report relating to the funds subject to reversion. Now that reversion is a real possibility, Counties are rushing to spend down their MHSA funds subject to such reversion. While we understand the urgency to spend these funds, this self-inflicted crisis cannot override the MHSA's mandates for meaningful stakeholder involvement in the CPP.

II. Stable and Affordable Housing

One issue facing mental health clients statewide is homelessness and home insecurity. With one quarter of all persons experiencing homelessness in the United States living in California, California has the largest homeless population in the country (Henry, Watt, Rosenthal, & Shivji, 2017). Additionally, most of California's homeless population (66%) lives in unsheltered conditions (Baiocchi, Price-Wolf, Hodson, Barker, & Foy, 2017). Forty-nine percent of all unsheltered persons in the country live in California. When ACCESS California participants were asked about mental health issues impacting their communities, 84.1% of participants reported homelessness and housing insecurity as a significant issue.

Prevalence of homelessness varies across the state, though a general growth trend is evident. Between 2015 and 2017, some of the largest increases in the number of homeless persons were seen in Alameda County (+39%), Butte County (+76%), Los Angeles County (+23%), and Sacramento County (+30%). However, it is worth noting that not all Counties experienced significant growth in homeless populations. For example, little change was observed in Yolo County (-.02%) and San Francisco County (-.53%). Mirroring statewide trends, the majority of homeless persons at the local level are living in unsheltered conditions. For example, in Sacramento County, 56% of homeless persons sleep outdoors, compared to the state prevalence rate of 66%. While it may be tempting to take comfort in the County rate being slightly lower than the state rate, it is worth noting that the County rate reflects an 85% increase since 2015 (Baiocchi, Price-Wolf, Hodson, Barker, & Foy, 2017). Researchers also note that the "chronically homeless are more likely to suffer from PTSD than the most unsheltered homeless group (54% compared to 46%), and more likely to have a mental condition of any type (64% compared to 57%)" (Baiocchi, Price-Wolf, Hodson, Barker, & Foy, 2017, p. 4).

III. Income Insecurity

The high rate of homelessness in California is likely related to another issue impacting mental health clients: a high rate of poverty. When assessed using the California Poverty Measure (CPM), 19.4% of all Californians (approximately 7.4 million people) lacked the resources required to meet basic needs in

2016. This was defined as $31,000/year for a family of four, which is approximately $7,000 higher than the poverty line defined by federal standards. The CPM is a more accurate measure of poverty in California as the federal standard does not account for California's high housing costs (Bohn, Danielson, & Thorman, 2018). 78% of ACCESS participants statewide reported poverty as significantly impacting their community.

Like rates of homelessness, poverty rates also vary across the state, but to a much larger degree. Between 2014 and 2016, the highest poverty rates in California were in Los Angeles County (24.3%) and Santa Cruz County (23.8%). The lowest rate was in El Dorado County, which saw a poverty rate of 11.8% (Bohn, Danielson, & Thorman, 2018). Please see Table 14 for a complete breakdown of poverty rates by County.

IV. Criminal Justice Reform

Thanks to a combination of fear and political posturing, the California prison system is among the worst in the nation. Despite California taxpayers spending $10 billion on the California corrections budget in 2009, federal courts found that the California prison system fails to meet the standards of inmate physical and mental health outlined in the constitution (D'elia, 2010; Brown v. Plata, 2011). According to a report from the Little Hoover Commission (D'elia, 2010), "California prisons are packed beyond capacity. The prisons fail to provide opportunities for offenders to participate in educational, vocational, or substance abuse treatment programs that could help them succeed once released" (p.144). Because of this, recidivism rates in California are among the highest in the nation. In 2011, the California recidivism rate (defined as the percentage of former inmates that commit new crimes within three years of their release date) was 67.5 %, and the number of prisoners in state custody was 175% of the designed capacity of the prison system (Couzens, 2013).

Criminal justice reform is a critical issue for those experiencing mental health challenges because studies show persons with SMI are overrepresented in the prison population. While only about 4% of the general population nationwide has a SMI, over 17% of persons entering jail have a SMI (Sayers, Domino, Cuddeback, Barrett, & Morrissey, 2016). It is well known among politicians, clinicians, and researchers that the prison system has become a de facto mental health system. According to researchers, "Jails have become the default mental health system in communities throughout the US for many people with severe mental illness. Some estimates suggest that approximately three-fourths of detainees with severe mental illness in large urban jails receive acute psychiatric inpatient treatment in the criminal justice system rather than in the mental health system" (Sayers, Domino, Cuddeback, Barrett, & Morrissey,

2016, p. 324). Although a nationwide problem, this is especially salient for Californians, with Sen. Scott Wiener saying, "We do have a very large conservatorship program in California—it's called jail" (Wiener, 2018). When ACCESS California participants were polled, 56.6% of respondents listed criminal justice reform as an important issue impacting their community (Appendix H).

V. Former Foster Youth

Although children in the foster care system are more likely to experience mental health challenges and utilize mental health services at a higher rate than the general population, engagement with the mental health system drops dramatically once youth become emancipated or age out of the foster care system (Anctil, McCubbin, O'Brien, & Pecora, 2007; Courtney & Dworsky, 2006; Harman, Childs, & Kelleher, 2000; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; McMillen & Raghavan, 2009; McMillen, Scott, Zima, Ollie, Munson, & Spitznagel, 2004; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009; Scozzaro & Janikowski, 2015; Villagrana, 2016; Villagrana, Guillen, Macedo, & Lee, 2018). This is significant as former foster youth tend to continue to have mental health challenges into adulthood at rates far greater than that of the general population (Villagrana et al., 2018). For example, 54.4% of former foster youth surveyed experienced current mental health challenges (AMI), compared to only 22.1% of the general population surveyed (Pecora, Williams, Kessler, Downs, O'Brien, Hiripi, & Morello, 2003; Villagrana et al., 2018). Post-traumatic stress disorder (PTSD) occurs at higher rates among former foster youth (25.2%) than the general population (4%) (Pecora et al., 2003; Villagrana et al., 2018). Additionally, former foster youth are at greater risk of negative outcomes such as dropping out of school, drug abuse, health complications, unemployment, incarceration, and homelessness while transitioning into adulthood (Bender, Yang, Ferguson, & Thompson, 2015; Courtney & Dworsky, 2006; Cusick, Havlicek, & Courtney, 2012; Harris, Jackson, O'Brien, & Pecora, 2009; Iglehart, & Becerra, 2002; Lee, Courtney, & Tajima, 2014; Villagrana et al., 2018; Villegas, Rosenthal, O'Brien, & Pecora, 2011; White, O'Brien, Pecora, & Buher, 2015).

VI. Access to Basic Mental Health Care

According to Coffman, Bates, Geyn, & Spetz (2018), in 2014, one in six adults in California were diagnosed as having a mental illness (mental health challenge). One in 25 adults in California were diagnosed as having a serious mental illness (SMI). In regards to children in California, one in 14 had an emotional disturbance, while 12.3% of adolescents experienced a major depressive episode between 2014 and 2015 (Coffman, Bates, Geyn, & Spetz, 2018). It is common for substance use disorders to cooccur with other mental health challenges (National Institute on Drug Abuse, 2017). Between 2014

and 2015, 6.6% of adolescents in California age 12 and over were diagnosed as having an alcohol use disorder. Additionally, California saw 11 drug overdose deaths per 100,000 people between 2013 and 2015, with some rural Counties seeing more than double the statewide rate (Coffman, Bates, Geyn, & Spetz, 2018; University of Wisconsin Population Health Institute, 2013; University of Wisconsin Population Health Institute, 2014; University of Wisconsin Population Health Institute, 2015). ACCESS California surveys found that 74.6% of respondents reported substance use as significantly impacting their communities.

Prevalence of mental health challenges in California varies by region. Based on data from 2010-2014, San Mateo County has the lowest prevalence of persons (all ages) with SMI (3.82%), while Lassen County has the highest (8.69%). When broadening the definition to include any mental illness (AMI) during this period, San Mateo County, again, has the lowest prevalence of mental health challenges among all age groups (11.22%), while Lassen County, again, has the highest (22.75%) (Holzer, 2014). Please see Table 15 for a breakdown of SMI prevalence by County and Table 16 for a breakdown of AMI prevalence by County.

Perhaps the most glaring issue facing mental health clients in California is the shortage of mental health care providers and resources. 78.3% of ACCESS participants statewide reported ease of access to the PMHS as being a "very important" issue (Appendix H). As of 2016, it is estimated there were between 75,000 (California Healthcare Foundation, 2018) and 80,000 (Coffman, Bates, Geyn, and Spetz, 2018) licensed mental health professionals in the state of California, which had a total population of 39.3 million that same year. However, it is important to note that the number of licensed mental health professionals does not reflect the number of mental health professionals actively providing care. For example, many psychiatrists maintain their licensure even after retirement. In fact, it is estimated that the number of licensed psychiatrists in California will reduce by 34% between 2016 and 2028 because of retirement (Coffman, Bates, Geyn, and Spetz, 2018). Additionally, not all licensed mental health professionals accept insurance, and the percentages of those that do are only tracked for psychiatrists. Based on findings from a 2015 study, 77% of psychiatrists practicing in California take private insurance, while 55% take Medicare, and only 46% take Medi-Cal (Coffman, Bates, Geyn, and Spetz, 2018). Estimates based on current service utilization patters suggest that by 2028, California will have 41% fewer psychiatrists and 11% fewer psychologists, LMFTs, LPCCs, and LCSWs (combined) than needed (Coffman, Bates, Geyn, and Spetz, 2018).

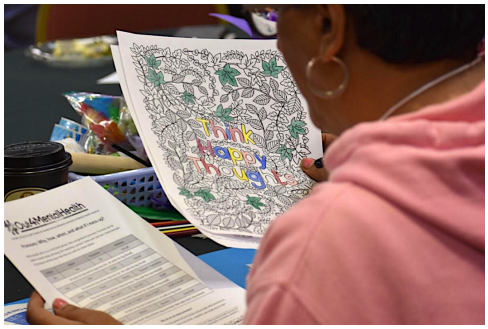
Importantly, licensed mental health professionals are not distributed evenly throughout the state. This forces mental health clients in rural communities to travel great distances for services, impacting costs,

work productivity, and service outcomes (Coffman, Bates, Geyn, and Spetz, 2018). See Table 17 for a breakdown of mental health professionals by type and region. Despite the high need for mental health services, Californians, historically, have had a difficult time getting these needs met. Of Californian adolescents who experienced a major depressive episode between 2011 and 2015, only 31.2% reported receiving treatment within the year, and only 37.2% of adult Californians with any mental illness reported receiving treatment within this same timeframe (Coffman, Bates, Geyn, & Spetz, 2018; Substance Abuse and Mental Health Services Administration, 2017). According to the National Alliance on Mental Illnesses (NAMI) California (2018), "fewer than one-third of adults and one-half of children with a diagnosable mental disorder receive mental health services in a given year." One reason for this is long wait times in the PMHS. Long wait times were frequently listed as a barrier by ACCESS survey participants, with the longest reported wait period being 7 months to see a doctor as a new patient.

