

Transformation of the Mental Health System Through Client and Family Leadership DRAFT

**Developed by the California MHSOAC Client and Family Leadership Committee
With an Introduction by MHSOAC Commissioner Eduardo Vega**

Introduction

Over the past several decades, the United States has made broad progress in advancing mental health policy on a national systemic scale. With the publication of the Surgeon General's Report on Mental Health in 1999, the Supreme Court's decision in Olmstead in 1999, major advances in services and supports, policies, programs and protections for people with mental health issues and their families have been articulated nationwide. In 2003, the President's New Freedom Commission Report, entitled *Achieving the Promise: Transforming Mental Health Care in America*¹, informed by clients and family members throughout, issued a bold challenge for massive change to the way mental health services are conducted, designed and discussed.

Meanwhile, in California, parallel efforts and promising programs held out the possibility of realizing such change if they could be implemented across the state. Many of these innovative efforts, spearheaded by advocates and such leaders as then, Assembly Member, later-Senate President Pro Tempore, Darrell Steinberg, created mental health initiatives including Assembly Bill (AB) 34, AB 2034, and others. Building on the remarkable achievements of these projects, Proposition 63, the Mental Health Services Act (MHSA) was approved by the voters in 2004 to fund new mental health programs across the state. The MHSA was viewed across the nation even then as the first real agent of transformation, the way one state would show that the promise *could* be achieved.

The MHSA is seen by many as the culmination of client and family advocacy, the outcome of fifty-plus years' work on the part of advocates against the discriminative, inequitable, insufficient, unjust and, in some cases, abusive mental health practices of the past. The MHSA replaces this legacy with services and supports informed by a recovery model based in dignity and hope in which clients and families access and receive culturally competent services, and are fully empowered in their communities to move beyond the effects of even the most severe mental illnesses. With resources strategically keyed to resiliency for children, the recovery vision and other revolutionary principles, the MHSA stands out as the first large scale mechanism with the capacity to accomplish such massive change.

Still, many questions about "transformation" and the MHSA remain. How will we know, for instance, or *can* we know, if California's system has reached a threshold worthy of being called client-centered, family-focused and culturally competent? How would this transformed system differ from what previously existed and what we see today, especially

¹ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. DHHS Pub. No. SMA-03-3831. Rockville, MD: 2003.

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with many MHSA projects already underway? What would an efficient, responsive and integrated system of recovery-based mental health supports look like?

No discussion of progress in the arena of public mental health or social change in America is valid without acknowledgment of the role of race, culture and ethnicity. The many cultures and languages of California in particular require that broad-scale thinking on mental health transformation address client and family needs in the context of diversity and cultural-effectiveness. Not all cultures see mental health issues, symptoms or recovery in the same way. This, along with history of discrimination and racial injustice, has fostered systems in which disparities of access to and quality of care leave many communities underserved or inappropriately served. For the MHSA to achieve its objectives, people must be served in ways that are coherent with and respectful of differing cultural views and traditions.

Transformation has been defined as “a change in the state of affairs so comprehensive as to have been unpredictable from the outset”. The process of getting there, if it is to be real, must be holistic and dynamic. It is probably not a linear or incremental process, or the result of placing the right building blocks in the right places, but instead the interactive effect of many changes acting on each other simultaneously over time.

This document is not designed to measure transformation, or to chart a course towards that destination. Rather it should act as an atlas for that destination, a guidebook that plots with some detail how a world successfully transformed by MHSA values might appear-- the crucial elements we would expect to see there, and the changes the people of this new world would come to expect as natural and dignified supports for human wellness.

The California Mental Health Services Oversight and Accountability Commission (MHSOAC) was established to ensure that the innovations of the MHSA proceed in their ground-breaking course, and that the lived-expertise of clients, parents, family members and communities provide continuous guidance along the way. Will this lead to transformation? Some say no, some say it already has -- that the very presence of such groups as the Client and Family Leadership Committee (CFLC) are evidence to that effect.

