



**Santa Cruz Mental Health & Substance Abuse Services  
Mental Health Services Act**

**INNOVATIVE PROJECT**

*¡Juntos Podemos!  
Together We Can!*

March 27, 2015  
Revised May 4, 2015

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# County of Santa Cruz

## HEALTH SERVICES AGENCY

1400 Emeline Avenue, Santa Cruz, CA 95060

(831) 454-4170 FAX: (831) 454-4663 TDD: (800) 523-1786

### LETTER FROM THE MENTAL HEALTH & SUBSTANCE ABUSE DIRECTOR

February 6, 2015

Santa Cruz County Mental Health & Substance Abuse Services has completed a draft Innovative Projects Plan of the Mental Health Services Act (MHSA/Proposition 63). This report has been prepared according to instructions from the Mental Health Services Oversight Accountability Commission (MHSOAC).

This report is available for public review and comment from February 6 to March 6, 2015.

There will be a public hearing on the Innovative Projects Draft Plan on Thursday, March 19, 2015 at 3:00 at 1400 Emeline, room 207, Santa Cruz, CA. You may provide comments in the following ways:

At the Public Hearing,  
By fax: (831) 454-4663,  
By telephone: (831) 454-4931 or (831) 454-4498,  
By email to [mhsa@co.santa-cruz.ca.us](mailto:mhsa@co.santa-cruz.ca.us),  
Or by writing to:

Santa Cruz County Mental Health & Substance Abuse Services  
Attention: Alicia Nájera, MHSA Coordinator  
1400 Emeline Avenue  
Santa Cruz, CA 95060

Sincerely,

Erik G. Riera  
Director, Behavioral Health

**Santa Cruz County Mental Health & Substance Abuse Services: Innovative Project**

**MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION**

- Three-Year Program & Expenditure Plan
- Innovative Project**
- Annual Update
- Annual Revenue and Expenditure Report

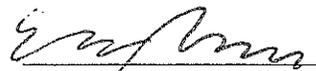
Santa Cruz County

Local mental Health Director	County Auditor-Controller
Name: Erik G. Riera	Name: Michael Beaton
Telephone Number: 831-454-4515	Telephone Number: 831-454-4449
E-mail: erik.riera@santacruzcounty.us	Email: michael.beaton@santacruzcounty.us
Local Mental Health Mailing Address:	
Santa Cruz County Mental Health & Substance Abuse Services 1400 Emeline Avenue Santa Cruz, CA 95060	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations section 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

Erik G. Riera  
Local Mental Health Director (Print)

 3-30-15  
Signature Date

I hereby certify that for the fiscal year ended June 30, 2014 the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892f); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 29, 2014, for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, that State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Michael Beaton  
County Auditor Controller (Print)  
Director of Administration & Fiscal Services

 3.30.15  
Signature Date

**COUNTY CERTIFICATION**

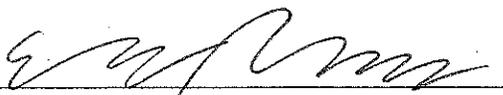
**County:** Santa Cruz

County Mental Health Director  <b>Name:</b> Erik G. Riera  <b>Telephone number:</b> 831-454-4515  <b>Email:</b> <a href="mailto:erik.riera@santacruzcounty.us">erik.riera@santacruzcounty.us</a>	Project Lead: To be determined  MHSA Coordinator  <b>Name:</b> Alicia Najera  <b>Telephone number:</b> 831-454-4931  <b>Email:</b> <a href="mailto:alicia.najera@santacruzcounty.us">alicia.najera@santacruzcounty.us</a>
<b>Mailing Address:</b> 1400 Emeline Avenue Santa Cruz, Ca 95060	<b>Mailing Address:</b> 1400 Emeline Avenue Santa Cruz, Ca 95060

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3351(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

	<u>3-30-15</u>	<u>Director, Behavioral Health</u>
Signature (Local Mental Health Director)	Date	Title

## **Description of Community Program Planning and Local Review Processes**

### **a) Description of the local stakeholder process including date(s) of the meeting(s):**

Last summer, Santa Cruz County Mental Health & Substance Abuse Services launched a strategic planning effort to identify the necessary community mental health needs and gaps in services. Community meetings were scheduled for September through December. Each month there was an evening meeting, and a morning meeting, as well as a meeting in North County and South County. The announcement of these meetings was disseminated to all stakeholders, as well as posted in three local newspapers each month. (Notes from these meetings were posted on our website (<http://www.santacruzhealth.org/cmhs/2cmhs.htm>).

The September meetings were held on September 9<sup>th</sup> (6 p.m. to 8 p.m. at 1080 Emeline Avenue, Santa Cruz) and on September 16 (from 9 a.m. to 11 a.m. in the City Council Chambers, 275 Main Street, Watsonville). Dr. Jerry Solomon facilitated the meetings, and introductory remarks and overview of services were presented by Erik Riera, Director of Mental Health & Substance Abuse Services, Dane Cervine, Chief of Children's Services, Bill Manov, Chief of Substance Abuse Services, Pam Rogers-Wyman, Chief of Adult Services, and Alicia Nájera, Behavioral Health Program Manager.

The audience was presented with the "Identified Gaps in the Behavioral Health System" document, which listed the needs and gaps areas identified by management staff based on a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis performed during a series of management retreats. The gap areas were grouped by "programs and services", "communication, collaboration and community education", "program staffing", "timely access to treatment", and "integrated models of care". This analysis was presented to the stakeholder groups as a starting point to promote further discussion and focus specifically on the needs and gaps areas within the overall system of care.

Participants broke out into small discussion groups, and answered the following questions:

1. In looking at the key need and gap areas that have been identified so far, are there any, from your perspective, that are missing? If so, what are they?
2. Which needs or gap areas are most important?
3. Which needs or gap areas should we focus on working first?
4. Are there specific needs or gap areas that may be unique or different for South County?

On September 9<sup>th</sup> there were 6 groups, and on the 16<sup>th</sup> there 5 groups. There was one group on each date that focused on children's services, the rest focused on adult services. The majority of the participants were adults aged 26 to 59 (72%), and thirty seven (37%) identified as clients/consumers. The demographic breakdown of participants from the September meetings is described in detail in the table in section b (below).