VII. Access to Crisis Mental Health Care

Among ACCESS participants surveyed, 89.7% reported ease of access to mental health crisis care as being a "very important" issue (Appendix H). Ease of access to crisis mental health care is commonly measured by the availability of inpatient psychiatric or crisis residential beds (slots). These slots are used for stabilizing persons experiencing a mental health crisis. Please see Table 18 for a breakdown of inpatient slots by care type. Unfortunately, like other mental health resources, inpatient slots are not distributed evenly throughout the state. Many clients in rural areas must travel for crisis services. This causes difficulties for clients attempting to arrange for ongoing, local care at the conclusion of a crisis situation.

RECOMMENDATIONS



When PMHS leadership neglects genuine stakeholder inclusion, clients and the agencies representing their interests must either become increasingly confrontational in their advocacy efforts (jeopardizing beneficial relationships and undermining coalition-building efforts) or adopt a "go along to get along" mentality (selling out their constituency for access to the levers of power). Neither approach serves the best interests of clients or increases the effectiveness of public mental health services. Rather than pursuing either of these courses, ACCESS seeks to build constructive relationships with Counties, statewide agencies, and the California legislature, all of which play a significant role in making the MHSA's vision for meaningful stakeholder involvement a reality, while at the same time faithfully representing clients' interests. Throughout this section, ACCESS provides feasible and cost-friendly solutions to increase client participation throughout the PMHS. Wherever possible, ACCESS offers its own free services to support PMHS leadership in implementing our recommendations.

I. Local-Level Recommendations to Increase Meaningful Stakeholder Involvement

1. Invest in the Community Program Planning Process

A. Literally, Invest MHSA Funding in the CPP

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

The MHSOAC's online fiscal tool, which was developed to better inform the public and create transparency as to how MHSA money is being spent at the local level, has been particularly illuminating. Upon our review of several years of cumulative data gathered from this tool, it is evident that the majority of

Counties are spending little to no money on the CPP. Tables 10-13 compare the MHSA funds Counties have received, the interest earned on these funds, the funds available for CPP use (up to 5% of Counties' annual MHSA budget per WIC § 5892(c)), and the actual CPP expenditures reported by Counties to the MHSOAC for fiscal years 2013-14 through 2016-17. In almost every case, the amount of annual interest Counties reported earning on their unspent MHSA funds vastly exceeds the level of MHSA funding these Counties have allocated to their local CPP in that same year. This is inexcusable.

This omission is not for lack of resources. As previously discussed, the California State Auditor has noted: "[t]he cumulative reserves of all 59 local mental health agencies equaled 47 percent of their total prior-year Community Support [CSS] funds" (California State Auditor, 2018). Indeed, local mental health agencies have "continue[d] to amass excess reserves instead of using these funds to provide additional mental health services" (California State Auditor, 2018).

There is finally actual data available to determine how much Counties are spending on their local CPP. The MHSOAC's online fiscal transparency tool makes evident that the majority of Counties are spending little to no money on the CPP. Tables 10-13 compare the MHSA funds Counties have received, interest earned on these funds, the funds available for CPP use (defined as 5% of the County's annual MHSA budget), and the actual CPP expenditures reported by Counties to the MHSOAC for fiscal years 2013/2014 through 2016/2017. In most cases, Counties are not even investing the interest they are making on the MHSA funds in the CPP.

The average spent by Counties on their local CPP was just $89,152.46 in 2013/2014, $79,494.47 in 2014/2015, $94,008.73 in 2015/2016, and $68,014.93 in 2016/2017. However, this average is not representative of the amounts actually spent by most Counties. In fiscal year 2013/2014, only five of the 59 counties reported spending any funds on planning at all. This trend is true for all years examined: four of 59 for 2014/2015, five of 59 for 2015/2016, and 15 of 59 for 2016/2017. In essence, the mode of total funds spent on CPP was $0 for each of the fiscal years examined.

Sincere and ongoing investment in authentic client involvement in the CPP could have significantly reduced – or even completely eliminated – the possibility of reversion for many Counties. In fact, it's hard to imagine that clients would have supported Counties' widespread amassing of unspent MHSA funds while such vast needs exist across the state. Most important to these discussions is the need for all stakeholders, including clients, to be fully educated in their understanding of the complex fiscal and budgetary issues governing the use of MHSA funding in their local communities. Far too often we hear

from County leadership that the issues are "too complex for clients to understand" and yet we see little or no investment in informing the public about such important concepts.

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), Community Empowerment Workshops, Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

B. Develop a Shared-Power Framework for Stakeholder Participation in the CPP

> There is general agreement that the mental health system needs to change. Consumers have been talking for years about what the problems are, expressing anger about mistreatment in the name of treatment. Consumers have received support for some of these viewpoints. Today, there are innovative programs, many of which are directed by consumers, jobs that have been created, and new policy development that has been influenced by consumer input. Yet, it just isn't enough. The mental health system has had its equal share of failures and advances. The climate of the general community is more volatile than ever; violence on the rise is often attributed to mental patients. Approaches are being considered that may further put consumers at risk for increased involuntary treatment. Consumers need to talk about issues from their different perspectives in order to develop workable solutions that will assure consumer survival (Bluebird, 2000, p. viii).

The above quote was taken from a resource published in the year 2000 – 18 years ago! Yet much of it still rings true in California today, even 14 years after the MSHA's passage. Empowering stakeholders to participate in local planning processes requires Counties' willingness to **share power** in important decision-making and view stakeholders as true collaborative partners in the development, planning, implementation, oversight, and evaluation of public mental health services. This is the only sustainable long-term solution, as we cannot possibly ensure proper accountability of MHSA funds unless we adhere to the Act's original intent and principles.

Until recently, no agreed upon framework existed to adequately address client participation in the local MHSA Community Planning Process, incorporating theory of change principles necessary to bring forth the system transformation called upon in the MHSA (Resource Description & Access, n.d). As recipients of public mental health services, clients must be recognized as the primary stakeholders in all aspects of system planning and included as integral components of client driven, recovery orientated systems of care. Despite these aspirations, the expected system transformation has yet to emerge, as local mental health agencies are resistant to share decision-making and the relinquishment of power that enables a robust CPP with clients at the center. In most instances, there is little oversight requiring authorities to

actually develop a CPP that fully embraces the level of partnership envisioned by the MHSA in which clients and community stakeholders are meaningfully involved in decisions regarding "mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations" (WIC § 5848(a)).

Until such oversight and enforcement mechanisms emerge, Counties must develop internal frameworks to ensure adherence to the MHSA's mandates. Such frameworks must necessarily include robust ethical considerations and commitments to shared power.

Principles of Community Engagement and Shared Power

According to the CDC's Principles of Community Engagement, Second Edition (2011), "community engagement" is defined as:

> [T]he process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Henry, 2011; Miller et al., 2005; Minkler et al., 2009).

Moreover, "[c]ommunity engagement requires participation of community members in projects that address their issues. Meaningful community participation extends beyond physical involvement to include generation of ideas, contributions to decision making, and sharing of responsibility. Among the factors that motivate people to participate are wanting to play an active role in bettering their own lives, fulfilling social or religious obligations, feeling a need for a sense of community, and wanting cash or in-kind rewards. Whatever people's motivations, obtaining meaningful community participation and having a successful, sustained initiative require that engagement leaders respect, listen to, and learn from community members. An absence of mutual respect and co-learning can result in a loss of time, trust, resources, and, most importantly, effectiveness" (Henry, 2011; Miller et al., 2005; Minkler et al., 2009).

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Engagement can be visualized along a continuum, based on the levels of community involvement, impact, trust, and communication flow in the community-agency relationship, ultimately culminating in the realization of genuine shared leadership:

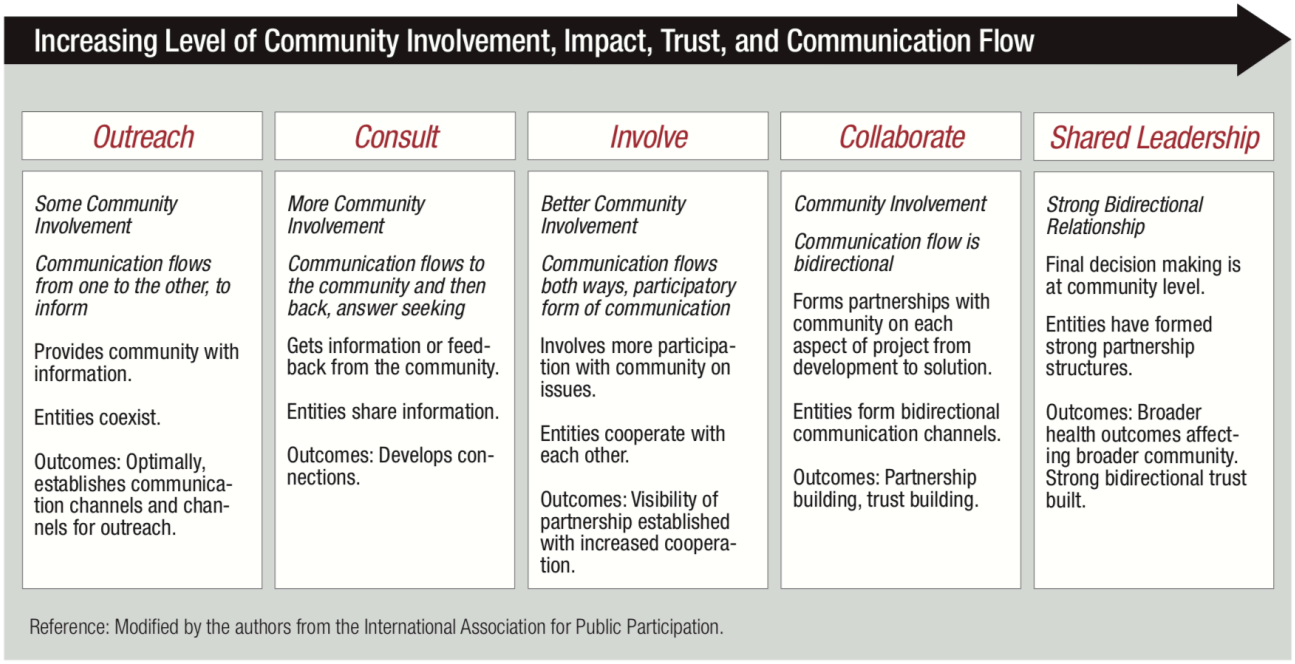

Figure 1.1. Community Engagement Continuum

There are **nine essential principles** of meaningful community engagement applicable to client stakeholder involvement in the CPP (Henry, 2011; Miller et al., 2005; Minkler et al., 2009).