What is certain is that the process initiated through the MHSA continues, that MHSA programs are effecting change across California, and that the crisis of budgetary, healthcare reform and other challenges ensures the pace of these changes will not slow. The hope of the CFLC is that further investigation and discussion about issues raised in this document will inspire increased client and family leadership as envisioned by the MHSA. If this MHSA vision is embraced it will result in more client/family member resources and more energy to engage the difficult and crucial work of transforming our communities into places where positive, dignified and effective mental health supports are available to all who need them and where personal wellness and health are embraced as a fundamental human right.

Eduardo Vega, Commissioner
Chair
Client Family Leadership Committee

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Background

The 2004 passage of California's Mental Health Services Act (MHSA) was viewed by mental health advocates everywhere as a watershed achievement culminating decades of effort to fundamentally re-design services and supports for people and families affected by mental illnesses.

While the need for such "transformation" has been recognized for some time -- first by advocates and then by public leadership, including the U.S. Surgeon General, the federal Department of Health and Human Services Administration, and the Substance Abuse and Mental Health Services Administration -- the vision of a client-centered and family-focused, culturally competent "recovery-model" system has eluded implementation in most of the country because funding for mental health services and supports has either been lacking, inflexible, or both.

The MHSA addresses and provides for many elements of a transformed mental health system, including significant stakeholder input in planning and service delivery, cultural and linguistic effectiveness, wellness/recovery/resiliency focused services and supports, housing, prevention and early intervention services, and resources for workforce education and training to enable these new programs to be realized. Now, more than six years since the MHSA was enacted there are multiple questions about transformation to explore. Are MHSA efforts in themselves effecting transformation? Should transformation be a goal of the MHSA at large? If an expectation of transformation is the goal, how will achievement of that promise be measured?

At the July 2010 MHSOAC meeting, Commissioner Vega made a presentation to the Commissioners, staff and others regarding client and family advocacy, perspective, history and priorities, with emphasis on the client and family role in transforming the mental health system through the Mental Health Services Act. Based on the Commission's interest in the subject presented, then-MHSOAC Chair, Andrew Poat, asked Commissioner Vega to direct the CFLC to draft a policy paper on how to account for system transformation from the client and family member perspective. This is entirely apt since, as envisioned by the MHSA, the most powerful resource for addressing these questions resides in the lived experience of clients, their family members and their communities.

The CFLC membership represents a broad spectrum of California stakeholders who have lived experience with mental illness and treatment personally or by family relationship. In addition to this expertise the CFLC is comprised of people from rural and urban communities, different linguistic and ethnic backgrounds, advocates, service providers, policy leaders, youth and older adults and people with multiple disabilities.

In response to its July 2010 charge, the CFLC convened to create the present discussion as a framework for examining, piece by piece, a whole vision of a transformed mental health system as seen by clients and families of people with mental illnesses, including those from underserved ethnic and cultural communities.

Over several months, the CFLC met to examine these questions and to articulate the crucial changes that would be necessary for a client-centered, family focused, culturally competent network of supports and services, as envisioned by the MHSA, to be realized.

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To advance more actionable discussions for program and policy-makers, the Committee used their process to identify barriers that would need to be overcome if transformation was to occur. This paper discusses the barriers identified and presents a vision of how things would look in a transformed system in several key areas relevant to mental health:

- Community Planning Processes
- Policymaking
- Cultural Competence and Effectiveness
- Mental Health Program and Service Delivery
- Housing
- Employment
- Education
- Prevention and Early Intervention
- Stigma, Abuse and Discrimination

The present discussion lays out in brief these major elements of a vision of a new reality that might easily take up thousands of pages. It points to specifics, none of which on their own would be sufficient to denote transformation, but all of which would be apparent in this transformed reality. Most likely, “true transformation” will only occur when these many pieces are dynamically interconnected in a truly new “system of care” which, in turn, transforms the social environment around it and creates a new world, or at least a world of vastly different possibilities for people affected by mental illness.

The CFLC examined major aspects of change, what these would look like in an ideal ‘transformed system’, MHSA statutory provisions/language relevant to this area, and goals associated with accomplishments or the elimination of barriers in this area.

Goals for Transformation of the Mental Health System Through Client and Family Leadership

Goals for Community Planning Processes:

- Mental health community planning activities are:
 1. always informed by the voices of persons with lived experience including those from underserved and/or inappropriately served cultural and ethnic groups and
 2. robust and ongoing regardless of fiscal issues.
- Clients and family members from served, underserved and/or inappropriately served community groups set local mental health goals and resource priorities.

