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Position of the California Network of Mental Health Clients (CNMHC) on Client Involvement in Local Mental Health Services Act (MHSA) Stakeholder Planning and Implementation

Overview

Client involvement is not only vital to an effective and inclusive Mental Health Services Act (MHSA) stakeholder process, but is mandated by the Act. This paper focuses on client involvement in MHSA planning and implementation of programs at the local level.

Clients have invested a great deal of time and effort into the MHSA and in developing and disseminating many of the principles that were ultimately written into the Act. For decades, California's mental health clients have called for the State's broken, crisis-based mental health system to be transformed into one that upheld client values of hope, recovery, self-determination and choice. In 2003, clients played a historic role in drafting some of the language of the initiative that would become the MHSA, working in partnership with family members, service providers and community advocates. That year, the Membership of the California Network of Mental Health Clients (CNMHC) voted to make the initiative our highest public policy priority. Clients around the State gathered thousands of voters' signatures to qualify the initiative, and then campaigned tirelessly for Proposition 63, in hopes that if voters approved it, its implementation would ultimately bring about the systems transformation that clients and other stakeholders envisioned.

The promise of a client-driven systems transformation

Central to our ability to achieve this transformation is the stakeholder process, as outlined in the Act. Prior to Prop 63's passage in November 2004, clients' role in local mental health policy planning and implementation was generally limited to an advisory capacity as members of local mental health boards and commissions (MHB/C) and public comment at meetings of MHB/C and Boards of Supervisors (BOS), along with offices of consumer affairs in some county mental health agencies and a limited number of state-level appointed positions on the California Mental Health Planning Council and the State Department of Mental Health (DMH) Client and Family Task Force.

In July 2003, the President's New Freedom Commission (NFC) recommended that in order to improve consumers' access to quality care and services, mental health systems should transform to a recovery model in which "mental health care is consumer and family driven" and systems "[i]nvolve consumers and families fully in orienting the mental health system toward recovery." Echoing the NFC's recommendations, the MHSA statutes, if approved by voters, would call for every county seeking to develop new and expanded programs for MHSA funding to conduct a stakeholder process of unprecedented breadth and inclusiveness, built upon principles of client and family involvement in all aspects of planning, implementation, oversight and evaluation. In September 2004, in eager anticipation of Prop 63's passage, the CNMHC proactively released a position paper outlining our priorities for the implementation of the Act, in which we stated:

Overarching all of the CNMHC's recommendations is the essential involvement of consumers in every aspect of the implementation of the Mental Health Services Act; starting with its planning, moving on to its execution, then to the oversight and evaluation. ⁱ

To this end, the Act now provides the following:

1. "Each plan and update shall be developed with local stakeholders including adults and seniors

with severe mental illness [and] families of children, adults and seniors”.ⁱⁱ

2. “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers”, including key recovery concepts of personal empowerment, respect, and self-determination, the promotion of consumer-operated services, reflecting the cultural, ethnic and racial diversity of mental health consumers, and planning for each consumer’s individual needs.ⁱⁱⁱ
3. “The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process”.^{iv}
4. “The administrative costs shall include funds 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”.^v
5. “[S]uccessful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.”^{vi}
6. The DMH Education and Training Five-Year Plan must include:
 - a. “Promotion of the employment of mental health consumers and family members in the mental health system”.
 - b. “Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs”.^{vii}

The Act also builds transparency into the process, stating that:

7. “A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.”
8. Each local mental health board “shall conduct a public hearing on the draft plan and annual updates at the close of the 30–day comment period”.^{viii}

Over the course of the first year following MHSA’s passage, the DMH conducted an intensive state-level stakeholder process in which many clients representing the CNMHC actively participated, working in collaboration with family members and individuals and organizations representing other stakeholders, to provide input into the Department’s requirements for the Community Services and Supports (CSS) component. These requirements were then rewritten, revised and issued as a set of emergency regulations, which remained in effect until the DMH proposed that they be made permanent. Following a public comment period, some further revisions and approval by the Departments of Finance and Office of Administrative Law, the MHSA-2 Regulations became permanent. These regulations codified and expanded upon many of the client principles that were incorporated in the CSS Requirements, stating that each county seeking MHSA funding is responsible for ensuring that:

9. Clients, family members, and individuals and family members representing unserved/underserved populations, and other stakeholders, have the opportunity to participate in the Community Program Planning Process.
10. Stakeholders, including clients and family members, who reflect the diversity of the demographics of each County, including but not limited to geographic location, age, gender, and race/ethnicity have the opportunity to participate.
11. Outreach is conducted to clients and families to ensure the opportunity to participate.^{ix}

12. Clients are involved in all aspects of the planning process.
13. Training is offered, as needed, to clients who are participating in the planning process.^x
14. “Client Driven” and “Wellness, Recovery and Resilience Focused” are adopted as general standards in MHSA program planning, implementation and evaluation.^{xi}

Roadblocks to transformation

Despite the lofty aspirations set forth in the MHSA statute and regulations, in the four years since the first round of local CSS planning began, the CNMHC has received widespread reports of a lack of meaningful stakeholder input into county MHSA planning processes. Mental health clients in many counties throughout the state have reported great frustration, discouragement and despondence over a number of roadblocks to client inclusion and participation in the local MHSA planning process. These barriers include:

1. **Roadblocks to clients’ ability to access the planning process.** Clients often have difficulty accessing meetings held in remote locations. Public access to MHSA Plans is often limited. Plans are often pre-developed by county staff, rather than in collaboration with stakeholders. Too much planning funding goes to highly paid consultants, rather than to peer outreach and engagement efforts, travel funds or stipends to increase client participation. Many county stakeholder processes have become inactive, despite on-going MHSA planning needs.
2. **Disrespectful treatment of clients who participate in the planning process.** Unresolved power differentials exist that prevent true collaboration. Too few clients are appointed to steering committees. Tokenism in client participation is evident in many counties. Clients’ input at meetings is often ignored. When clients are chosen for leadership roles, they are often picked by county officials rather than selected by their peers. Language access barriers often prevent clients and family members from participating.
3. **Retaliation in response to complaints.** When clients who receive or seek services from, work for or contract with local mental health agencies participate in, file a complaint about, openly express disagreement with or even ask a question about the local MHSA process, plan or program implementation, they risk being made the target of retaliatory actions. Such actions, ranging from being removed from MHSA steering committees, mental health boards and other planning bodies to harassment in or termination of services or employment – as well as the threat, stated or implicit, that such actions will be carried out – have had a silencing effect on many client voices.
4. **Divisive treatment of clients in the local MHSA bidding process.** Long-established client-run self-help programs staffed entirely by clients that have bid for MHSA funding have often received little or no MHSA funds, while newly launched, county-run wellness/recovery programs in the same counties, staffed by a mix of clients and non-client clinicians, have often received much more funding. This trend, along with the selection of client leaders by county officials, has been named frequently by clients as contributing to favoritism towards clients who have been picked as leaders, creating rifts between groups of clients in a county or region who only recently worked together on projects in a supportive, non-competitive way.
5. **Inconsistent quality of plans.** The lack of quality control in the stakeholder process results in wide variability in the quality of plans, and there appears to be widespread reluctance to reject poor quality plans. Clients report a lack of quality assurance in review processes of the plans once they are developed. This problem seems to be especially widespread with county Workforce Education and Training (WET) plans.
6. **Challenges to inclusion of racial, ethnic and cultural communities.** In February 2008, the DMH convened a meeting with agency representatives including the CNMHC, United Advocates for

Children and Families (UACF), the National Alliance on Mental Illness (NAMI) California, and a workgroup cultural brokers representing racial and ethnic communities. The cultural brokers workgroup discussed, in depth, what worked in the MHSA process, identifying four main themes related to the inclusion of racial, ethnic and cultural communities:

- A. Challenges to inclusion of racial, ethnic and cultural communities in stakeholder processes.
- B. A lack of transparency and improved communication on when meetings are held.
- C. A lack of trust in the decision-making process.
- D. Overall issues with the stakeholder implementation process.^{xii}

These roadblocks are seen as not only impeding client involvement in the planning of MHSA programs, but standing in the way of progress in the transformation of mental health systems to a client-driven model that upholds principles of wellness, resiliency, self-determination, choice, cultural and linguistic competency. Faced with a new sense of divisiveness and competition within the client community that was less marked or non-existent before the MHSA, with many clients who are newcomers to policy work with great passion and enthusiasm getting traumatized by a process they find actively antagonistic to their involvement and their recovery, some long-time client advocates and early self-help pioneers have given up all hope of achieving any client-driven system transformation through the MHSA, concluding that the process only harms clients and the self-help/peer support movement.