The first two principles should occur before the commencement of engagement activities: (1) clarify goals and purpose of engagement efforts and determine precise communities to be engaged; and (2) understand the culture of the community in terms of economics, power structures, demographics and historical context.

Next, Counties should focus on (3) establishing trusting relationships and creating a process for mobilizing the community. For such relationships to materialize, Counties must (4) accept and understand that self-determination and responsibility are basic rights right of all participants, and that no external entity (County governments) should prevent the community from acting to advance its needs. Finally, the necessary ingredients for successful community engagement are: (5) recognition that improving mental health outcomes must include partnerships with primary stakeholders; (6) mutual respect and knowledge of various cultures and diversity of needs when designing, planning, and implementing any CPP; (7) investment in resources for ongoing capacity building of clients; (8) relinquishment of power and decision

making authority to allow for interventions the community seeks; and (9) long term commitment and investment of resources to undergird these efforts (Henry, 2011; Miller et al., 2005; Minkler et al., 2009).

Therefore, meaningful client involvement requires organizational change on the part of the public agencies hosting stakeholder groups and meetings, moving transformation from an aspirational concept to a reality. For transformative processes to take shape, leadership must value the client voice and provide meaningful opportunities for engagement, candid feedback, recommendations and budget/funding questions. The current lack of investment in planning, training and capacity building related to the MHSA places the onus on mental health clients to pursue knowledge about MHSA, County budgets, local planning processes, funding streams, mental health boards and commissions without assistance from the County itself. It is no wonder, then, that 40% of community stakeholders report "lack of understanding of MHSA requirements and standards" pose a notable barrier to participation in the CPP (Appendix K).

ACCESS Stakeholder Bill of Rights

To facilitate this change on the state and local levels, ACCESS developed a truly unique resource for stakeholders, Counties, and statewide mental health agencies alike, addressing the involvement of stakeholders in PMHS decision-making. We strongly encourage all public mental health agencies (County and state) to adopt this Stakeholder Bill of Rights (SBOR), which is included in Appendix P of this Report.

The Preamble lists the SBOR's fundamental purposes, which are to:

- Foster transparency, fiscal responsibility, and public accountability within California's Public Mental Health System;
- Protect the rights of mental health Stakeholders receiving services in California's Public Mental Health System;
- Strengthen, support, and expand grassroots, Stakeholder-led public mental health advocacy;
- Promote individual and community empowerment;
- Increase meaningful Stakeholder participation and community inclusion, in public mental health planning and program design, service delivery, and evaluation;
- Facilitate collaboration and communication amongst Stakeholders, community members, Local Mental Health Agencies, State Mental Health Agencies, service providers, legislators, policy-makers, and other state and local entities that influence the Public Mental Health System; and

- Ensure effective and necessary improvements in public mental health policy, programming and services delivery.

The SBOR goes on to identify and define six specific rights of PMHS clients and other community stakeholders:

- **Transformation:** We, the Stakeholders, have the right to a PMHS that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA.
- **Information:** We, the Stakeholders, have the right to full transparency in our PMHS.
- **Education:** We, the Stakeholders, have the right to fully understand the meaning and implications of facts and data relevant to our PMHS.
- **Representation:** We, the Stakeholders, have the right to competent and adequate representation when important decisions are made in our PMHS.
- **Participation:** We, the Stakeholders, have the right to shape policy and meaningfully participate in all important programming and funding decisions in our PMHS.
- **Consideration:** We, the Stakeholders, have the right to submit grievances to our PMHS, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.

These rights are further elaborated upon throughout the SBOR, providing guidance and instruction for PMHS leadership to fully incorporate stakeholders as equal partners in all PMHS decision-making.

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

C. Provide Regular and Ongoing Training to County Staff, Local MH Boards, and MHSA Steering/Advisory Committee Members

The MHSA requires Counties to provide training as needed to enable County staff to establish and sustain a Community Program Planning Process (9 CCR § 3300(c)(3)(A)). Counties do not appear to be actively investing in such training.

Due to steady turnover and retirements, Counties have lost vital institutional knowledge related to the MHSA's intent and requirements. Without ongoing educational efforts or enforcement mechanisms

related to the MHSA's foundational principles and legislative mandates, Counties have overlooked their obligation to place stakeholders' interests first in MHSA plans and programs. Counties need expertise and guidance more than ever. Yet, as discussed throughout this Report, state-level oversight appears to be lacking in this regard.

ACCESS' MHSA Basic Training for PMHS leadership has been particularly effective and eye opening for participants this year. Many local- and state-level policy makers 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 public mental health system, stakeholder inclusion and accountability, fiscal transparency, or open meeting laws prior to assuming the responsibilities of their position. 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. This training assists local- and state-level policy makers better understand their role and how to effectuate the transformative change and community participation envisioned under the MHSA.

Feedback from these trainings demonstrates how important it is for Counties to constantly reinforce the MHSA's core concepts. When asked what they learned in this training, participants gave the following responses (Appendix M):

- Clarification about General Standards
- Strategies to engage and improve a CPP process
- Broader definition of MHSA regulations
- Up to 5% of MHSA can be used for CPP
- Brown Act, CPP Process
- Just about everything. I didn't know a thing
- I knew about MHSA but not how in-depth it is
- A better understanding of MHSA and terminology and overall foundation for me to continue to learn.
- Consumers want to have a voice. We need to make sure the opportunity occurs always!
- MHSA Standards used to determine program compliance
- A better understanding of the MHSA guidelines, process, stakeholder engagement
- Understanding MHSA a lot better and empowered me to know how I can do my part

Again, this is a training for PMHS **leadership**, not the general public. Attendees included County employees, members of local mental health boards, and members of County MHSA steering/advisory committees. This training and the expertise of ACCESS program staff are freely available to all local- and state-level mental health agencies and MHSA planning workgroups. ACCESS recommends that Counties and statewide agencies in the PMHS conduct annual training of all board members, commissioners, and steering committee representatives regarding the MHSA's General Standards and stakeholder inclusion principles.

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), eLearning modules, Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

D. Provide Regular and Ongoing Training to Community Stakeholders

Even when clients are actively engaged in the MHSA planning processes, their involvement typically lacks essential knowledge of system navigation, budget allocations, integrated service delivery, and funding streams. This results in a client advocacy culture in California whereby participants largely feel tokenized and whose efforts fail to impact transformative change. Meaningful stakeholder involvement requires an investment in training and education of the populace.

Expert theorists in the field of community engagement, including Paulo Freire in his work Pedagogy of the Oppressed (1970), suggest that oppressed peoples can overcome their conditions through the use of educational efforts. Therefore, informed clients are essential to informed action (Freire, 1970).

The MHSA requires Counties to provide training as needed to stakeholders, clients, and when appropriate the client's family, who are participating in the Community Program Planning Process (9 CCR § 3300(c)(3)(B)). Naturally, any such trainings should address the MHSA's components, requirements, and funding provisions. Yet more than 43% of stakeholders that ACCESS surveyed report not knowing if their County provides trainings on the CPP/MHSA planning process. This confusion is not limited to stakeholders. Among local agency leadership surveyed, 27.6% were unsure if their local agency hosted a MHSA training for stakeholders on a regular basis. Although 51.9% of local agency leadership surveyed reported hosting such trainings, 27.6% were unsure how frequently the trainings occurred (Appendix J).

One way to ensure local stakeholders are knowledgeable about the MHSA's standards is for Counties to actually provide these mandated trainings. In fact, one of the basic rights enumerated in the SBOR is

Education, which is directly relevant to the quality and quantity of Counties' stakeholder trainings. To wit:

Education: We, the Stakeholders, have the right to fully understand the meaning and implications of facts and data relevant to our PMHS.

A. We have the right to have PMHS Information – including related processes and procedures – thoroughly explained to us in a clear and meaningful way. We have the right to have PMHS Information explained in the language and format we best understand.

B. We have the right to receive training and guidance from our [County] to facilitate our effective participation in the deliberative process and help us better understand the functions and operations of our PMHS (Appendix P)

ACCESS' Regional Community Empowerment Workshops are another excellent resource to fulfill the Counties' training mandates. These local workshops held in each of the five MHSA regions provide vital support to ACCESS Ambassadors and community stakeholders, training them to participate in public meetings and effectively advocate for their mental health needs. This half-day training educates community members about the MHSA's basic requirements and the local community planning process, and helps them craft their own public statements. The group then attends a local mental health meeting together where ACCESS staff and Ambassadors support and coach participants in publicly advocating for mental health services and policies that positively impact client outcomes.

Stakeholders in attendance have reported learning the following things from this training (Appendix N):

- MHSA information
- Techniques and preparations, stakeholders bill of rights
- Greater clarity on the MHSA laws involve and right to know process of clients and consumers and family members (peers too)
- My rights and that I can contact people in authority and speak my opinion. I have a voice and there are people out there to support me
- What audience one needs to speak to
- How to educate myself on opportunity to be heard
- We need more education, training, and support to counties peers and family members

- I learned the best ways to present my opinions: the right audience and the way to dress, etc.
- Advocacy tools and strategies
- The importance of peers in the planning and implementation of MHSA programs
- That we should have representation and know who it is
- How to speak before leaders
- Process of advocacy/approach to presentation
- I learned so much about how MHSA works
- That I have a voice as a local agency and family member. How to address issues and present them to the appropriate entities effectively
- I have a stronger voice than I had originally thought

If our experience this year is indicative of the needs of stakeholders across the state, clients are hungry for this information. Once trained, they are excited to demonstrate their new-found knowledge and exercise more effective advocacy techniques on the local level to make a real difference in their communities.

A third educational resource, also available through ACCESS, is the Local Advocacy Toolkit, included herewith as Appendix Q. This toolkit is intended to aid in training community stakeholders 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.

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), eLearning modules, Ambassador Boot Camp, Local Advocacy Toolkit, MHSA 101 training, Local Advocacy 101 training, Community Empowerment Workshops, eLearning modules, Advocacy webinars, Learning Series webinars, Advocacy Helpline, Stakeholder Bill of Rights.

2. Adopt a Minimum Number of Positions for Clients on MHSA Steering/Advisory Committees

While local mental health boards are required to fill a specific number of positions with clients and family members, MHSA steering/advisory committees are under no similar obligation. To increase stakeholder

representation in important decision-making processes, ACCESS recommends that Counties adopt a minimum number of client representatives in the local CPP.