Goals for Policymaking:

- Clients and families including those from underserved ethnic/cultural communities, drive mental health system policymaking.
- Mental health policy is informed by wellness/recovery/resiliency principles, the lived experience of clients and family members, including those from underserved and/or inappropriately served ethnic/cultural communities, community needs and values, and ongoing outcome evaluation.
- Clients and family members have active roles in ongoing local and statewide efforts to evaluate mental health services and analyze client and system outcomes.

Goals for Cultural Competence and Effectiveness:

- As a result of individuals from underserved and inappropriately served cultural/ethnic populations being employed by or working in collaboration with the mental health system at all levels:
 1. barriers to access for cultural/ethnic groups are diminished and a vision of wellness, recovery and resiliency is evident in communities of color.
 2. the mental health workforce is a blend of persons with and without lived experience including those from underserved and/or inappropriately served cultural/ethnic populations.
 3. the system and communities are fully informed and empowered to deliver mental health services that are culturally and linguistically appropriate.

Goals for Mental Health Program and Service Delivery:

- All mental health programs reflect wellness/recovery/resiliency model values and standards for service delivery.
- Services are always delivered with dignity and respect for the individual being served, are voluntary in nature and employ soft intervention modes.
- All clients and family members have access to culturally appropriate services and get what they need to recover in a supportive network of care that is integrated rather than fragmented.
- Clients and family members are fully empowered in program settings.
- Recovery-focused “client-run programs and family supports” are an integral part of the mental health system.

Goals for Housing:

- Quality, affordable housing is available for persons with mental illness or emotional disturbance and their families in all communities in California.
- Various types of housing assistance and supports, including but not limited to emergency housing, housing subsidies, Section 8 housing, master leased housing, shared housing and general affordable housing, is adequately available for individuals served at all levels in the mental health system.

Goals for the Employment of Clients and Family Members in the Mental Health System:

- Employment or other productive activity is an expectation and focus of service for clients regardless of their physical setting (i.e., residential or institutional setting). This includes support for clients and family members being employed in the mental health system or community workforce at all stages of recovery.
- Clients and family members, including those from underserved and/or inappropriately served cultural/ethnic groups, are employed in significant roles throughout the mental health system and in the community workforce.

Goals for Education:

- The mental health system views education and the necessary supports to advance job skills and return to the workforce as central to recovery and program design.

- Higher education programs exist across California offering certificate and other degree programs for persons with lived mental health experience in preparation for employment in the mental health system.

Goals for Prevention and Early Intervention:

- As a result of long term strategies and campaigns aimed at reducing stigma and discrimination toward persons with mental illness or serious emotional disturbance in California:
 1. there is a reduction in discrimination toward persons with mental illness or serious emotional disturbance.
 2. families, employers, primary care health care providers, school personnel and other community members are more likely to recognize the early signs of potentially severe and disabling mental illness and seek assistance.
- Prevention, Early Intervention (PEI) resources that include peer and/or family support, are sufficient and used effectively to reduce the negative outcomes of mental illness on individuals and communities and to increase timely access to services for underserved and/or inappropriately served populations.

Goals for Reduction in Stigma, Abuse and Discrimination:

- Stigma does not prevent persons from seeking help with mental health issues, family well-being, and personal recovery for the individual.
- Abusive, dehumanizing and demeaning practices are eradicated from the system of mental health care.
- Discrimination against people diagnosed with mental illnesses and their families is eliminated in health care settings, employment, housing, education, and social or civic activities.

Community Planning Process

The community planning process is integral to a mental health system understanding the impact of its various policies and procedures from the perspective of those being served and those not typically served. This includes persons from multiple backgrounds who are receiving services and those from ethnic and cultural populations that are underserved and/or inappropriately served. The MHSA clearly values the voices of clients and families² in all aspects of the mental health system and requires that Plans and Updates for MHSA funds shall be developed with adults and seniors with severe mental illness and families of children. As a result of the MHSA, counties in California have developed community planning processes that have involved thousands of stakeholders across the state. Despite this improvement and achievement in involving stakeholders in planning, there are still barriers to maintaining the momentum of this process and the continued interest and investment of stakeholders.