Based on a review of the participants in the September meetings, we held focus groups for groups that were under-represented. The groups were: families, older adults, veterans/veteran advocates, LGBTQ youth, monolingual Spanish speakers, and transition age youth.

*Santa Cruz County Mental Health & Substance Abuse Services: Innovative Project*

The **Families** focus group was held on October 14, 2014 at the Simpkins Swim Center in Live Oak at 7:00 p.m. There were 18 community members in attendance. The group was facilitated by Dr. Solomon and two staff were in attendance.

The **Older Adult** focus group was held on October 15, 2014 at 1080 Emeline, Santa Cruz at 9:30 a.m. There were 20 community members in attendance. The group was facilitated by Dr. Solomon, and there were 5 staff in attendance.

The **Veterans/Veteran Advocates** focus group was held on October 16, 2014 at the Veteran's Memorial Building in Santa Cruz at 1:00 p.m. There were 13 community members in attendance. The group was facilitated by Dr. Solomon, and there were 4 staff in attendance.

The **LGBTQ Youth** focus group was on October 16, 2014 at the United Way in Capitola at 3:30. There were 8 community members in attendance. The group was facilitated by Dr. Solomon, and there were 2 staff in attendance.

The **Monolingual Spanish Speakers** focus group was on October 16, 2014 at the Watsonville City Community Room at 6:30 p.m. There were 16 community members in attendance. The group was facilitated by Jaime Molina, and 2 additional staff were in attendance.

The **Transition Age Youth (TAY)** focus group was held on October 17, 2014 at Mariposa in Watsonville at 1:00 p.m. There were 8 community members in attendance. The group was facilitated by Dr. Solomon and there was one staff member in attendance.

Additionally, the Santa Cruz County Sheriff (Dave Hart) and the Behavioral Health Court Judge (Jennifer Morse) were interviewed as key informants.

In November we met with the community on the 18<sup>th</sup> in Watsonville and the 20<sup>th</sup> in Santa Cruz. The focus of these meetings was to give the community an overview of what we heard and our next steps. Participants reviewed our revised grid of gaps in services, based on input from the September and October meetings, and had a chance to add to that list. We also gave information about what constitutes an Innovative Project, including the Mental Health Oversight Accountability Commission (MHSOAC) "Innovation Decision Path for Counties" document and a document we created titled "MHSA Innovative Projects Workgroup". (See these documents in the attachments.)

On November 19, the Director of Behavioral Health was invited to speak at a monthly NAMI Meeting at the Live Oak Senior Center, and presented the Draft Needs and Gaps analysis to family members there to solicit additional input on the beginning phases of an Innovation Draft Plan.

The December meetings for the Mental Health and Substance Abuse Services strategic planning efforts were focused specifically on Innovative Projects, one of the service components of the Mental Health Services Act. We reiterated the requirements for the Innovative Projects,

including the fact that these projects are time limited (and the current Innovative Project is slated to end in June, 2015). We reviewed the proposed ideas, and heard feedback and additional ideas from the community.

On Thursday, January 08, 2015, we held an Innovation Program work group (open to anyone who wished to attend) at 9:00 a.m. at the Simpkins Swim Center, 979 17<sup>th</sup> Avenue, Santa Cruz. We provided an overview of the strategic planning process, reviewed and refined (with the community input) our proposed Innovation Project, and answered lingering questions about what constitutes an Innovative project. (We also disseminated the MHSOAC's document titled "Innovation Answers these Questions", which is included in the attachment section of this document.)

**b) General description of the stakeholders who participated in the planning process and that the stakeholders who participated met the criteria established in section 3200.270:**

The County works closely with the Local Mental Health Board, contract agency representatives, family members, NAMI, consumers, Mental Health Client Action Network (MHCAN), Mariposa Wellness Center, agencies representing underserved communities (the Diversity Center, Queer Youth Task Force, Barrios Unidos, Migrant Head Start), community based agencies (such as Encompass, Front Street Inc., Pajaro Valley Prevention & Student Assistance, Family Services), educational institutions, social services, probation, juvenile detention, county jail, law enforcement, community resource centers, employment and health.

The demographic breakdown for the planning meetings is listed below. Additionally we held focus groups with monolingual Spanish speakers, older adults, family members, veterans and veteran advocates, transition age youth, LGBTQ youth, and had two key informants (the Sheriff and the Behavioral Health Court Judge).

**Demographics for September Strategic Planning meetings**  
(89 total in Santa Cruz; 54 total in Watsonville)

AGE	9/9/14 Santa Cruz	9/17/14 Watsonville
Under 15	0	0
16-25	0	6
26-59	65	38
60+	22	5
Blank	2	5

Gender	9/9/14	9/17/14
Man	30	22
Woman	56	29
Other	2	0
Blank	1	3

Language	9/9/14	9/17/14
English	88	38
Spanish	0	2
English/Spanish	2	9
Other	1	0
Blank	0	5

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Ethnicity	9/9/14	9/17/14
Black/African American	7	4
Latino	3	16
White	54	19
Native American	1	5
Mixed	12	3
Other	9	2
Blank	3	5

9/9/14: of the "Mixed", one identified as Native/White, another as Native/Latino/White

9/17/17: of the "Mixed", one identified as Latino/White, another as Latino/Native American.

Group Representing	9/9/14	9/17/14
Client	38	16
Family	4	0
Law Enforcement	1	0
Social Services	4	4
Veteran/Vet Advocate	1	0
Education	4	4
Health Care	2	1
Mental Health provider	16	17
AOD service provider	5	1
General Public	4	2
LGBTQ	1	0
Other	6	4
Blank	3	5

9/9/14: 14 represented more than one group. Client & MH provider = 8; family & general public = 1; social services & MH = 2; client & family = 2; health & general public = 1. (These were listed under the first group named in this pairing.)

9/17/14: 8 represented more than one group. Client & MH provider = 5; client & social services = 1; mental health & aod = 2. (These were listed under the first group named in this pairing.)

**c) The dates of the 30 day review process:**

The draft plan of the Innovation Project was available for review and comment from February 6 to March 6, 2015.