3. Hire Designated Client Advocates/Liaisons in Each County Mental Health System

To ensure the client voice is included at all levels of the PMHS – not just in initial program planning and development – all Counties should employ a designated Client Advocate/Liaison position. The Client Advocate/Liaison must have personal lived experience of recovery from a mental health challenge and experience receiving services in the PMHS. The Client Advocate/Liaison serves as a member of the County's leadership team and represents the collective interests of clients at all management-level internal planning, development, implementation, oversight, evaluation, and quality improvement meetings and discussions. The Client Advocate/Liaison also participates on interview panels and takes part in hiring discussions when candidates for leadership positions within the County are considered.

4. Expand Peer Support Services and Increase Opportunities for Peer Advocacy

The MHSA requires Counties to provide peer support services as part of the CSS programming component (9 CCR § 3610(b)). Yet, peer support workers remain an underutilized resource available to clients, providers, policy makers, and other community stakeholders. Peers are persons with no power differential that have shared life experience with public mental health clients. They are able to offer empathy, validation, and can offer each other practical advice and suggestions for strategies that other professionals might not know about.

Peer support is generally cost-effective and cost saving. Optum Health, a managed care company, has shown substantial reductions in average inpatient days for people receiving peer support. In two of their managed care contracts, Optum saw an average 80.5 percent reduction of inpatient days, and a 32 percent reduction of involuntary hospitalizations for people receiving peer run respite services (Bergeson, 2013). Additionally, peer support increases the length of time that individuals spend in the community before their first psychiatric hospitalization (Repper & Carter, 2011). Ron Manderscheid, Ph.D., the Executive Director of the National Association of County Behavioral Health Directors estimates that within the next five years peers will make up in excess of 20 percent of the behavioral health workforce (MHA, 2018).

Advocacy is an essential core competency for the peer support role. According to SAMHSA, peers provide leadership and advocacy "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 [clients]" (SAMHSA, 2015). Peers do this in the following ways:

- Using knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc). to ensure that [clients'] rights are respected;
- Advocating for the needs and desires of [clients] in treatment team meetings, community services, living situations, and with family;
- Using knowledge of legal resources and advocacy organization to build an advocacy plan;
- Participating in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families;
- Educating colleagues about the process of recovery and the use of recovery support services;
- Actively participating in efforts to improve the organization;
- Maintaining a positive reputation in peer/professional communities (SAMHSA, 2015).

While most of this work is done within the provision of services and in treatment settings, peers can also effectively advocate at the system level. They know what is happening on the ground and are highly familiar with what is working and what isn't for clients on a County level. Counties and their providers should encourage peers to use this unique perspective to influence outcomes for clients in their communities.

ACCESS Resources: Ambassador Boot Camp, Local Advocacy Toolkit, MHSA 101 training, Local Advocacy 101 training, Community Empowerment Workshops, eLearning modules, Advocacy webinars, Learning Series webinars, Advocacy Helpline, Stakeholder Bill of Rights, and Nor Cal MHA's WISE and WISE U program resources.

II. State-Level Recommendations to Increase Meaningful Stakeholder Involvement

1. 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 Health Care Services (DHCS) (California State Auditor, 2018).

In addition, the State's responsibilities related to overseeing MHSA funding changed significantly in 2011. Specifically, before 2011, state law required the State to approve local mental health agencies' plans to use MHSA funds before issuing those funds to them. Under this process, the MHSA required that the local mental health agencies submit plans to DMH detailing how they intended to use their MHSA funds over the next three years. DMH would then evaluate these plans, and if it approved them, the State Controller's Office (State Controller) distributed funds to the local mental health agencies. However, the 2011 change in state law eliminated this requirement. Instead, the State Controller now distributes MHSA funding from the [Mental Health Services] Fund directly to the local mental health agencies each month (California State Auditor, 2018).

The California State Auditor's report lists three key findings related to DHCS' oversight of County MHSA spending that remain relevant to this Report:

- DHCS has not developed a process to recover unspent funds from local mental health agencies. As a result, the local mental health agencies have had less incentive to spend MHSA funds on mental health programs in a timely manner and had amassed unspent funds of $231 million—not including reserves—as of the end of fiscal year 2015–16 that the State might have been able to reallocate to other local mental health agencies.
- In the absence of DHCS' guidance, local mental health agencies have not consistently spent the interest they have earned on MHSA funds. As a result, they had accumulated $81 million in unspent MHSA interest as of the end of fiscal year 2015–16.
- DHCS has neither established a formal process to maintain oversight of local MHSA reserves—which totaled $535 million as of the end of fiscal year 2015–16— nor required the local mental health agencies to adhere to a standard reserve level. We estimate that local mental health agencies held between $157 million and $274 million in excessive reserves as of the end of fiscal year 2015–16 (California State Auditor, 2018).

Moreover, the Auditor found:

- DHCS has made minimal efforts to ensure that local mental health agencies submit their annual reports on time. As a result, some local mental health agencies have not submitted timely annual reports for years, hampering DHCS' ability to calculate MHSA reversion amounts and to properly oversee MHSA spending.
- DHCS has been slow to implement oversight of local mental health agencies' MHSA spending and programs. Although DHCS developed a MHSA fiscal audit process in 2014, it has limited the audits'

usefulness because it focused its reviews on data and processes that were at least seven years old.

- DHCS has not developed regulations to establish an appeals process for local mental health agencies to challenge findings. **In addition, it has not implemented a program review process to ensure the MHSA projects that local mental health agencies operate comply with program requirements contained in statute and regulations** (California State Auditor, 2018).

The Auditor provided additional elaboration on this final point:

> [DHCS] has been slow to implement a comprehensive MHSA program review process that will enable it to assess how each local mental health agency allocates, spends, and monitors its MHSA funds. **In our August 2013 report, we noted that we had found no evidence that the State conducted systematic and comprehensive monitoring of local mental health agencies to ensure that their MHSA programs were both effective and compliant with MHSA requirements.** Thus, we recommended that [DHCS] conduct such comprehensive on-site MHSA program reviews. We remain concerned that **[DHCS] has still not fulfilled this recommendation**. A 2016 amendment to state law requires that at least once every three years [DHCS] conduct program reviews of the local mental health agencies' performance contracts. The intent of the program reviews is to determine the local mental health agencies' compliance with the terms of the performance contracts and with MHSA requirements. Although this law took effect in 2016, [DHCS] has yet to establish a schedule of program reviews and does not anticipate beginning the program reviews until July 2018 at the earliest. [DHCS] indicated that it first needs to develop the review process. (California State Auditor, 2018).

As the Auditor's report makes clear, since at least 2013, DHCS has not enforced **any** of the MHSA's statutory and regulatory requirements, which necessarily include those governing the General Standards and CPP. And because these are non-fiscal requirements, one can surmise that DHCS is even less likely to scrutinize Counties' actions and omissions as they relate to the General Standards and CPP.

DHCS Recommendations:

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

- Develop a review process that scrutinizes the quality and quantity of client and stakeholder involvement in the development, planning, implementation, oversight, and evaluation Counties' mental health plans and MHSA-funded services. Ensure Counties thoroughly document their outreach, engagement, and inclusion strategies to ensure client voices are the primary driver of all MHSA programming and funding decisions.

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

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), eLearning modules, Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

2. Mental Health Services Oversight and Accountability Commission (MHSOAC)

The State also provides oversight of the MHSA funds through the MHSAOC, which consists of 16 voting commissioners and supporting staff, led by an executive director. Established by the MHSA, the MHSOAC's main statutory responsibilities include providing technical assistance to local mental health agencies, evaluating local and statewide projects and programs supported by MHSA funds, and approving local mental health agencies' use of Innovation funds. Innovation is the only MHSA program that specifically requires state approval before the local mental health agencies can spend these funds (California State Auditor, 2018).

Section 5845(d)(3) of the Welfare and Institutions Code permits the MHSOAC to "establish technical advisory committees such as a committee of consumers and family members" to assist in carrying out its duties and responsibilities, while Section 5846(d) of the Code states:

> The [MHSOAC] shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

The State of California provides administrative funding to the MHSOAC, in part, to "assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services" (WIC § 5892(d)).

The MHSOAC's stated mission is to:

> [P]rovide the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system (MHSOAC, 2016).

Finally, the MHSOAC's governance philosophy provides:

> Integrity and sound stewardship are paramount in the governance of all Commission activities. The MHSOAC will govern itself with an emphasis on the following:
>
> (a) Being objective and encouraging diversity in viewpoints;
>
> (b) Making decisions in an efficient and timely manner;
>
> (c) Striving for results and outcomes;
>
> (d) Focusing on outward vision and strategic leadership and less on administrative detail;
>
> (e) Using collaboration rather than individual decisions-making processes;
>
> (f) Being proactive rather than reactive (MHSOAC, 2016).

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

The California legislature has entrusted the MHSOAC with substantial influence over Counties' use of MHSA funds and expects the MHSOAC to use its oversight role to help Counties meet their obligations under the MHSA. To accomplish such oversight, Counties and stakeholders need a standard bearer. In the not so distant past, the DMH was this standard bearer, encouraging Counties to walk the walk and holding them accountable when they did not, particularly in the creation of MHSA programs. Since the

DMH dissolved and its duties were shifted to the DHCS in 2012, there remains a palpable absence of leadership on the state level to ensure Counties and statewide agencies alike adhere to the MHSA's General Standards and vision for meaningful stakeholder involvement (California State Auditor, 2018). Today, clients and other stakeholders throughout California need the support and stature of the MHSOAC – as the funder of multiple statewide stakeholder advocacy contracts – to support our efforts and ensure that our voices are actually heard, listened to, and valued throughout the PMHS. Only then will stakeholders have a genuine opportunity to effectuate positive change in the PMHS.

MHSOAC Recommendations:

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

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

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

- Provide ongoing guidance and recommendations to the MHSOAC (both Commissioners and staff) regarding the MHSA's mandates for meaningful stakeholder involvement in the CPP, integration of the General Standards into all MHSA programs and services, and the effectiveness of the MHSOAC's stakeholder outreach and engagement efforts;
- Identify additional opportunities for stakeholder participation in the MHSOAC's activities; and
- Help the MHSOAC develop and evaluate its legislative objectives and priorities.