The MHSA has promised great leaps of collaboration and transformation, but too little of this promise has materialized for most clients. Many who have endeavored to get involved or who have taken newly created jobs in the mental health workforce and found the workplace hostile and unsupportive, have wound up homeless, in jails and hospitals, having seemingly followed the reverse trajectory of the “recovery success stories” that sold the MHSA to the client movement in 2004.

Glimmers of hope on the horizon

These concerns notwithstanding, the CNMHC recognizes that there has been some progress made in state and local mental health agencies, who have taken concrete steps towards transforming and integrating the mental health workforce and policy-making bodies from within. We honor and applaud the leadership roles that clients and family members have taken on and continue to fulfill on the Mental Health Services Oversight and Accountability Commission (OAC) in their capacities as Commissioners, including both Chair and Vice Chair, as well as staff and consultants. We appreciate that client representation in the OAC has somewhat increased by appointing some consumers/survivors as non-Commissioner members of various standing Committees, Workgroups and Technical Resource Groups. We further acknowledge that the agency did choose several members of the CNMHC to fill these positions.

Likewise, the California Mental Health Planning Council has shown leadership in its inclusion of clients among both Council Members (including the Chair) and staff (including the executive staff). And the California Mental Health Directors Association has similarly included persons with lived experience in the mental health system in key staff and executive board positions. The CNMHC acknowledges these advancements and their positive impact on client involvement in the MHSA.

We recognize as well that the California Department of Mental Health (DMH) has made significant strides in terms of incorporating wellness/recovery principles into its *CSS Requirements* and hiring a small number of consumer/survivor consultants on its CSS Plan Review Team, Client/Family Pool of Experts, and several staff in the capacities of Consumer/Family Liaison and Associate Mental Health Specialist (involved in planning for and implementation of the Mental Health Service Act and with

drafting relevant documents). Many of these peers have often been extraordinarily helpful and insightful, although their duties thus far have not been central to MHSA planning or implementation.

Finally, some of the counties have also hired clients who openly serve their peers in full-time positions that utilize their first-hand expertise. We hope to see many more counties follow suit. We also want to caution counties that hiring consumers within a department should by no means serve as a substitute for ongoing support of client-led self-help programs through contracts, and these contracts should be of equal or greater scale with non-client professional contracting agencies.

However, some of the key recommendations of the CNMHC in 2004 regarding full and meaningful prioritization of client participation at every level and stage of the implementation process have not been adopted thus far in planning local stakeholder processes. For many clients and survivors, especially those from unserved and underserved communities, a stakeholder process that has been all too often inaccessible and exclusionary has resulted in a growing distrust for the MHSA and its potential for transforming clients' grim daily reality of stigma and discrimination.

This barricade to transformation must end if the MHSA goals of truly transforming the mental health system are to be achieved. With the highest goals and principles of the client movement and the Act in mind, we have developed the stakeholder process recommendations below.

Overcoming roadblocks to transformation: Recommendations

Recognizing and ending the prejudice and discrimination that have plagued the MHSA stakeholder process over the past three years, the following recommendations aim to promote full and meaningful client participation at every level of the stakeholder process.

Counties should work together with clients to implement the following changes statewide:

1. Stakeholder outreach and engagement

- a. **Peer outreach workers and education specialists.** Primary attention should be given to hiring and training client/survivor peer MHSA stakeholder outreach workers and MHSA education specialists at the local level who represent unserved and underserved ethnic, cultural, age and disability groups that have been thus far underrepresented at stakeholder meetings.^{xiii}
 - i. Peer outreach work should involve brief one-on-one contact with clients/survivors from each unserved/underserved community in culturally specific settings, as outlined in the State DMH's *Community Services and Supports Three-Year Program and Expenditure Plan Requirements* for county mental health departments under Outreach and Engagement Funding.^{xiv xv}
 - A. Outreach workers should go into their respective communities on an ongoing basis and talk to other persons who are seeking, receiving, have tried to access or have received mental health services, persons who have been coercively or forcibly treated as outpatients or in hospital settings, and those who have recently exited foster homes, juvenile and criminal justice systems, hospitals or other institutions and who may be homeless.
 - B. Once initial contacts are made and dialogue is established, the term *stakeholder engagement* should be used in the sense of "encouraging people to engage in the planning and implementation process", as distinct from simply connecting people with services.
 - ii. Peer MHSA education specialists' work should involve planning, coordinating and presenting educational training events on an ongoing basis.