**d) Methods used by the county to circulate for the purpose of public comment the draft of the annual update to representatives of the stakeholders interests, and any other interested party who requested a copy of the draft plan:**

The draft plan was distributed to the Local Mental Health Board, contractors, and to other stakeholders. It was also posted on our Internet site, and made available in hard copy to anyone who requested it. We placed two ads in the Santa Cruz Sentinel (on February 14 and March 1), the Watsonville Pajaronian (on February 14 and February 28), and the Aptos Times (on February 22) to inform the community at large of its availability.

**e) Date of the Public hearing held by the local Mental Health Board:**

The Public Hearing was on March 19, 2015 at 3:00 p.m.

**f) Summary and analysis of substantive recommendations received during the 30-day public comment period and description of substantive changes made to the proposed plan:**

The following are changes were made to the draft plan based on comments received:

- Why peers are considered “helpers” and families were “partners”. We changed the wording to recognize that both peers and families are partners.
- Budget detail was not included in the draft plan. We have added that.
- The term “mental health center” was used in a couple of places. This is a term we haven’t previously used and raised some questions. It was replaced with “Santa Cruz County Mental Health & Substance Abuse Services”.
- Changed the primary purpose to “increase quality of services, including better outcomes”. We had previously checked all four possible primary purposes; the other three are to “increase access to underserved groups”, “promote interagency collaboration”, and “increase access to services”. The program will embody all of these purposes, but for sake of evaluation we are focusing on this primary purpose.
- Added specific information to the general standards (community collaboration, cultural competence, client-driven, family-driven, wellness/recovery/resilience focused, and integrated service experience for clients and their families.
- Added a budget narrative, including explanation about FTE’s, administrative costs, and operating expenses.

**Innovation Work Plan Narrative**

**Date:** March 19, 2015

**County:** Santa Cruz

**Work Plan #:** 1

**Work Plan Name:** ¡Juntos Podemos! (Together We Can!)

**Purpose of Proposed Innovation Project (check all that apply)**

- Increase Access to underserved groups
- X Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

**Briefly explain the reason for selecting the above purpose(s).**

During the Strategic Planning process and stakeholder sessions, participants identified a number of critical needs and gaps areas within the system, including the need to expand and leverage the availability of peer partner and family partner staff within the County mental health services teams to support individuals in achieving more positive treatment outcomes, provide education about alternative supports to individuals and families from the peer and family perspective, and develop a team model where peer and family partners, along with clinical staff work as collaborative team members and partners to more effectively support the needs of the individual and their family. The stakeholder groups identified the challenges inherent in working with individuals who are often isolated and not inclined towards treatment, and how that isolation often extends to family members, particularly those who have loved ones who are adults and in need of services but do not want family involved in supporting their recovery goals. Family members often end up isolated themselves, and not connected to what is being provided through the traditional treatment team, when current best practice models demonstrate the effectiveness of involving family in supporting the care of their children. This is a population that is often hard to reach, and the focus of the Innovative Project being proposed is to leverage the strengths, skills and unique perspective of peers and family partners on the County treatment teams to support the needs of these individuals and family members.

During the course of the stakeholder meetings, a number of examples were provided of peer and family members being included in supporting the individual, but none of peer and specially trained family partners working as staff on the team together. In addition, the idea of including family partners as active members of a team is a common and accepted approach on a children's team, but not on a team serving adults. Conversely, peers are a well-established and well valued resource in supporting the work of adult teams, but have not been studied as an integral component of a team working with adolescents. A number of comments were made about the inherent challenges that this presents as peers and family members understandably bring different perspectives to the care and support of an individual, sometimes presenting opposing perspectives of how best to accomplish those outcomes. Comments were also provided during the stakeholder process indicating that peers did not necessarily want family members on the team, and we were left with an unanswered question of how to effectively put together a program

where both the peers, the clinicians, and family partners saw each other as valued members of the team, effectively collaborating to support the individual and their family, when the family could become a valued resource to the team and the individual they are working with. From the peer perspective, there are a number of alternative approaches and supports which would complement and add to the clinical supports provided by the team, but may not necessarily be supported by the family, which again raised the question of how to build a cohesive team where all three perspectives are equally represented, respected and supported in a more holistic approach to supporting the individual, and also their family.

### **General Standards**

Development and planned implementation of the ¡Juntos Podemos! (Together We can!) Innovation Project included the MHSA general standards, as described below.

- **Community Collaboration:**

Santa Cruz County Mental Health & Substance Abuse Services had an extensive strategic planning process (as described previously). Santa Cruz County Mental Health & Substance Abuse Services plans on having ongoing community stakeholder participation as ¡Juntos Podemos! rolls out. We plan on having a small group of community stakeholders involved in the hiring process of the peer and family partners, as well as the Office of Consumer & Family Affairs post. Additionally, we will rely on a small evaluation team that will provide feedback to the Applied Research Survey and County evaluation team. The general community will be invited to attend periodic meetings, and receive information and updates about the program. These community stakeholder meetings will be one of the ways in which the community can ask questions, and provide input in order to strengthen the program.

- **Client-driven and Family-driven Services:**

The roll of the peer partner, family partner and mental health clinician is to engage clients in services and supports that are most effective for them. These service providers will honor the fact that the client's input and decision about what is needed and what is most helpful will be the crucial factor in developing a treatment strategy. Similarly, families will have primary decision-making roll in the mental health care of their own children. The Office of Consumer and Family Affairs manager will provide oversight to the peer and family partners, and be responsive to consumers' and families' needs and requests for services. Additionally, the peer and family partners, and mental health clinicians will use the ANSA (Adult Needs & Strengths Assessment). This assessment tool is based on communication between the client and the providers to design individualized treatment plans. ANSA is an effective instrument for providing client-driven, and family-driven services.

- **Wellness, Recovery & Resilience Focused Services:**

The peer and family partners, the Office of Consumer & Family Affairs manager, and the mental health clinician, will be using the ANSA. This assessment tool embraces the wellness model, as its focus is not on assessing for mental illness, but on needs and strengths of the client. Additionally, they will be using PREP (Prevention & Recovery in Early Psychosis). This is an evidence-based practice that utilizes the principals of recovery and resiliency, by promoting the fact that individuals with a mental health disability can have a fulfilling and productive life, and/or a reduction in symptoms. The treatment team will embrace the

philosophy of Recovery and Resiliency, by instilling hope, optimism and problem-solving skills.