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

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), eLearning modules, Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

III. Legislative Recommendations to Increase Meaningful Stakeholder Involvement

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

ACCESS seeks to change this paradigm by working directly with the MHSOAC, DHCS, and the California Legislature to secure minor changes to the MHSA's statutes and regulations to increase client stakeholder participation on the state and local levels. These legislative and regulatory updates include:

- Creating clearer guidelines and enforcement mechanisms around the requirement for Counties to set aside up to 5% of their annual MHSA funding for the Community Program Planning Process (per WIC § 5892(c) and 9 CCR § 3300(d));

- Requiring each County's MHSA Community Program Planning Process (mandated under 9 CCR § 3300) be comprised of a committee or advisory body that is subject to the Ralph M. Brown Act and comply with all open meeting laws applicable to local government agencies and bodies;

- Requiring each County's MHSA Community Program Planning Process (mandated under 9 CCR § 3300) be comprised of a committee or advisory body that reflects the ethnic diversity of the client population in the County and is at least 50% clients and family members (the same requirements applied to local mental health boards per WIC § 5604(a));

- Establishing minimum percentages or ratios of peer provider positions (mandated under 9 CCR § 3610(b)) to clinical provider positions in County mental health systems;

- Developing standardized definitions of the peer roles identified in 9 CCR § 3610(b), including the types of personal lived experience required to work with specific populations served in the Public Mental Health System;

- Requiring each County to fund a full-time designated Client Advocate/Liaison position to serve as part of the County's management team and provide systemwide representation and advocacy for the interests and concerns of public mental health clients in that County;

- Expanding the application of the MHSA's existing stakeholder inclusion requirements (mirroring the requirements placed on Counties under WIC § 5848(a) and 9 CCR § 3300) to all state-level agencies responsible for implementing and/or overseeing MHSA-funded programs (e.g., DHCS, MHSOAC, OSHPD, etc).; and

- Establishing minimum funding requirements for the state-level agencies identified above to develop and implement their own inclusive stakeholder planning process for implementing and/or overseeing MHSA-funded programs (similar to the County mandates in WIC § 5892(c) and 9 CCR § 3300(d)).

ACCESS Resources: On-Call Technical Assistance, Leadership Webinars, Advocacy Webinars, Learning Series Webinars, Position Papers, Legislative Advocacy, Policy Updates, In-Person Leadership Trainings (MHSA Basic Training and Shared Power and Collaborative Decision-making), eLearning modules, Stakeholder Bill of Rights, MHSA Program Planning Guidelines, Regional ACCESS Ambassadors.

LESSONS LEARNED

Throughout the data collection and report writing process, ACCESS California was able to make several observations that will lead to improvements in future efforts. For example, much of the available research and statistics regarding issues relevant to mental illness in California is not published in scientific journals (peer-reviewed journals). Because of this, many works lack a methodology section with an appropriate level of detail that would allow for replication. ACCESS will therefore intentionally seek out peer-reviewed research moving forward, and will make efforts to publish findings.

Another limitation that can be improved in the next cycle is the data collection and analysis process. Participants were sometimes confused by the questions asked in surveys, resulting in incomplete surveys, irrelevant responses, and responses from unintended participants. Furthermore, data was analyzed in part using an internet-based survey platform (Survey Gizmo) as opposed to more traditional statistical analysis software (SPSS, SAS, Python, R, etc.). The resulting findings were therefore narrower in scope than originally intended. Moving forward, ACCESS will utilize evidence-based practices during survey creation and dissemination. Additionally, ACCESS will engage in stringent data analysis using appropriate software and will record the methods of data collection and analysis in sufficient detail in order to allow for replication.

Additionally, ACCESS has learned from PMHS leadership and clients that more training is needed on MHSA requirements than initially anticipated. Moving forward, advocacy efforts will revolve around increasing participants' understanding of MHSA requirements and procedures, promoting significant discussion and thoughtful deliberation about services and programs, and ensuring stakeholders are truly knowledgeable about the complex issues at stake. Furthermore, ACCESS will continue to provide extensive training and support to ACCESS Ambassadors. ACCESS Ambassadors are clients from across the state of California who provide their unique perspectives to inform the ACCESS program's work, as well as perform wider advocacy-related activities on both local and state levels. In the future, fiscal expenditures reporting can be used as a tool to monitor community outreach and engagement efforts by

counties. Although CPP expenditures alone cannot determine the success of outreach efforts, examining reported expenditures can provide insight as to whether counties are making a minimum effort.

Finally, it is imperative for leadership and stakeholders alike to understand that legislative policy does not occur in a vacuum. More emphasis is needed on data collection and analysis regarding the impacts and efficacy of current legislation and policies. It is ineffective to continuously seek legislative and policy changes prior to thoroughly understanding how present policies are affecting stakeholders. Additionally, analyzing data on current legislation and policies may reveal that pain points are due to lack of adherence to legislation and policies as intended, as opposed to a problem with the legislation and policies themselves.

ON THE HORIZON: 2019 & BEYOND

ACCESS is learning from the past and looking to the future. With the second year of our program upon us, we will integrate the lessons learned from Year One to shape the activities related to our Year Two annual theme: Recovery Oriented Systems, Services and Outcomes.

ACCESS' primary goal is to strengthen and expand client stakeholder advocacy through individual and community empowerment. To accomplish this goal, ACCESS will continue to seek ongoing feedback from clients to inform our statewide legislative priorities to ensure our advocacy efforts remain focused on the most pressing issues affecting California's client communities. Our commitment to elevating clients as the drivers of ACCESS' programming activities and policy goals honors the role of clients as intended by the MHSA. In doing so, we are able to consistently generate new and innovative approaches that stem directly from clients' actual experiences and circumstances on the ground throughout California's PMHS.

Meaningful change cannot take place in the PMHS without the inclusion of all parties that impact client services and experiences. To maximize collaboration and effectuate positive change throughout California's public mental health system ACCESS will continue to work closely with Counties, statewide agencies, policy makers, providers, communities, and the general public in an effort to create system outcomes that are truly client driven and recovery oriented.

ACCESS' Year Two trainings and planned activities will continue to support clients at the local level and support communities in effectively advocating for their own needs. Our training philosophy is rooted in community empowerment and capacity building principles to provide the necessary skills for clients and other stakeholders to carry on advocacy activities independent of the ACCESS program.

There are many ways in which interested individuals may participate in the ACCESS program. We invite you to visit our website at **www.accesscalifornia.org** to learn more about what we are doing and sign up for our quarterly newsletter and email alerts.

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TABLES

Table 1: Participant County of Residence

Table 1: Participant County of Residence		
County	**TOTAL**	**Percentage**
Alameda	**18**	**1.6**
Amador	**37**	**3.3**
Berkley	**1**	**0.1**
Butte	**9**	**0.8**
Calaveras	**2**	**0.2**
Colusa	**1**	**0.1**
Contra Costa	**12**	**1.1**
Del Norte	**1**	**0.1**
El Dorado	**3**	**0.3**
Fresno	**7**	**0.6**
Glenn	**1**	**0.1**
Humboldt	**15**	**1.3**
Kern	**11**	**1.0**
Lassen	**6**	**0.5**
Los Angeles	**247**	**21.8**
Madera	**2**	**0.2**
Marin	**7**	**0.6**
Mariposa	**7**	**0.6**

Table 1: Participant County of Residence		
County	**TOTAL**	**Percentage**
Merced	**2**	**0.2**
Modoc	**60**	**5.3**
Monterey	**4**	**0.4**
Napa	**2**	**0.2**
Nevada	**3**	**0.3**
Orange	**21**	**1.9**
Placer	**59**	**5.2**
Plumas	**1**	**0.1**
Riverside	**35**	**3.1**
Sacramento	**218**	**19.3**
San Bernardino	**25**	**2.2**
San Benito	**1**	**0.1**
San Diego	**1**	**0.1**
San Francisco	**11**	**1.0**
San Joaquin	**38**	**3.4**
San Luis Obispo	**2**	**0.2**
San Mateo	**42**	**3.7**
Santa Barbara	**2**	**0.2**
Santa Clara	**2**	**0.2**

Table 1: Participant County of Residence		
County	**TOTAL**	**Percentage**
Santa Cruz	**5**	**0.4**
Shasta	**13**	**1.1**
Sierra	**10**	**0.9**
Siskiyou	**2**	**0.2**
Solano	**13**	**1.1**
Sonoma	**5**	**0.4**
Stanislaus	**100**	**8.8**
Sutter	**1**	**0.1**
Tri-City	**7**	**0.6**
Trinity	**1**	**0.1**
Tulare	**3**	**0.3**
Tuolumne	**14**	**1.2**
Ventura	**4**	**0.4**
Yolo	**12**	**1.1**
Yuba	**3**	**0.3**
Other/None of the Above	**23**	**2.0**

Table 2: Participant Race/Ethnicity

Table 2: Participant Race/Ethnicity		
Race/Ethnicity	**Total**	**Percentage**
African American/Black/African	**133**	**13.2**
American Indian/Native American/Alaskan Native	**68**	**6.8**
Asian	**90**	**8.9**
Caucasian/White/European	**493**	**49.0**
Latino/Hispanic	**197**	**19.6**
Middle Eastern	**9**	**0.9**
Pacific Islander	**16**	**1.6**

Table 3: Participant Gender

Gender	Total	Percentage
Androgynous	**8**	**0.9**
Female	**637**	**70.8**
Male	**233**	**25.9**
Female/Transwoman/MTF	**5**	**0.6**
Male/Transman/FTM	**6**	**0.7**
Questioning my gender	**1**	**0.1**
Other	**10**	**1.1**

Table 4: Participant Sexual Orientation

Sexual Orientation	Total	Percentage
Bisexual/Pansexual	64	7.6
Gay	26	3.1
Heterosexual/Straight	676	79.8
Lesbian	35	4.1
Questioning my sexuality	13	1.5
Queer	18	2.1
Other	15	1.8

Table 5: Participant Age

Age	Total	Percentage
18-24	48	5.3
25-39	156	17.4
40-64	613	68.2
65+	82	9.1

Table 6: Participants Identifying as Clients/Consumers

Client/Consumer?	Total	Percentage
Yes	770	78.7
No	190	19.4
Not Sure	18	1.8

Table 7: Participants Utilizing the PMHS

PMHS?	Total	Percentage
Yes, currently	316	31.1
Yes, previously	298	29.4
No	359	35.4
Not Sure	42	4.1