- A. These ongoing training events must serve as culturally and linguistically appropriate sounding boards for unserved and underserved community members to communicate their specific issues and concerns
 - B. The training events should offer useful resources and skills that empower clients to participate meaningfully in the MHSA planning process, from designing new culturally competent programs that would serve their communities to implementing, overseeing and evaluating these programs.
- iii. Counties should contract with client-run organizations to assist in the hiring and training of these peer outreach workers and MHSA education specialists in each county, and to assist in the educational training events.
 - iv. Client/survivor peer MHSA outreach workers and MHSA education specialists may be separate positions or combined, but the positions should be salaried .5 or 1.0 FTE jobs with additional funding for office and meeting space, transportation and materials.
 - A. These positions must be restricted to people with lived experience in the mental health system, with background in one or more unserved/underserved communities as defined above.
 - B. Community involvement, fluency in each county’s threshold languages, both spoken and written, and experience in the MHSA stakeholder process should be desired qualifications.
 - C. Educational requirements should be limited to high school diploma, GED or equivalent, as any requirements over and above this level are unnecessarily restrictive and tend to exclude clients.

2. Meeting attendance

- a. **Travel scholarships.** Counties must prioritize consumer/survivor scholarships to pay for the cost of travel, ground transportation, and meals for low-income people representing unserved/underserved communities (as defined above) who wish to attend stakeholder meetings on the state and local level.
- b. Peer outreach workers should be given detailed instructions, basic informational flyers and simple scholarship application forms in the appropriate languages, so as to allow clients/survivors or outreach workers to easily fill out and return to the county via email, fax, US mail, or hand delivery.

3. Makeup of local steering committees and other planning bodies

- a. **A client- and family-driven process calls for majority representation.** Taking our cue from local mental health boards and commissions, a minimum of fifty (50) percent plus one (1) clients and family members (including parents or caregivers of children or youth) should be required in the membership of all local steering committees and other stakeholder decision-making bodies before those bodies can be permitted to make legally binding decisions regarding plans. No less than twenty-five (25) percent plus one (1) of the total membership and no less than fifty (50) percent plus one (1) of the client and family membership should be comprised of clients/survivors.

4. Employment of client consultants and experts at the state and local levels

- a. **Clients/survivors should be consistently hired** as consultants and experts, both in-house and out-sourced, for all MHSA activities conducted by state-level agencies including the CA DMH, Planning Council and OAC.
- b. Counties should hire clients/survivors as consultants and staff, both in-house and out-sourced, at *all* levels and in *all* aspects of local MHSA planning and implementation.
- c. Priority should be given to hiring clients/survivors who represent one or more

unserved/underserved communities as defined above.

- i. Community involvement, fluency in each county's predominant non-English languages, both spoken and written, and experience in the MHSA stakeholder process should be desired qualifications, and educational requirements should be limited to high school diploma, GED or equivalent.
- d. Again, counties should contract with client-run organizations to assist in the hiring and training of these consultants on both the state and local levels.
 - i. The CNMHC Office of Self-Help/Technical Assistance and Support Center has begun to assemble a pool of client experts who are well suited for these positions.

5. Quality assurance

- a. **In planning process design and rollout.** Start-up problems with stakeholder processes have been widely reported across the state since the inception of the MHSA. However, we are now well into implementation of the Act, and by all indicators the stakeholder processes are appearing to become even less robust in many counties. CNMHC recommends that the OAC immediately undertake leadership of a quality improvement process with these goals:
 - i. Understanding and disseminating county planning processes that result in a high degree of stakeholder satisfaction.
 - ii. Training of stakeholder and county leaders together in facilitation and process techniques that result in successful planning processes.
 - iii. Sanctions of poor county planning processes that are inconsistent with the requirements of the Act.
- b. **In plan writing.** We are past the initial phase of the MHSA, when the difficulty of managing the process resulted in collegial approval of plans even when their quality was below acceptable standards.
 - i. We support a strengths-based approach that provides technical assistance and supports to counties who have difficulty developing quality plans.
 - ii. However, it is essential for those agencies charged with approval of plans to reject plans that fail to meet quality standards.