- **Cultural Competence:**

The ¡Juntos Podemos! program is designed to effectively engage and retain individuals of ethnically and diverse backgrounds to quality services that are needed. This is the County's Cultural Awareness Mission Statement:

*Our goal is to support our consumers, youth, and family members with culturally appropriate resources, encouragement, tools and skills so they may achieve the quality of life they desire.*

*As an agency we challenge ourselves to develop ever-greater cultural awareness and sensitivity to acknowledge and embrace individual differences, including language, beliefs, values, attitudes, healing practices, sexual orientation, physical and mental abilities.*

*We endeavor to build on existing strengths, develop new skills and maximize the opportunity for recovery and optimal health of our community.*

The ¡Juntos Podemos! peer and family partners, Office of Consumer & Family Affairs, as well as the mental health providers, will all be expected to provide culturally sensitive, recovery focused services to the clients they are serving. This includes providing services in the client's language (using bilingual staff or translation services, as needed) and utilizing the client's strengths, and forms of healing unique to an individual's racial/ethnic, cultural, geographic, socio-economic, or linguistic population or community when providing services or support.

- **Integrated Service Experience for Clients and Families:**

During the Strategic Planning process, we heard from many that navigating the system when seeking services was frustrating and difficult. The Office of Consumer & Family Affairs Director will play a crucial role with clients and family members in navigating the full range of services, both within the mental health system, and the community resources, and help access needed services in a timely manner.

### **Contribution to Learning**

**Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new application or practices/approaches that have been successful in non-mental health contexts. (Suggested length – one page)**

The proposed innovative project leverages existing research demonstrating the effectiveness of peers as effective supports to the individual and the importance of engaging family members in the clinical services provided to the individual and makes two significant changes to the model. The first involves hiring peer and family partners to be trained and work as members of the treatment team to support each of the individuals and their family members who are receiving services through the team. The

*Santa Cruz County Mental Health & Substance Abuse Services: Innovative Project*

second important change to the proposed model is looking at how the County of Santa Cruz can develop an infrastructure to support the work of peer and family partners on the team in a way that each of the diverse and often times contradictory approaches offered by each perspective is valued and supported to the benefit of the individual and the family, as well as the work they themselves provide. This approach is inclusive of the need for a cultural change within the clinical staff on the team as well, to consider other approaches to care, working through the challenges of including family when the individual may not necessarily see the value in engaging their family in treatment, and also determining when it is not appropriate to engage family in supporting the individual, but nevertheless finding a path to supporting the family with their own needs. It is anticipated that at the end of this Innovative Project, the County will have a model that can be applied to other Counties to more effectively support the inclusion of peer and family partners on different treatment teams to work collaboratively and effectively to support better outcomes for all the individuals being served by the team, including those outside the scope of treatment, which is often times the family themselves.

A review of current research and dialogue<sup>i</sup> in the area of peer and family inclusion on mental health treatment teams highlights a number of key areas that emerged as well throughout the stakeholder feedback process as important principles and measures of success for this project:

1. Peer partners and family partners need to be accepted as equal partners/members of the treatment team.
2. The team must avoid using peer partners and family partners for menial tasks, like transportation, and instead utilize them as resources to support recovery education, active problem solving, and alternative supports and strategies for and individuals recovery goals.
3. The role of peer partners and family partners have to be balanced to “avoid co-optation, where peer partners and family partners look more like a traditional clinician than a peer.”<sup>ii</sup>
4. Peer partners and family partners will have access to peer support “for sharing the challenges and accomplishments of mutual problem solving, personal and professional growth and development, and early identification of pressure points”<sup>iii</sup> through staff development, training and support coordinated through the Office of Consumer and Family Affairs.

The Innovative Project proposed, will establish several key positions within Santa Cruz County Mental Health & Substance Abuse Services to support this work. Included in that infrastructure is the creation of an Office of Consumer and Family Affairs (OCFA), which will work with peers and family members to develop a training curriculum and practice model to support the work of the peers and family partners who will be hired into paraprofessional positions on the team. The OCFA Director will have a strong administrative connection to each of the teams this model is being piloted with, as well as working within an advocacy role to assist family members and individuals served in connecting to peers and family members on the team, and providing navigation and orientation to new individuals and families coming into services for the first time.

The peer and family partners will initially work with our Transitional Aged Youth treatment team that is also being trained to work with older adolescents and young adults experiencing a first episode

psychosis using the PREP model. PREP is inclusive of utilizing peers and engaging the individual's family, but as part of this Innovative Proposal, the County is planning to include peer and family partners on the team who are not part of the individual's family themselves.

This team, and particularly the PREP component, was selected because they will be working with both adolescents and young adults, and provides an opportunity to utilize peers and family partners in a new way- specifically by working with population age groups that they do not ordinarily work with. A lot has been studied on the positive effects of the family partner model in working within the children's services system, but not in the adult services system. Conversely, there is a lot of research supporting the inclusion of peers on adult services team, but not necessarily in supporting building resiliency with children. Furthermore, little has been researched on how to have peers and family partners complement the work each performs, and work together to assist the individual in supporting recovery from two often times different perspectives, but also support the work each other does on the team. Although the current PREP model is inclusive of peer partners and family partners, the focus will be expanded as part of this Innovations Project, to support more inclusion on the team, a greater focus on supporting families, and engaging in outreach activities, and for the peer partners and family partners to work with age groups outside their traditional areas of focus. Innovations funds will not be utilized to support the training of staff in PREP.

The County is seeking to learn more about how to structure the training of these staff, and develop an infrastructure that will support a positive collaborative relationship among all members of the team, and support the cultural change within the team that supports seeing each of the member of the team- the peer partner, the family partner, and the clinicians as equally valuing and supporting the sometimes contradicting approaches and perspectives offered in support of the individual. If done effectively, we anticipate improving retention rates, satisfaction with services from both the consumer and family members, and improved support of the individual's recovery goals. Over time, we expect the addition of this new model to be expanded to additional teams within Santa Cruz County Mental Health & Substance Abuse Services.

In the second and third year of the project, and through the fifth year of the project, an additional peer partner and family partner will be added to the County's Recovery Team, which is envisioned as a full service partnership team, and will allow for the lessons learned in the first two years of the project to be applied to an additional team to continue to refine and modify the training and staff development model that is integral to this proposal.