Table 8: Participants Identifying as Having a Disability

Disability?	Total	Percentage
Yes	498	56.5
No	360	40.9
Not Sure	23	2.6

Table 9: Participants Identifying as Being a Veteran

Veteran?	Total	Percentage
Yes	**48**	**5.9**
No	**759**	**94.1**

Table 10: MHSA Budget Spent on Planning by County for Fiscal Year 2013/2014

Table 10: MHSA Budget Spent on Planning by County for Fiscal Year 2013/2014					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Alameda	44,212,366	227,446	2,210,618	0	0.000
Alpine	1,127,136	15,782	56,356	0	0.000
Amador	2,028,904	2,891	101,445	0	0.000
Berkeley, City of	3,694,468	8,019	184,723	0	0.000
Butte	7,231,345	31,360	361,567	0	0.000
Calaveras	2,193,817	20,694	109,691	0	0.000
Colusa	1,826,855	16,832	91,343	0	0.000
Contra Costa	28,085,079	197,673	1,404,254	0	0.000
Del Norte	1,922,936	17,656	96,147	0	0.000
El Dorado	5,025,862	22,542	251,293	0	0.000
Fresno	30,410,221	987,745	1,520,511	0	0.000
Glenn	1,933,329	7,591	96,666	0	0.000
Humboldt	4,460,014	34,359	223,001	53,997	0.012
Imperial	6,144,384	30,993	307,219	1,414,862	0.230
Inyo	1,303,975	5,146	65,199	0	0.000

Table 10: MHSA Budget Spent on Planning by County for Fiscal Year 2013/2014					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Kern	26,245,298	185,194	1,312,265	0	0.000
Kings	5,091,971	80,727	254,599	0	0.000
Lake	2,557,999	5,339	127,900	0	0.000
Lassen	1,925,976	2,615	96,299	0	0.000
Los Angeles	353,022,452	4,114,253	17,651,123	3,730,981	0.011
Madera	5,497,073	32,612	274,854	0	0.000
Marin	7,005,706	25,373	350,285	0	0.000
Mariposa	1,313,984	-429	65,699	0	0.000
Mendocino	3,112,057	21,099	155,603	0	0.000
Merced	9,098,881	89,924	454,944	0	0.000
Modoc	1,225,379	7,443	61,269	0	0.000
Mono	1,277,986	27,860	63,899	0	0.000
Monterey	14,492,348	16,445	724,617	0	0.000
Napa	4,163,391	25,722	208,170	0	0.000
Nevada	3,407,655	57,426	170,383	0	0.000
Orange	100,457,559	547,650	5,022,878	0	0.000
Placer	8,437,953	308,276	421,898	0	0.000
Plumas	1,770,182	11,801	88,509	0	0.000
Riverside	63,546,121	374,779	3,177,306	0	0.000
Sacramento	39,714,957	118,878	1,985,748	0	0.000
San Benito	2,470,408	27,505	123,520	49,707	0.020
San Bernardino	65,217,074	380,586	3,260,854	0	0.000

Table 10: MHSA Budget Spent on Planning by County for Fiscal Year 2013/2014					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
San Diego	101,281,498	674,291	5,064,075	0	0.000
San Francisco	22,944,624	137,900	1,147,231	0	0.000
San Joaquin	20,875,792	133,152	1,043,790	0	0.000
San Luis Obispo	8,420,467	20,788	421,023	0	0.000
San Mateo	20,164,554	110,292	1,008,228	0	0.000
Santa Barbara	14,353,411	14,042	717,671	0	0.000
Santa Clara	56,803,960	611,312	2,840,198	0	0.000
Santa Cruz	9,122,077	75,201	456,104	0	0.000
Shasta	5,999,242	33,872	299,962	0	0.000
Sierra	1,151,480	24,063	57,574	0	0.000
Siskiyou	2,140,321	19,703	107,016	0	0.000
Solano	12,508,563	77,601	625,428	0	0.000
Sonoma	9,942,665	105,860	497,133	0	0.000
Stanislaus	15,930,046	173,648	796,502	10,448	0.001
Sutter	N/A	N/A	N/A	N/A	N/A
Tehama	2,479,528	18,983	123,976	0	0.000
Tri-City	6,794,377	39,022	339,719	0	0.000
Trinity	1,273,167	6,915	63,658	0	0.000
Tulare	15,082,912	414,182	754,146	0	0.000
Tuolumne	2,341,744	13,350	117,087	0	0.000
Ventura	25,730,030	76,622	1,286,502	0	0.000
Yolo	6,714,804	34,005	335,740	0	0.000

Table 11: MHSA Budget Spent on Planning by County for Fiscal Year 2014/2015

Table 11: MHSA Budget Spent on Planning by County for Fiscal Year 2014/2015					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Alameda	62,487,164	335,021	3,124,358	0	0
Alpine	1,577,732	22,372	78,886	0	0
Amador	2,839,999	7,690	142,000	0	0
Berkeley, City of	5,147,265	12,082	257,363	0	0
Butte	10,122,222	44,093	506,111	0	0
Calaveras	3,070,841	22,419	153,542	0	0
Colusa	2,869,377	30,204	143,469	0	0
Contra Costa	39,312,664	239,517	1,965,633	0	0
Del Norte	2,691,668	24,517	134,583	0	0
El Dorado	7,035,053	31,361	351,753	0	0
Fresno	42,567,330	1,148,849	2,128,367	0	0
Glenn	3,306,217	13,200	165,311	0	0
Humboldt	6,242,996	36,837	312,150	0	0
Imperial	8,600,727	40,477	430,036	2,497,690	0.29040452
Inyo	1,825,264	6,813	91,263	0	0
Kern	36,737,393	228,845	1,836,870	0	0
Kings	7,227,216	88,724	361,361	0	0
Lake	3,514,767	3,437	175,738	0	0
Lassen	2,695,924	7,461	134,796	0	0
Los Angeles	494,750,406	5,023,798	24,737,520	2,152,959	0.00435161
Madera	7,569,492	77,691	378,475	0	0
Marin	9,806,379	36,715	490,319	0	0

Table 11: MHSA Budget Spent on Planning by County for Fiscal Year 2014/2015					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Mariposa	1,839,276	3,331	91,964	0	0
Mendocino	5,690,527	14,254	284,526	0	0
Merced	12,759,887	173,415	637,994	0	0
Modoc	1,715,251	8,936	85,763	0	0
Mono	1,788,888	31,363	89,444	0	0
Monterey	20,285,961	20,238	1,014,298	0	0
Napa	5,827,793	30,006	291,390	0	0
Nevada	4,769,935	32,451	238,497	0	0
Orange	140,617,525	814,669	7,030,876	0	0
Placer	12,411,197	276,857	620,560	0	0
Plumas	2,477,849	25,126	123,892	0	0
Riverside	90,193,280	413,273	4,509,664	0	0
Sacramento	55,591,825	-32,187	2,779,591	0	0
San Benito	3,458,004	25,216	172,900	0	0
San Bernardino	91,288,935	449,293	4,564,447	0	0
San Diego	141,770,850	871,866	7,088,543	0	0
San Francisco	32,117,207	154,501	1,605,860	0	0
San Joaquin	29,221,318	207,798	1,461,066	0	0
San Luis Obispo	11,786,721	44,747	589,336	0	0
San Mateo	28,225,750	185,730	1,411,288	0	0
Santa Barbara	20,691,480	3,549	1,034,574	0	0
Santa Clara	79,512,506	658,291	3,975,625	0	0
Santa Cruz	12,768,813	86,796	638,441	0	0

Table 11: MHSA Budget Spent on Planning by County for Fiscal Year 2014/2015					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Shasta	8,397,563	48,117	419,878	0	0
Sierra	1,611,808	27,319	80,590	0	0
Siskiyou	2,995,958	35,112	149,798	0	0
Solano	17,509,117	118,406	875,456	0	0
Sonoma	19,673,284	0	983,664	0	0
Stanislaus	22,298,408	182,274	1,114,920	30,510	0.00136826
Sutter	N/A	N/A	N/A	N/A	N/A
Tehama	3,470,770	25,104	173,539	0	0
Tri-City	9,466,166	40,373	473,308	0	0
Trinity	1,782,141	6,787	89,107	0	0
Tulare	21,112,614	473,981	1,055,631	0	0
Tuolumne	3,316,766	35,584	165,838	0	0
Ventura	36,016,136	66,630	1,800,807	0	0
Yolo	9,399,185	37,185	469,959	9,015	0.00095913

Table 12: MHSA Budget Spent on Planning by County for Fiscal Year 2015/2016

Table 12: MHSA Budget Spent on Planning by County for Fiscal Year 2015/2016					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Alameda	51,382,665	477,829	2,569,133	0	0.000
Alpine	1,445,960	28,471	72,298	0	0.000
Amador	3,018,466	14,706	150,923	0	0.000
Berkeley, City of	4,298,016	30,155	214,901	44,665	0.010
Butte	8,317,466	64,741	415,873	0	0.000
Calaveras	3,310,907	31,803	165,545	0	0.000
Colusa	2,278,538	56,028	113,927	0	0.000
Contra Costa	32,115,245	413,011	1,605,762	0	0.000
Del Norte	2,370,353	26,020	118,518	0	0.000
El Dorado	5,872,014	44,486	293,601	0	0.000
Fresno	34,286,955	1,281,223	1,714,348	0	0.000
Glenn	3,397,676	16,465	169,884	0	0.000
Humboldt	5,136,840	47,693	256,842	0	0.000
Imperial	7,099,464	64,198	354,973	3,049,976	0.430
Inyo	1,620,184	12,749	81,009	0	0.000
Kern	29,787,062	347,918	1,489,353	0	0.000
Kings	6,001,268	103,693	300,063	0	0.000
Lake	3,117,966	6,054	155,898	0	0.000
Lassen	2,386,159	17,865	119,308	0	0.000
Los Angeles	405,033,272	6,636,406	20,251,664	2,302,936	0.006
Madera	6,252,445	0	312,622	0	0.000
Marin	8,056,062	40,964	402,803	0	0.000

Table 12: MHSA Budget Spent on Planning by County for Fiscal Year 2015/2016					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Mariposa	1,636,260	0	81,813	0	0.000
Mendocino	3,631,819	22,469	181,591	0	0.000
Merced	10,409,436	243,995	520,472	0	0.000
Modoc	1,543,521	13,052	77,176	0	0.000
Mono	1,597,701	36,794	79,885	0	0.000
Monterey	N/A	N/A	N/A	N/A	N/A
Napa	4,864,953	32,970	243,248	0	0.000
Nevada	4,037,594	48,607	201,880	0	0.000
Orange	N/A	N/A	N/A	N/A	N/A
Placer	10,169,162	332,958	508,458	0	0.000
Plumas	2,216,103	27,998	110,805	0	0.000
Riverside	72,774,551	482,607	3,638,728	0	0.000
Sacramento	45,006,603	772,484	2,250,330	0	0.000
San Benito	2,940,573	23,495	147,029	0	0.000
San Bernardino	74,413,626	692,497	3,720,681	0	0.000
San Diego	116,376,612	1,087,252	5,818,831	0	0.000
San Francisco	26,160,492	132,751	1,308,025	0	0.000
San Joaquin	23,766,877	397,109	1,188,344	0	0.000
San Luis Obispo	9,737,419	75,409	486,871	0	0.000
San Mateo	N/A	N/A	N/A	N/A	N/A
Santa Barbara	17,108,549	-19,227	855,427	0	0.000
Santa Clara	65,677,489	1,087,286	3,283,874	0	0.000
Santa Cruz	10,557,459	110,126	527,873	0	0.000