Because multiple planning processes occurred as the various MHSA components rolled out for Community Services and Supports, Prevention and Early Intervention, Workforce, Education and Training, Housing, and Innovation, many stakeholders experienced burnout over time. Continuing to engage and maintain the interest of stakeholders who have previously been part of the process, while reaching out to new stakeholders, is challenging. Although it becomes more difficult when combined with the fiscal crises currently facing Counties in California, it also becomes more essential for communities to plan in a way that will produce the best outcomes for the persons served which in turn translate to positive, cost efficient system outcomes.

In a transformed mental health system:

1. Local mental health departments are successful in continuously engaging stakeholders through the use of timely information and updates, community education, publicity and outreach, planned stakeholder meetings and strategies for motivation and reduced stakeholder burnout.
2. Fiscal problems do not translate to less of an investment in community planning and stakeholder involvement.
3. Opportunities for stakeholder input are characterized by open two-way communication whereby information is solicited and provided.
4. Outreach continues to increase to existing stakeholders and community groups, persons with lived experience including those from underserved and/or inappropriately served cultural/ethnic population groups, MHSA Advisory/Steering Committees, Mental Health Boards, mental health advocacy groups, law enforcement and the justice system including probation, educators, child welfare organizations, providers and non-profits.
5. Improved outreach to underserved cultural and ethnic populations is enhanced by the use of ethnic/cultural community partners in those communities.

² All references to clients and family members include those acting as caregivers and include clients and family members from underserved and/or inappropriately served cultural/ethnic populations.

MHSA Provision Related to Community Planning Process:

Welfare and Institutions Code (WIC) Section 5848(a) provides, in part, “Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests.”

Policymaking

Too often, in traditional mental health systems, policies and procedures have been developed without significant input from those with lived experience, namely clients and family members including those from underserved and/or inappropriately served ethnic and cultural communities. As a result, policies and procedures are sometimes developed without a belief in the recovery/resiliency model, without knowledge about the needs of specific ethnic and cultural populations, without outcome information and generally without information from key informants that could improve overall system outcomes. Frequently clients and family members lack the information and/or education to effectively participate in policymaking and are further discouraged by the tedium of meetings, the use of jargon or other confusing language, and the lack of interpretation services and translated materials for cultural/ethnic groups.

In a transformed mental health system:

1. Clients and family members, including those from underserved and/or inappropriately served cultural/ethnic population groups, are employed in the mental health system in policymaking positions.
2. Clients and family members not employed in policymaking positions, including those from underserved and/or inappropriately served cultural/ethnic population groups, are offered the information and education necessary to effectively participate in policymaking activities.
3. System resources are dedicated to policy positions for those with lived experience, advocacy training for clients and family members and mentorship of those leaders seeking to become policymakers.
4. Mental health policies are informed by ongoing local and statewide efforts to evaluate mental health services and analyze client and system outcomes. Clients and family members have active roles in all these efforts.
5. Clients and family members are frequently employed in the mental health system to collect various types of outcome data from individuals being served as part of local and/or statewide evaluation efforts.
6. The system provides opportunities for a continuous dialogue between stakeholders, decision makers and those implementing programs, listens to issues raised by clients and family members and incorporates their voices throughout the system.
7. As a result of a continuous dialogue and the information exchanged between policymakers and clients and family members, learning takes place among all participants and shifts in policy are implemented as appropriate.
8. Policymakers openly disclose themselves as clients and/or family members without fear of stigma and discrimination.

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9. Staff and others are sensitive to the use of jargon and other confusing language that may prevent client and family member participation and input.
10. Interpretation services and translated materials are available as required when policymakers, clients and family members are meeting to discuss policy issues.

MHSA Provisions Related to Policymaking:

1. WIC Section 5878.1(a) provides, in part, "It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family."
2. WIC Section 5822(h) provides, "The State Department of Mental Health shall include in the five-year plan: (h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f)."
3. WIC Section 5846(e) provides, "The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations."
4. WIC Section 5848(a) provides, in part, "Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests."