6. Cultural and linguistic competency

- a. **Multi-ethnic coalition.** As recommended by the cultural brokers at the DMH Stakeholder Process Workgroup meeting in February, the DMH should approve and support the creation of a multi-ethnic coalition of members who have expertise in areas related to multi-ethnic/cultural communities, who represent, or who work with racial, ethnic and cultural groups. This coalition and its members will be recognized as a key stakeholder and will be represented in all MHSA workgroups and committees related to MHSA programs and funding.
 - i. **Staffing, funding, and infrastructure.** The DMH should dedicate and identify a staff member to coordinate, organize and convene such a coalition and to fund travel, a meeting place and other associated expenses or to contract with a entity from the community to perform these tasks.
- b. **Racial/ethnic and culturally specific stakeholder processes.** Counties should create racial/ethnic and culturally specific stakeholder processes for MHSA, which should be headed by their ethnic services managers.
 - i. **Increase representation of racial, ethnic and cultural communities in stakeholder process at all levels.** This should include recognition of the languages spoken in diverse communities.

- c. **Develop on-going relationships and co-operative arrangements** such as representation on decision-making bodies with ethnic, racial, and cultural communities, in order to build capacity and to hear the voices of these diverse communities. Single meeting/focus group opportunities for stakeholder input are not sufficient.
- d. **Need for resources to support the ongoing development** and voices of diverse communities beyond these recommendations.^{xvi}

The California Network will soon be taking a look at the results of our annual MHSA client involvement survey for the third year in a row. We are still compiling data from last year’s survey as well as our survey of counties on issues affecting client employment. We look forward to reporting on our findings later this year.

For the MHSA stakeholder process to truly succeed, for the road to transformation to be free of blockades, it must uphold self-determination and choice, cultural and linguistic competency, and peer-run self-help and mutual support programs, along with meaningful consumer employment at every level of the mental health system. As the eyes of the world watch California’s experiment unfold, it is up to our counties and state agencies to provide adequate funding to encourage networking and community building among unserved and underserved client groups, allowing them to reach consensus on common goals and collectively take their seats at the stakeholder tables. Only then can true transformation and healing take place.

ⁱ California Network of Mental Health Clients (CNMHC), “Position Paper on the Implementation of the Mental Health Services Act”, September 2004.

ⁱⁱ Mental Health Services Act of 2004 (MHSA), Section 10, Part 3.7, Oversight and Accountability, added to California Welfare and Institutions Code (WIC), Division 5, Section 5848 (a).

ⁱⁱⁱ MHSA, Section 7, WIC Section 5813.5 (d).

^{iv} MHSA, Section 15, Mental Health Services Fund, WIC Section 5892 (c).

^v MHSA, Section 15, WIC Section 5892 (d).

^{vi} MHSA, Section 2 (e).

^{vii} MHSA, Section 8, WIC Section 5822 (g) and (h)

^{viii} MHSA, Section 10, WIC Section 5848 (a) and (b).

^{ix} California Code of Regulations, Title 9, Division 1, Chapter 14, Sections 3200.040, 3200.050, 3200.270, 3300 (a), (b) (3), (3) (A), (4) and (5).

^x CA Code of Regulations, Title 9, Division 1, Chapter 14, Section 3300 (c) (1) and (3).

^{xi} CA Code of Regulations, Title 9, Division 1, Chapter 14, Section 3320 (a) (3) and (5).

^{xii} Connie Reitman, Suzanna Gee, “Including Racial, Ethnic and Cultural Communities in the MHSA Stakeholder Process”, presented at a meeting of the DMH Stakeholder Process Workgroup, Feb. 27, 2008.

^{xiii} The term *unserved/underserved communities* must include communities of color, immigrant and Native American communities, lesbian, gay, bisexual, transgender, queer and questioning people, people with experience in the foster care, juvenile and criminal justice systems, and people who are homeless, recently homeless and at risk of becoming homeless.

^{xiv} California Dept. of Mental Health, *Mental Health Services Act Community Services and Supports Three-Year Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08*, August 1, 2005, Pp. 32, 37.

^{xv} *Culturally specific settings* may include (but are not limited to) Native American reservations, rancherias and urban community centers, churches and other religious and cultural centers in African American, Latino and Asian American communities, recreation centers and after-school programs for youth, homeless people on city streets, homeless shelters and transitional housing programs for young people, single adults and families, single-room-occupancy (SRO) hotels, residential psychiatric or drug/alcohol treatment programs, board-and-care facilities, hospitals, jails and nursing homes.

^{xvi} Reitman, Gee, “Including Racial, Ethnic and Cultural Communities”.