### **Proposed Training Models (Peer and Family Partner)**

The following training models are currently being considered for the peer partner and family partner, with some potential modifications to support their work in a clinical setting, which will be developed over the course of this project:

- Wellness Recovery and Action Planning: WRAP using the Mary Ellen Copeland model
  - Peer partners, Family partners, and clinical staff
- Intentional Peer Support (IPS)
  - Peer partners, Family partners, and clinical staff
- Family to Family training from NAMI

- Family Partners, Peer Partners, clinical staff
- County service orientation
  - Peer Partners, and Family Partners
- Shared Decision Making training
  - Peer Partners, Family Partners, clinical staff
- Twelve Aspects of Staff Transformation by Mark Ragins, MD
  - Clinical Staff
- Wellness, Recovery & Resiliency: A Basic Skills Curriculum for Consumers and Family Members in the Mental Health Workforce (San Mateo County Behavioral Health & Recovery Services)
- Other trainings as developed through the evaluation process

### **Evaluation Plan**

Santa Cruz County Mental Health & Substance Abuse Services will work with Applied Survey Research (ASR), an independent evaluator, to evaluate the implementation and impact of ¡Juntos Podemos! (¡JP!). Upon funding, ASR will be contracted to develop and submit a fully articulated evaluation plan for review and approval. Like the intervention itself, the evaluation will follow a participatory approach in which representatives of key program stakeholder groups will be asked to provide input on fundamental aspects of the evaluation such as stating primary and secondary evaluation questions, selection of new measures, creation of data collection/management procedures, problem solving emerging challenges, interpretation of findings, reporting, and making data-based recommendations.

The evaluation will include a focus on the formative questions posed earlier in the proposal: (1) What are the key strategies for creating and maintaining effective treatment teams that include peer partners, family partners, and clinicians (2) How do these treatment teams impact consumer treatment retention, satisfaction with services, and perceived support for recovery treatment goals? Information gathered to answer these questions will be used to iteratively improve the ¡JP! Model. Data collection methods and sources may include questionnaires, interviews, and clinical records. Baseline data collection will occur during the first year of funding with a cohort of the population who would be eligible for ¡JP! Follow-up data collection with ¡JP!-enrolled consumers and their treatment teams will occur on a schedule to be determined by the evaluation team. Evaluation of treatment team functioning may include measures such as agreement/consensus about treatment goals and strategies; clarity of roles and responsibilities; self-efficacy to perform roles and responsibilities; and perceived support, value, trust, and respect among treatment team members.

Data analysis will include descriptive frequencies to answer evaluation question 1 and comparative methods (baseline cohort with enrolled cohort, controlling for differences at treatment intake) to answer question 2. Because the purpose of the evaluation is to provide generalizable knowledge for the state of California, the study would be considered research and its research protocol would be subject to review and oversight by ASR's federally approved Institutional Review Board (IRB) for the protection of human subjects. ASR would be responsible for leading the development and submission of the ¡JP! Research protocol for IRB review, including consent procedures. ASR will work closely with County staff to delineate

study recruitment, enrollment, and data collection responsibilities and will coordinate with analysts to obtain de-identified clinical records if these are included in the final evaluation plan.

### **Timeline**

**Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.**

- **Year One: July 1, 2015 to June 30, 2016**

Deliverables Year 1:

1. Disseminate ¡Juntos Podemos! Innovation plan to the other counties in California by July, 2015.
2. Evaluation planning. Contract with Applied Research Survey (ASR) to develop the evaluation tools.
3. Recruitment begins for Office of Consumer and Family Affairs Director: August 2015
4. Hire Office of Consumer and Family Affairs Director: September 2015
5. Develop organizational and team structure, supervision model: December 2015
6. Develop interview questions and selection criteria for peer and family partners: December 2015
7. Develop draft training curriculum for family partners, peer partners, and clinical staff: December 2015
8. Develop draft outcomes data and stakeholder review: December 2015
9. Publish training curriculum draft and solicit comment through stakeholder process: January 2016
10. Finalize training curriculum: February 2016
11. Baseline evaluation: January 2016 for clinical staff, peer and family partners March 2016
12. Hire peer and family partners (1 of each) with stakeholder participation: March 2016
13. Train peer partner, family Partner, and clinical Staff: March 2016
14. Peer and family partner staff begin work on team: March 2016
15. Stakeholder Meeting to review Year 1 progress: June 2016

- **Year Two – Four: July 1, 2016 to June 30, 2020**

1. Year 2 to Year 3: Add a peer partner and family partner to another treatment team at County Behavioral Health.
  - a. Hire Peer and Family Partner: Spring Year 2
  - b. Train Peer and Family Partner: Spring Year 2
  - c. Peer and family partner begin work on team: Summer Year 3
2. Annual evaluation process: Applied Survey Research: May of each fiscal year
3. Annual Stakeholder Meeting: June of each fiscal year
4. Modifications to training protocol: As needed during year
5. Outcomes data: Ongoing throughout the fiscal year

- **Year Five –: July 1, 2020 to June 30, 2021**

1. Final report prepared: October 2020
2. Develop sustainability plan and budget December 2020

*Santa Cruz County Mental Health & Substance Abuse Services: Innovative Project*

3. Review of sustainability plan with stakeholders: January 2021
4. Final stakeholder meeting: June 2021
5. Propose sustainability plan to Board of Supervisors for approval: June 2021

**BUDGET**

**INNOVATION 5-YEAR BUDGET SUMMARY**

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
	FY15/16	FY16/17	FY17/18	FY18/19	FY19/20	
Labor	272,079	422,561	441,434	457,206	473,447	2,066,727
Operating	94,071	66,665	34,502	35,070	35,655	265,963
Program Evaluation	73,230	48,923	47,594	49,228	50,910	269,884
Administrative Overhead	65,907	80,722	78,529	81,226	84,002	390,386
<b>Total</b>	<b>505,287</b>	<b>618,871</b>	<b>602,059</b>	<b>622,730</b>	<b>644,014</b>	<b>2,922,960</b>