Cultural Competence and Effectiveness

No discussion of progress in the arena of public mental health or social change in America is valid without acknowledgment of the role of race, culture and ethnicity. The many cultures and languages of Californians in particular require that broad-scale thinking on mental health transformation address client and family needs in the context of diversity and cultural-effectiveness. Not all cultures see mental health issues, symptoms or recovery in the same way. This, combined with a history of discrimination and racial injustice, has fostered disparities in access to system services and disparities in quality of care for cultural and ethnic communities leaving them un-served, underserved and/or inappropriately served. For the MHSA to achieve its objectives people must be served in ways that are coherent with and respectful of differing cultural views and traditions.

In a transformed mental health system:

1. The mental health system has engaged and developed successful relationships with all of the cultural and ethnic communities who were historically underserved and/or inappropriately served.
2. There are mental health service providers and/or programs in every county from traditionally underserved and/or inappropriately served cultural and ethnic communities.

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3. What have been traditional disparities in access to mental health services for underserved and/or inappropriately served persons from cultural/ethnic communities have been eliminated.

For more detailed information about the MHSOAC's role and focus with regard to cultural and linguistic competence please refer to the Cultural and Linguistic Competence Group Workplan presented to the MHSOAC September 28, 2007 available at the following link:

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2007/CLCTRG_WorkplanPresentation_07Sep21.pdf

MHSA Provisions Related to Cultural Competence and Effectiveness:

1. Section 2(b) of the Findings and Declarations section finds in part "No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care."
2. Section 3(c) of the Purpose and Intent section identifies as one purpose and intent to "expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations."
3. WIC Section 5840 (a) provides that "the State Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations."
4. WIC Section 5813.5(d)(3) indicates county planning for services shall "reflect the cultural, ethnic and racial diversity of mental health consumers."
5. WIC Section 5822 provides for what the Department of Mental Health shall include in its 5-Year Education and Training Plan.

Included is the following:

- (i) "promotion of the inclusion of cultural competency in the training and education programs cited in subdivisions (a) through (f)."
6. WIC Section 5830(a)(1) provides that one purpose of Innovative Programs is to increase access to underserved groups.

Mental Health Program and Service Delivery

How mental health systems organize their programs and deliver mental health services and supports may be most significant in terms of effecting the personal recovery of the individuals and families they serve and overall system transformation.

To be successful, a sincere belief in recovery and resiliency must be both obvious and evident in mental health systems. Whether in community mental health and/or

inpatient/residential settings, nothing is more obvious than the words and actions of mental health staff; from Directors to administrators, to supervisors and direct line staff. If the words and expectations of those working in the mental health system are not consistent with recovery and resiliency, individuals and families being served by the system are less likely to achieve those outcomes. Actions must include providing services with dignity and respect for the individuals being served such as alternatives to seclusion and restraint and other soft intervention modes. Evidence of recovery is present in mental health systems when large numbers of persons with lived experience are employed in the system, client-run services are readily available and given support, and positive outcomes are documented as experienced by persons served in that system.

Services must also be designed to meet persons and families where they are with regard to personal circumstance, culture and ethnicity. This may require addressing the comprehensive needs of individuals and families such as housing, physical health, and/or substance use. Frequently the offer of mental health treatment alone may be refused or less than successful. Instead the offer of services and supports that address other essential needs first may lead the individual and/or family to accept mental health treatment. Whether services and supports are provided by mental health or other types of providers, mental health acting as a single point of responsibility for the service needs of those with the most complex and comprehensive needs results in integrated, more effective services.

In a transformed mental health system:

1. MHSA values, including the focus on recovery and resiliency, are the foundation of all public mental health programs.
2. Each county has a client and family task force or similar body reporting to the county mental health director on all program planning.
3. Programs and services are “integrated” with an identified single point of responsibility for service planning.
4. Services are voluntary in nature.
5. Services are designed to foster independence.
6. Programs and services are designed to consider various cultural/ethnic issues including delivering services where people live, in their own language and with regard to their economic situation.
7. Mental health systems aggressively recruit, train and employ persons with lived experience including those from underserved and/or inappropriately served cultural/ethnic populations.
8. System resources are dedicated to supporting client-run services including services provided by underserved and/or inappropriately served cultural/ethnic population groups.
9. Fiscal and organizational resources are available to client-run groups and organizations.
10. All mental health systems have eliminated or have a timeline for eliminating seclusion and restraint.
11. All mental health systems have alternatives to crisis services that utilize a “soft intervention” mode.