Table 12: MHSA Budget Spent on Planning by County for Fiscal Year 2015/2016					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Shasta	6,944,792	44,690	347,240	0	0.000
Sierra	1,470,859	30,436	73,543	0	0.000
Siskiyou	2,578,575	64,606	128,929	0	0.000
Solano	14,500,656	196,573	725,033	0	0.000
Sonoma	16,204,091	0	810,205	0	0.000
Stanislaus	18,138,470	247,817	906,924	104,036	0.006
Sutter	N/A	N/A	N/A	N/A	N/A
Tehama	2,912,920	34,024	145,646	0	0.000
Tri-City	7,883,721	62,766	394,186	0	0.000
Trinity	1,587,998	8,182	79,400	0	0.000
Tulare	19,895,092	377,466	994,755	0	0.000
Tuolumne	2,861,581	0	143,079	0	0.000
Ventura	29,808,249	161,915	1,490,412	0	0.000
Yolo	7,645,375	109,959	382,269	44,902	0.006

Table 13: MHSA Budget Spent on Planning by County for Fiscal Year 2016/2017

Table 13: MHSA Budget Spent on Planning by County for Fiscal Year 2016/2017					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Alameda	65751467	$640,380.00	3,287,573	0	0.000
Alpine	1,439,433	45,916	71,971	62,213	0.040
Amador	2,760,691	21,546	138,034	13,780	0.004
Berkeley, City of	5,539,336	59,920	276,967	4,666	0.001
Butte	10,570,149	77,778	528,507	0	0.000
Calaveras	3,018,998	59,625	150,950	0	0.000
Colusa	2,435,808	28,515	121,790	0	0.000
Contra Costa	43,511,910	696,085	2,175,596	0	0.000
Del Norte	2,582,153	49,702	129,108	34,244	0.010
El Dorado	7,340,274	67,844	367,014	0	0.010
Fresno	45,395,403	1,416,210	2,269,770	0	0.000
Glenn	3,172,275	37,243	158,614	0	0.000
Humboldt	6,528,702	78,787	326,435	110,952	0.017
Imperial	9,043,623	52,968	452,181	14,929	0.001
Inyo	1,746,502	29,221	87,325	0	0.000
Kern	39,332,265	922,004	1,966,613	0	0.000
Kings	7,548,080	0	377,404	0	0.000
Lake	N/A	N/A	N/A	N/A	N/A
Lassen	2,575,467	0	128,773	0	0.000
Los Angeles	520,880,543	11,607,398	26,044,027	1,437,646	0.003
Madera	8,020,039	115,498	401,002	0	0.000
Marin	11,844,395	111,794	592,220	0	0.000

Table 13: MHSA Budget Spent on Planning by County for Fiscal Year 2016/2017					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Mariposa	1,753,207	8,827	87,660	0	0.000
Mendocino	4,487,955	50,851.33	224,398	0	0.000
Merced	13,493,300	349,484	674,665	0	0.000
Modoc	1,606,570	25,798	80,329	0	0.000
Mono	1,702,653	55,497	85,133	0	0.000
Monterey	N/A	N/A	N/A	N/A	N/A
Napa	6,113,291	37,245	305,665	0	0.000
Nevada	N/A	N/A	N/A	N/A	N/A
Orange	149,084,385	2,167,797	7,454,219	672,743	0.005
Placer	13,379,087	393,089	668,954	0	0.000
Plumas	N/A	N/A	N/A	N/A	N/A
Riverside	98,359,403	943,636	4,917,970	185,994	0.002
Sacramento	59,606,711	1,533,854	2,980,336	0	0.000
San Benito	N/A	N/A	N/A	N/A	N/A
San Bernardino	97,475,792	1,298,475	4,873,790	434,072	0.004
San Diego	149,675,305	1,736,365	7,483,765	0	0.000
San Francisco	33,990,315	191,650	1,699,516	0	0.000
San Joaquin	31,285,640	729,942	1,564,282	0	0.000
San Luis Obispo	12,476,912	122,084	623,846	0	0.000
San Mateo	29,942,982	292,026	1,497,149	778,855	0.026
Santa Barbara	24,202,885	9,074	1,210,144	0	0.000
Santa Clara	83,375,838	1,629,711	4,168,792	0	0.000
Santa Cruz	N/A	N/A	N/A	N/A	N/A

Table 13: MHSA Budget Spent on Planning by County for Fiscal Year 2016/2017					
County	**MHSA Revenue Received**	**Interest Earned on MHSA Funds**	**5% of MHSA Budget**	**Reported Funds Spent on Planning**	**% of MHSA Budget Spent on Planning**
Shasta	8,760,997	79,147	438,050	0	0.000
Sierra	1,479,389	59,560	73,969	3,978	0.003
Siskiyou	N/A	N/A	N/A	N/A	N/A
Solano	18,240,751	280,804	912,038	0	0.000
Sonoma	20,729,067	58,124	1,036,453	0	0.000
Stanislaus	24,859,879	106,725	1,242,994	112,986	0.005
Sutter	N/A	N/A	N/A	N/A	N/A
Tehama	3,554,631	50,574	177,732	13,543	0.004
Tri-City	10,299,125	114,823	514,956	0	0.000
Trinity	1,690,741	11,150	84,537	0	0.000
Tulare	22,428,231	608,834	1,121,412	0	0.000
Tuolumne	3,309,607	47,438	165,480	0	0.000
Ventura	37,828,722	273,144	1,891,436	132,280	0.003
Yolo	9,995,252	114,866	499,763	0	0.000

Table 14: Poverty Rates by County (Bohn, Danielson, & Thorman, 2018)

Poverty rates vary widely across California's counties

County	Poverty rate (%)	County	Poverty rate (%)	County	Poverty rate (%)
Alameda	16.7	Madera	16.6	San Luis Obispo	18.5
Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne	13.4	Marin	17.0	San Mateo	16.6
Butte	20.6	Merced	18.4	Santa Barbara	23.0
Colusa, Glenn, Tehama, Trinity	17.2	Monterey, San Benito	19.3	Santa Clara	16.0
Contra Costa	14.8	Napa	16.7	Santa Cruz	23.8
Del Norte, Lassen, Modoc, Plumas, Siskiyou	15.5	Nevada, Sierra	17.2	Shasta	17.8
El Dorado	11.8	Orange	20.9	Solano	15.6
Fresno	19.6	Placer	12.9	Sonoma	17.1
Humboldt	19.6	Riverside	18.3	Stanislaus	15.7
Imperial	20.3	Sacramento	17.3	Sutter, Yuba	16.4
Kern	18.9	San Bernardino	18.2	Tulare	20.3
Kings	16.8	San Diego	20.1	Ventura	18.3
Lake, Mendocino	21.6	San Francisco	18.9	Yolo	20.2
Los Angeles	24.3	San Joaquin	15.8		

SOURCE: Estimates from the 2014–2016 CPM combined.

NOTE: For some counties, poverty rates cannot be calculated individually. Those counties are grouped. All estimates are subject to uncertainty due to sampling variability. The uncertainty is greater for less populous counties and county groups (because of smaller survey sample sizes). The median county margin of error is ±2.1 percentage points. Margins of error calculated for a 99 percent confidence interval. For more county-level information and poverty rates by state assembly, state senate, and federal congressional districts, see our interactive maps.

Table 15: Prevalence of SMI by County (Holzer, 2014)

Table 15: Prevalence of SMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Alameda	**65,175**	**1,491,482**	**4.37**
Alpine	**60**	**1,041**	**5.78**
Amador	**2,326**	**37,876**	**6.14**
Butte	**12,537**	**220,577**	**5.68**
Calaveras	**2,291**	**46,731**	**4.9**
Colusa	**1,284**	**21,321**	**6.02**
Contra Costa	**44,323**	**1,041,274**	**4.26**
Del Norte	**2,206**	**29,114**	**7.58**
El Dorado	**8,181**	**178,447**	**4.58**
Fresno	**54,841**	**915,267**	**5.99**
Glenn	**1,729**	**28,299**	**6.11**
Humboldt	**7,982**	**129,623**	**6.16**
Imperial	**10,800**	**166,874**	**6.47**
Inyo	**930**	**17,293**	**5.38**
Kern	**52,127**	**807,407**	**6.46**
Kings	**10,769**	**148,764**	**7.24**
Lake	**4,008**	**65,279**	**6.14**
Lassen	**2,996**	**34,473**	**8.69**

Table 15: Prevalence of SMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Los Angeles	**525,468**	**9,848,011**	**5.34**
Madera	**10,948**	**148,632**	**7.37**
Marin	**10,998**	**250,750**	**4.39**
Mariposa	**940**	**17,792**	**5.29**
Mendocino	**4,988**	**86,040**	**5.8**
Merced	**14,653**	**245,321**	**5.97**
Modoc	**547**	**9,107**	**6.01**
Mono	**647**	**12,927**	**5**
Monterey	**23,718**	**410,370**	**5.78**
Napa	**7,058**	**134,650**	**5.24**
Nevada	**4,484**	**97,751**	**4.59**
Orange	**138,721**	**3,026,786**	**4.58**
Placer	**15,078**	**348,552**	**4.33**
Plumas	**959**	**20,122**	**4.77**
Riverside	**116,577**	**2,125,440**	**5.48**
Sacramento	**74,268**	**1,400,949**	**5.3**
San Benito	**2,732**	**55,058**	**4.96**
San Bernardino	**113,970**	**2,017,673**	**5.65**
San Diego	**152,305**	**3,053,793**	**4.99**

Table 15: Prevalence of SMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
San Francisco	**32,816**	**815,358**	**4.02**
San Joaquin	**37,978**	**674,860**	**5.63**
San Luis Obispo	**14,273**	**266,971**	**5.35**
San Mateo	**27,493**	**718,989**	**3.82**
Santa Barbara	**20,727**	**407,057**	**5.09**
Santa Clara	**70,391**	**1,784,642**	**3.94**
Santa Cruz	**12,759**	**256,218**	**4.98**
Shasta	**10,526**	**181,099**	**5.81**
Sierra	**156**	**3,174**	**4.93**
Siskiyou	**2,470**	**44,634**	**5.53**
Solano	**19,880**	**407,234**	**4.88**
Sonoma	**22,264**	**472,102**	**4.72**
Stanislaus	**29,287**	**510,385**	**5.74**
Sutter	**5,317**	**92,614**	**5.74**
Tehama	**3,720**	**61,138**	**6.08**
Trinity	**776**	**14,165**	**5.48**
Tulare	**26,806**	**429,668**	**6.24**
Tuolumne	**3,230**	**55,175**	**5.85**
Ventura	**37,192**	**802,983**	**4.63**