**Budget Narrative**

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Fy 15/16	FY 16/17	FY 17/18	FY 18/19	FY 19/20	
<b>LABOR</b>						
Office of Consumer & Family Affairs- 1FTE	137,901	146,525	153,053	160,037	167,327	764,843
Mental Health Aide (Peer Partner)- 1 FTE	67,089	70,929	73,262	75,323	77,737	364,340
Mental Health Aide (Family Partner) - 1 FTE	67,089	70,929	73,262	75,323	77,737	364,340
Mental Health Aide (Peer Partner) - 1 FTE	-	67,089	70,929	73,262	75,323	286,603
Mental Health Aide (Family Partner) - 1 FTE	-	67,089	70,929	73,262	75,323	286,603
<b>Total</b>	<b>272,079</b>	<b>422,561</b>	<b>441,434</b>	<b>457,206</b>	<b>473,447</b>	<b>2,066,728</b>
<b>OPERATING</b>						
Cell/desk phone monthly fees	2,016	2,076	2,139	2,203	2,269	10,703
Mileage	4,347	4,477	4,612	4,750	4,893	23,079
Network Connection Fees	6,084	6,267	6,455	6,648	6,848	32,301
Staff Supplies (.05% of salary)	1,360	2,113	2,207	2,286	2,367	32,301
Trainings	15,000	15,000	15,000	15,000	15,000	75,000
Annual Stakeholder meetings costs	1,000	1,000	1,000	1,000	1,000	5,000
Computers (\$1,000 each)	3,000	2,000	-	-	-	5,000
I-phones (\$200 each)	600	400	-	-	-	1,000
Cars (\$30,332 each)	60,664	30,332	-	-	-	90,996
Car Service Maintenance	-	3,000	3,090	3,183	3,278	12,551
<b>Total</b>	<b>94,071</b>	<b>66,665</b>	<b>34,502</b>	<b>35,070</b>	<b>35,655</b>	<b>265,963</b>
	336,150	489,226	492,936	492,276	509,102	2,332,691
<b>CONTRACTOR</b>						
Program Evaluation	73,230	48,923	47,594	49,228	50,102	269,884
<b>Total</b>	<b>73,230</b>	<b>48,923</b>	<b>47,594</b>	<b>49,228</b>	<b>50,102</b>	<b>269,884</b>
<b>TOTAL PROGRAM EXPENSES</b>	<b>439,380</b>	<b>538,149</b>	<b>523,530</b>	<b>541,504</b>	<b>560,012</b>	<b>2,602,575</b>
<b>ADMINISTRATIVE OVERHEAD (15%)</b>	<b>65,907</b>	<b>80,722</b>	<b>78,529</b>	<b>81,226</b>	<b>84,002</b>	<b>390,386</b>
<b>GRAND TOTAL</b>	<b>505,287</b>	<b>618,871</b>	<b>602,059</b>	<b>622,059</b>	<b>644,014</b>	<b>2,992,961</b>

# ATTACHMENTS

**Mental Health Services Act (MHSA)  
Innovative Programs Workgroup**

**What is the task of the MHSA Innovative Programs work group?**

The tasks of the Workgroup are to:

1. Initiate a planning process that involves getting input from stakeholders.
2. Adhere to State requirements for the Plan.
3. Develop and present proposal to the MHSA Steering Committee, including proposed priorities for the Plan.

**What is MHSA?**

In 2004 California passed Proposition 63, known as the Mental Health Services Act. It imposes a tax on California's millionaires and the money is used to provide Mental Health Services. The Department of Mental Health, along with the Oversight Accountability Commission and the California Mental Health Directors Association, provide guidance for the Counties for the MHSA requirements. Three components of MHSA focus on direct clinical services (Prevention and Early Intervention, Community Services and Supports, and **Innovative Programs**), and three focus on infrastructure (Workforce Education and Training, Capital Facilities, and Information Technology).

**What is an Innovative Program?**

An Innovative project is defined as one that contributes to learning rather than a primary focus on providing a service. Innovative Programs are available for a range of approaches, including, but not limited to:

- Introduction of a new mental health practice;
- Substantial change of an existing mental health practice, including significant adaptation for a new setting or community. *Note: Approaches that have been successful in one community cannot be funded as an Innovative Program in a different community even if the approach is new to that community, unless it is changed in a way that contributes to learning.*
- New application to the mental health system of a promising community approach or an approach that has been successful in non-mental health contexts or settings.

Proposed Innovative projects that have previously demonstrated their effectiveness in a mental health setting and that do not add to the learning process or move the mental health system towards the development of new practices/approaches may be eligible for funding under other MHSA components. However, an Innovative project may include a Prevention and Early Intervention (PEI) strategy if it were distinct from the PEI requirements, such as targeted to a group not listed as a "priority population", and/or being of longer duration.

**Voluntary Participation**

Innovative projects must be designed for voluntary participation.

**What are the priorities of the Innovative Programs component?**

The funds for this component must be used for one of the following purposes:

- To increase access to underserved groups;
- To increase the quality of services, including better outcomes;
- To promote interagency collaboration;
- To increase access to services.

**Time Limit**

Innovative projects are similar to pilot or demonstration projects and are subject to time limitations to assess and evaluate their efficacy.

**What are the Essential Elements of MHSA as they apply to Innovation?**

- Community Collaboration: initiates, supports and expands collaboration and linkages, especially connections with systems, organizations, healers and practitioners not traditionally defined as a part of mental health care.
- Cultural Competence: Demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes.
- Client Driven Mental Health System: Includes the ongoing involvement of clients (and participants in prevention programs) in roles such as, but not limited to, implementation, staffing evaluation and dissemination.
- Family Driven Mental Health System: Includes the ongoing involvement of family members in roles such as, but not limited to, implementation, staffing, evaluation and dissemination.
- Wellness, Recovery and Resiliency: Increases resilience and/or promotes recovery and wellness.
- Integrated Service Experience: Encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members.

**What is the Scope of Innovation?**

Innovative projects may address issues faced by children, transition age youth, adults, older adults, families, neighborhoods, communities, counties, multiple counties, or regions. As long as the Innovative project contributes to learning and maintains alignment with the MHSA Essential Elements it may affect any aspect of mental health practices or assessment of a new application of a promising approach to solving persistent, seemingly intractable mental health challenges.