12. All mental health systems have processes for “whistle-blowing” that ensure no retaliation.

MHSA Provisions Related to Mental Health Program and Service Delivery:

1. Section 2(e) of the Findings and Declarations Section provides, in part, “With effective treatment and support, recovery from mental illness is feasible for most people.”
2. WIC Section 5813.5(d) provides “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
 - (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
 - (2) To promote consumer-operated services as a way to support recovery.
 - (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
 - (4) To plan for each consumer’s individual needs.”

Housing

The MHSA suggests that programs that have previously demonstrated their effectiveness in California be expanded with MHSA funds. One of the effective programs cited was the AB 34 program for homeless adults in California, nationally recognized as a “housing first” program. Housing first programs are generally characterized by the prioritization of housing services for individuals being served over their acceptance of mental health treatment. What became apparent in AB 34/2034 programs was the therapeutic significance of having a stable place to live and the foundation this provides for individuals’ ability and desire to make progress in other aspects of their lives. Outcomes from these programs documented significant reductions in homeless days, hospital days and jail days for the persons being served. One factor that made AB 34/2034 programs unique and successful was their ability to use program funds in a flexible way to subsidize and/or support housing for persons coming from the streets, hospitals and jails.

Given the understanding that flexible program dollars and fiscal housing supports are a critical element of effective programs, MHSA funds were identified to support specific types of housing available under the Community Services and Supports (CSS) component of the MHSA. Within CSS, MHSA funding supports various types of housing including Full Service Partnership housing, General System Development Housing, and the MHSA Housing program. Among the types of housing offered are subsidized rental units, rental units Master Leased by the county or contract provider, and affordable community housing units available as a result of the MHSA Housing projects developed. Even with the MHSA’s significant investment in increasing housing resources and supports, barriers remain.

In a transformed mental health system:

1. Typical resistance (Not in My Back Yard – Nimby-ism) to having clients and families living in various communities is reduced and when encountered overcome with effective engagement strategies.
2. Different types of housing and the amount of housing available is increased for families and individuals to share including housing for persons from underserved and/or inappropriately served cultural/ethnic population groups.
3. There are increased resources to finance affordable housing for persons with mental illness and/or their families.
4. Rules and regulations do not inappropriately prevent family members without mental health diagnoses from sharing housing with a family member receiving mental health services.
5. Support services are available for persons in all types of housing.
6. The mental health system provides for peer staff, volunteer and paid, in all types of housing, including crisis housing. This includes peer staff from underserved and/or inappropriately served cultural/ethnic population groups.
7. In-home-support services are widely available.
8. Property management firms working with housing units available to persons with mental illness and/or their family have experience with and/or are educated about the population being served including those from underserved and/or inappropriately served cultural/ethnic population groups.
9. Understanding of HUD regulations is increased in the community.
10. There are processes in place to protect persons from losing their housing when they are hospitalized.
11. Housing is available for persons with multiple disabilities: including but not limited to physical, substance use and/or mental illness.
12. Clients with criminal records or credit issues have less difficulty securing housing because property management firms and others are familiar with waivers or accommodations frequently offered to persons with mental health issues.
13. Increased numbers of collaborative groups working on housing projects (partnerships) are established.
14. The mental health system provides for recovery and respite housing as an alternative to hospitalization.
15. Counties and the State collect and track information related to the outcomes of MHSA and other housing for persons with mental illness and their families.

MHSA Related Provisions for Housing:

The Act identifies homelessness as one of the negative outcomes of untreated mental illness and the reduction of homelessness as one of its major goals.

Section 2(d) of the MHSA, provides, in part, “The people of the State of California hereby find and declare in a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the street homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe

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mental illness. We can and should offer these people the care they need to lead more productive lives.”

WIC Section 5840(d) indicates that the Prevention and Early Intervention program shall identify strategies to reduce the negative outcomes of untreated mental illness including homelessness.