Table 15: Prevalence of SMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Yolo	**10,199**	**199,407**	**5.11**
Yuba	**4,716**	**72,925**	**6.47**

Table 16: Prevalence of AMI by County (Holzer, 2014)

Table 16: Prevalence of AMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Alameda	**185,814**	**1,491,482**	**12.46**
Alpine	**149**	**1,041**	**14.33**
Amador	**6,024**	**37,876**	**15.9**
Butte	**32,779**	**220,577**	**14.86**
Calaveras	**5,938**	**46,731**	**12.71**
Colusa	**3,204**	**21,321**	**15.03**
Contra Costa	**121,879**	**1,041,274**	**11.7**
Del Norte	**5,525**	**29,114**	**18.98**
El Dorado	**21,721**	**178,447**	**12.17**
Fresno	**137,993**	**915,267**	**15.08**
Glenn	**4,264**	**28,299**	**15.07**
Humboldt	**20,434**	**129,623**	**15.76**
Imperial	**27,315**	**166,874**	**16.37**

Table 16: Prevalence of AMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Inyo	**2,372**	**17,293**	**13.72**
Kern	**128,494**	**807,407**	**15.91**
Kings	**27,938**	**148,764**	**18.78**
Lake	**9,708**	**65,279**	**14.87**
Lassen	**7,841**	**34,473**	**22.75**
Los Angeles	**1,419,709**	**9,848,011**	**14.42**
Madera	**26,170**	**148,632**	**17.61**
Marin	**30,255**	**250,750**	**12.07**
Mariposa	**2,431**	**17,792**	**13.66**
Mendocino	**12,476**	**86,040**	**14.5**
Merced	**36,326**	**245,321**	**14.81**
Modoc	**1,327**	**9,107**	**14.57**
Mono	**1,808**	**12,927**	**13.99**
Monterey	**62,055**	**410,370**	**15.12**
Napa	**18,397**	**134,650**	**13.66**
Nevada	**11,946**	**97,751**	**12.22**
Orange	**387,068**	**3,026,786**	**12.79**
Placer	**40,606**	**348,552**	**11.65**
Plumas	**2,476**	**20,122**	**12.3**

Table 16: Prevalence of AMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Riverside	**298,063**	**2,125,440**	**14.02**
Sacramento	**194,032**	**1,400,949**	**13.85**
San Benito	**7,285**	**55,058**	**13.23**
San Bernardino	**291,429**	**2,017,673**	**14.44**
San Diego	**413,848**	**3,053,793**	**13.55**
San Francisco	**105,092**	**815,358**	**12.89**
San Joaquin	**96,153**	**674,860**	**14.25**
San Luis Obispo	**39,573**	**266,971**	**14.82**
San Mateo	**80,654**	**718,989**	**11.22**
Santa Barbara	**56,401**	**407,057**	**13.86**
Santa Clara	**203,646**	**1,784,642**	**11.41**
Santa Cruz	**35,063**	**256,218**	**13.68**
Shasta	**26,022**	**181,099**	**14.37**
Sierra	**414**	**3,174**	**13.05**
Siskiyou	**6,036**	**44,634**	**13.52**
Solano	**53,743**	**407,234**	**13.2**
Sonoma	**61,170**	**472,102**	**12.96**
Stanislaus	**73,893**	**510,385**	**14.48**
Sutter	**13,340**	**92,614**	**14.4**

Table 16: Prevalence of AMI by County (Holzer, 2014)			
County	**Cases**	**Pop.**	**Percent**
Tehama	**9,127**	**61,138**	**14.93**
Trinity	**1,892**	**14,165**	**13.35**
Tulare	**65,226**	**429,668**	**15.18**
Tuolumne	**8,458**	**55,175**	**15.33**
Ventura	**101,087**	**802,983**	**12.59**
Yolo	**28,266**	**199,407**	**14.18**
Yuba	**11,398**	**72,925**	**15.63**

Table 17: Licensed Mental Health Professionals by Region

(California Health Care Foundation, 2018, p.44)

Licensed Mental Health Professionals, by Region

California, 2016

PER 100,000 POPULATION

LOWER THAN STATE AVERAGE

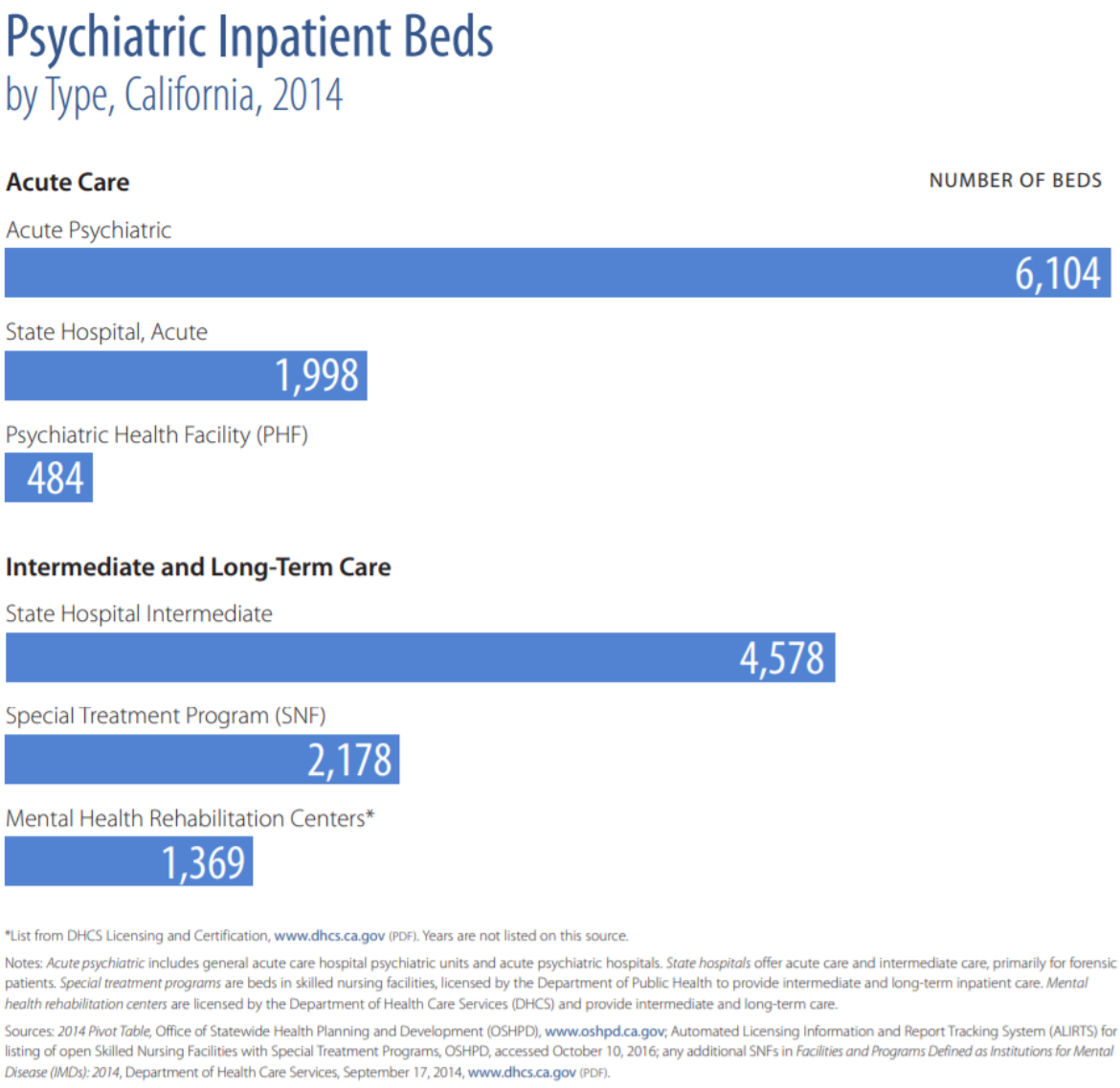
	COUNSELORS	LICENSED CLINICAL SOCIAL WORKERS	MARRIAGE AND FAMILY THERAPISTS	PSYCHIATRIC NURSES	PSYCHIATRISTS	PSYCHOLOGISTS
Central Coast	3.6	45	120	0.9	15	45
Greater Bay Area	4.6	66	118	1.3	25	71
Inland Empire	1.9	26	41	0.3	8	16
Los Angeles County	2.4	56	80	0.9	15	46
Northern and Sierra	3.3	46	86	0.9	9	23
Orange County	3.7	42	82	0.5	10	39
Sacramento Area	3.7	57	76	0.3	15	35
San Diego Area	3.8	48	71	1.1	16	52
San Joaquin Valley	1.4	25	35	0.1	7	16
State Average	**3.1**	**48**	**80**	**0.8**	**15**	**43**

Notes: *Psychiatrists* includes those who designate psychiatry as their primary specialty. County is determined by location of psychiatrist's primary practice. County of psychologists is the county of personal residence. County of licensed clinical social workers and licensed marriage and family therapists is determined by each licensee's chosen address of record. See Appendix A for map of counties included in each region.

Sources: UCSF analysis of Department of Consumer Affairs, Professional Licensee Masterfile, June 2016; Healthforce Center at UCSF; "Annual Estimates of the Resident Population April 1, 2010 to July 1, 2016," US Census Bureau, factfinder.census.gov.

Table 18: Inpatient Slots* by Care Type (California Health Care Foundation, 2018, p.39)

* Note - ACCESS California recommends the use of the word "slots" in place of "beds," and did not create the following graphic.



LIST OF APPENDICES

NAME	DESCRIPTION
Appendix A	2018 ACCESS Initial Stakeholder Feedback Survey
Appendix B	2018 ACCESS Stakeholder Annual Survey
Appendix C	2018 ACCESS Local Agency & Provider Annual Survey
Appendix D	2018 ACCESS Satisfaction & Barriers Survey
Appendix E	2018 ACCESS Ambassador Boot Camp - Participant Evaluation
Appendix F	2018 ACCESS Leadership Training Pre-Post-Survey with Demographics
Appendix G	2018 ACCESS Community Empowerment Workshop Pre-Post-Survey with Demographics
Appendix H	2018 ACCESS Initial Stakeholder Feedback Survey Report
Appendix I	2018 ACCESS Stakeholder Annual Survey Report
Appendix J	2018 ACCESS Local Agency & Provider Annual Survey Report
Appendix K	2018 ACCESS Satisfaction & Barriers Survey Report
Appendix L	2018 ACCESS Ambassador Boot Camp - Participant Demographics and Evaluation Report
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