Possible Innovative Projects (outside of practices/approaches currently considered part of mental health) proposed projects might have an impact on:

- Administrative/governance/organizational practices, processes or procedures
- Advocacy
- Education and training for service providers (including non-traditional mental health practitioners)
- Outreach, capacity building and community development
- Planning
- Policy and system development
- Public education efforts
- Research
- Services and/or treatment interventions

**Innovation Decision Path for Counties**

The following are key decisions counties need to make, through their community program planning, regarding their Innovation component of the Mental Health Services Act (MHSA). Counties won't necessarily consider the decision points in a prescribed order.

Issue for County	Barrier	Essential Purpose for Innovation (MHSA)	County's Learning/ Change Goal	Innovative Mental Health Practice/ Approach to Test
What significant, local challenge (consistent with the one or more of the four MHSA purposes) does the county want to address by piloting and evaluating a new/ changed mental health approach?	What (besides funding) has prevented the county from meeting this challenge? Why are existing (in the field of mental health) approaches lacking, insufficient, or inappropriate?	Which of the four MHSA Innovation purposes for Innovation is the primary area of intended change and learning? (Note that all four are likely to be the focus of improved service if Innovation is successful)	What will the county and the field of mental health learn by piloting this new or changed practice? How will the county measure the impact (mental health outcomes) of the Innovation and the key elements that contributed to successful outcomes?	What specific new, adapted, or adopted mental health practice or approach does the county want to try out as its vehicle for learning? If the Innovation is successful, what practice will the county continue (without Innovation funding)? How is the practice consistent with applicable MHSA General Standards?

**Issue for County**

- Issue to be addressed by Innovation funding, to be selected by community planning that focuses on priorities for piloting new/adapted mental health practices. Ideas for relevant Innovations can be generated from various sources, including previous community program planning.
- Writing Work Plan: Describe basis for selection of Innovation in *Community Program Planning* section of Work Plan.
- Guidelines: "INN projects may address issues faced by children, transition-age youth, adults, older adults, families (self-defined), neighborhoods, tribal and other communities, counties, multiple counties, or region."
- Issue can be any element of mental health, not just direct services

**Barrier: Why aren't we doing this already?**

- The Innovation should address a community mental health challenge for which there are no existing approaches (in the field of mental health) or existing mental health approaches are not relevant to the county's need for some specific reason
- Community program planning analyzes barriers (why we need to try out a new/changed approach) from perspectives of diverse, representative participants, informed by data and previous community planning discussions.
- If the county already knows, based on research or other evidence, that the proposed approach is likely to be successful and the main/only barrier is lack of funding, then Innovation is not an appropriate source of funds.
- Writing Work Plan: Addressing why existing mental health approaches don't exist or aren't relevant to county's goals can be relevant to several Work Plan sections: e.g. *Community Program Planning, Contribution to Learning*
- Guidelines: "As long as the INN project contributes to learning and maintains alignment with the MHSA General Standards...it may affect virtually any aspect of mental health practices or assessment of a new application of a promising approach to solving persistent, seemingly intractable mental health challenges."

### Essential Purpose for Innovation

- Typically learning goals cluster around a *single* Essential Purpose. It is useful to select one priority Essential Purpose even if, from a service perspective, the proposed mental health practice/approach will affect all four Essential Purposes.
- Writing Work Plan: Selected Essential Purpose is relevant to most sections of work plan, including *Project Measurement*.
- Guidelines: "Counties must select one or more of these purposes for each INN project. The selected purpose(s) will be the key focus for learning and change."

### County's Learning/Practice Change Goal

- Useful questions: What will the county learn about new/changed mental health practice and how will the learning be applied? What will be different (in the county and in the field of mental health) if the Innovation is successful?
- How will the county determine if the Innovation should be replicated? What aspects of the Innovation should be replicated? What are the best ways/areas to apply this Innovation?
- How will community members expected to benefit from the Innovation contribute to refining and answering learning questions?
- Learning/change goals and outcomes should be consistent with the selected Essential Purpose for Innovation.
- Writing Work Plan: County should include: a) brief statement of learning/practice change goal in *Project Description*; b) discussion of expected learning/change in *Contribution to Learning*; c) timeframe for learning and communicating results in *Timeline*; d) proposed outcomes and measurement of learning goals in *Project Measurement*.
- Guidelines: "An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service."

### Mental Health Practices/Approaches County Wants to Try Out

- Selected mental health practice/approach must be consistent with Essential Purpose and learning/change goals.
- Selected mental health practice/approach must meet all applicable MHSA General Standards. (Standards that could apply, apply).
- Writing Work Plan: In *Project Description*, explain how mental health practice/approach meets definition of Innovation (see below), including which element of definition applies. If County is proposing an adapted mental health practice, specify which specific elements are new/changed and contribute to learning.
- In *Project Measurement*, include a discussion of how the County plans to measure the impact of the new practice (new/changed elements of an adapted practice). Describe participants and other stakeholders will participate in the review and assessment.
- Guidelines: "INN projects are novel, creative and/or ingenious mental health practices/approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals." "By providing the opportunity to 'try out' new approaches that can inform current and future practices/approaches in communities, an Innovation contributes to learning...."
- Guidelines: "Selected mental health practice/approach must contribute to learning in one of three ways: 1) Introduces new mental health practices/approaches including prevention and early intervention that have never been done before, or 2) makes a change to an existing mental health practice/approach, including adaptation for a new setting or community, or 3) introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings."
- Guidelines: "An established practice that is new to the County and otherwise unchanged cannot be funded under the Innovation component."

## **Innovation Answers these Questions**

### **Primary Purpose**

1. What is the community's need for this service? Why are existing approaches inappropriate or lacking so the county needs to create/adapt a new approach?
2. Why is the selected primary purpose the focus of Innovation (whatever is new or changed) and therefore a key element of what the county will measure?
3. Optional: in addition to the selected primary purpose, what other purposes will the service meet, if successful?

### **Program Description**

1. What are the key elements of the program and which of these are new/changed compared to established mental health practice? How will these program elements allow the county to test the key learning goal?
2. Which program elements are known now and which will be developed during the course of the Innovation?
3. How will this program (not planning for this program) specifically meet General Standards, with brief examples? If a specific General Standard doesn't apply, why does it not apply?

### **Contribution to Learning**

1. Which Innovation definition does this program meet and why (how do you know)? Specifically how is this approach new to mental health or adapted from existing mental health practice? If this program is an adapted mental health practices, what specific elements differ from common mental health practice (not practice in the county but in the field) and why?
2. What are the county's learning goals with regard to whatever is new or changed compared to existing mental health practice?
3. What are the expected outcomes and the key questions regarding program elements that might bring about these outcomes?

### **Program Measurement**

1. How will the county measure each learning goal, both expected outcomes and determining which elements of the program contributed to these outcomes and therefore will be recommended for adoption and replication?
2. How will community members, especially program participants, be involved in all stages of assessing Innovation?

### **Timeline**

1. What is the timeline for reaching a conclusion about the viability of the Innovation and communicating the results to others?
2. How long will determining the viability of the approach take and what are the key steps along the way?

## 12 Aspects of Staff Transformation

By Mark Ragins, MD

There is a lot of talk about transforming our mental health system into a consumer-driven recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff will require a proactively guided process of staff transformation to succeed. This paper describes 12 aspects of staff transformation.

1. Looking Inward and Rebuilding the Passion: Recovery work requires staff to use all of themselves in passionate ways to help people. It cannot be done effectively in a detached routinized way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, staff has to look inwards to remember why our hearts brought them into this field in the first place. For many staff, our hearts have been buried under bureaucracy, paperwork, under-funding, frustrations, and burn out. Staff must be nurtured, encourage to play and explore, to bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must effectively promote their staff before further transformation can occur.
2. Building Inspiration and Belief in Recovery: Staff spend the vast majority of our time and emotions on people who are doing poorly or in crisis. We neglect the stories of our own successes and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and also known in darker times. We also need to be familiarized with the extensive research documenting recovery and the concept of the "clinicians' illusion" that gets in the way of us believing in this research. Ongoing experiences of people achieving things we "know are impossible" are crucial.
3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives: Recovery staff treat "people like people" not like cases of various illnesses. The pervasive culture of medicalization is reinforced by the infrastructure. Goal setting needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.
4. Moving from Caretaking to Empowering, Sharing Power and Control: Staff have generally adopted a caretaking role towards people with a mental illness. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and mentally ill people are comfortable with them. Analogously, to how parents must stop being caretakers for our children to become successful adults, staff must stop being caretakers for people we work with to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns that become involved as staff try to become more empowering. There may also be personal issues around power and control. Most staff feel most

efficient and effective when we are in control and people are doing what we want them to. Especially when facing repeated failures, or crisis, frustration is likely to grow. We are likely to reject collaboration and want to take more power and control.

5. **Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles:** Recovery requires breaking down the “us vs. them” walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. Working alongside mentally ill people as peers (not as segregated, second-rate staff) is probably the single most power stigma-reducing and transforming experience for staff. For people with mental illness to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups, art shows, etc., where staff and mentally ill people interact in different roles.
6. **Valuing the Subjective Experience:** Staff have been taught to observe, collect and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve this collaborative partnership, staff must appreciate not just what’s wrong with a person, but how that person understands and experiences what’s happening. Knowing what it would be like to be that person, what they’re frightened off, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, “case conferences” (shouldn’t these be “people conferences?”), team meetings, and supervision all should value subjective understandings.
7. **Creating Therapeutic Relationships:** Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, treatment prescription, and treatment compliance. Staff can be interchangeable, professionally distant, even strangers, so long as the diagnosis, plan and compliance is preserved. Recovery work relies on the same foundation as psychotherapy: (1) an ongoing trusting, collaborative, working relationship, (2) a shared explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person’s goals together. Staff need to gain, or regain, these skills. Program designs must prioritize relationships so staff can create and maintain relationships.
8. **Lowering Emotional Walls and Becoming a Guiding Partner:** People repeatedly tell us that we are the most helpful when we re personally involved, genuinely caring, and “real”. Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance come together against lowering emotional walls. Staff needs lots of discussion and administrative support to change in spite of these strong contrary forces. To best support a person on their path of recovery, staff need to act not as detached experts giving them maps and directions, but to actually become involved, walking alongside them as guides, sharing the trip, even growing and changing themselves on the trip. Staff’s emotional and physical fears of the people we work with need to be dealt with as well as to lower the walls.
9. **Understanding the Process of Recovery:** Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed, treated, symptoms relieved, and function regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a very different process - the process of recovery. Analogously to the grief process hospice works with, the recovery process can be described by a series of 4 stages: (1) hope – believing something better is possible, (2) empowerment - believing in ourselves, (3) self-responsibility - taking actions to recover, and (4) attaining meaningful roles apart from the illness. As hospice staff help people die with dignity, recovery staff help people live with dignity. Staff

need to grow in their understanding of the recovery process and build their skills in promoting recovery.

10. **Becoming Involved in the Community:** Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, to find their niches. Recovery cannot be achieved while people are segregated from their communities or protected in asylums. To support this, staff must work in the community. We can't be segregated from our communities or act solely as protectors in asylums. We need to be welcomed and valued and to find our niches. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.
11. **Reaching Out to the Rejected:** Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well with the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight". Each of these people has different serious obstacles to engagement and treatment, and staff often have serious prejudices against them. A "counter-culture of acceptance" needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. The system transformation will not be considered a success if we continue to reject these people in need.
12. **Living Recovery Values:** "Do as I say, not as I do" is never a good practice. When the walls and barriers are reduced and emotional relationships enhanced in a good recovery program, it's even harder to hide. Staff must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. When staff are working based on our personal core gifts, the people we're working with will more likely respond based on their personal core gifts. In recovery, the same rules and values apply to all of us.

By describing these 12 aspects of staff transformation I have tried to create both a proactive curriculum for staff transformation and a guide for recovery oriented leaders to use in program design, supervision, and staff support.

Footnotes

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<sup>i</sup> Ken Braiterman, Peer Support in CMHC's is an Oxymoron, Peer Support Pioneer says. Mad in America, July 19, 2012.

<sup>ii</sup> Peer Support and Peer Providers: Redefining Mental Health Recovery. Presentation September 21, 2010, <http://www.promoteacceptance.samhsa.gov/>, page 44

<sup>iii</sup> Peer Support and Peer Providers: Redefining Mental Health Recovery. Presentation September 21, 2010, <http://www.promoteacceptance.samhsa.gov/>, page 47