Employment:

Among evidence-based practice programs and other recovery-focused programs, employment has long been recognized as significant to a person’s recovery. In turn, this personal achievement is magnified in its effect on the persons and systems surrounding the individual. Expectations from many are still that employment is an unreasonable goal for the majority of persons with mental illness. For the person receiving services, the expectation may be that the system has little to offer them in terms of improving their own quality of life outcomes, and their personal recovery. When someone does become successfully employed or involved in other meaningful activity, expectations are raised for everyone, the individual receiving mental health services and the community around them. As such, employment is a significant factor in reducing stigma in both the eyes of the mental health system and the community. This is true whether the employment is in the mental health system or in the general community workforce.

When one individual with life experience becomes successfully employed in the mental health system the positive results on the system are numerous. The success is positive for the person now employed, for persons receiving services who may now deal with a fellow client as a service provider, for fellow workers who may raise their expectations for all the persons they serve, and for administrators and policymakers recognizing the value and contribution of the employee.

When one individual with life experience from an underserved and/or inappropriately served cultural/ ethnic group becomes successfully employed in the mental health system the benefit is not only all the positive results noted above but the added success of strengthening relationships between the mental health system and various cultural/ethnic populations. When there are as many individuals with life experience successfully employed in the mental health system as those without, the result will be transformation.

In a transformed mental health system:

1. Employment or other productive activity is a standard expectation for persons receiving mental health services.
2. Mental health services include a focus on employment both within and outside the mental health system.
3. Lived experience is highly valued throughout the system and acknowledged as an element of quality improvement when included in service delivery.
4. Training in peer support and peer support standards are standardized across programs and the state.
5. Persons with lived experience are included in hiring processes at all levels.

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6. Clients and family members, including those from underserved and/or inappropriately served cultural/ethnic groups are supported to become employed at all levels in the mental health system.
7. Clients and family members, including those from underserved and or inappropriately served cultural/ethnic groups are employed throughout the mental health system to collect and report various types of outcome information from individuals being served as part of local and/or state evaluation efforts.

MHSA Provisions Related to Employment:

1. WIC Section 5813.5(d) (2) provides, in part, “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: . . . (2) To promote consumer-operated services as a way to support recovery.”
2. WIC Section 5822 provides for what the Department of Mental Health shall include in its 5-Year Education and Training Plan.

Included is the following:

- (g) Promotion of the employment of mental health consumers and family members in the mental health system.”

Education

Education, like employment, cannot be underestimated in being significant to recovery and leading to improved life outcomes for individuals and the community. Education may be essential for persons whose goals include employment that will result in earning a living wage and perhaps foregoing Social Security Income (SSI). Although some supported education programs existed prior to the MHSA, most counties did not include a focus on education in their service planning. Similar to employment, in the minds of many clients and service providers, education is not considered a realistic goal. Stigma is a frequent barrier for someone with mental illness seeking an education that will prepare them for employment. There is also a lack of information about careers in the mental health system for persons with lived experience, including those from underserved and/or inappropriately served cultural/ethnic populations, and the schooling necessary to be prepared for such a career.

In a transformed mental health system:

1. Mental health programs include a focus on education and/or employment.
2. System resources support working with educational institutions to reduce stigma about mental health clients going to school and to promote positive educational outcomes.
3. Program staff support education goals for clients, including being aware of appropriate accommodations that may be offered for persons going to school.

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4. Program services include education about career ladders in the mental health system for persons with lived experience including those from underserved and/or inappropriately served cultural/ethnic populations.
5. An assessment tool to evaluate “lived experience” is available to mental health systems in California to utilize in their hiring practices.
6. Education and employment services establish goals that result in clients earning a living wage.
7. All institutions of higher learning have mental health peer support groups on their campuses.
8. Educational scholarships are available to people with lived experience including those from underserved and/or inappropriately served cultural/ethnic populations.

MHSA Provisions Related to Education:

WIC Section 5822 provides for what the Department of Mental Health shall include in its 5-Year Education and Training Plan.

Included are the following:

- (d) Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce and reduce stigma associated with mental illness.
- (e) Identify strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

Prevention and Early Intervention (PEI)

The inclusion of funding and services focused on Prevention and Early Intervention is one factor that makes the MHSA unique and contributes to the national attention the Act has received. The MHSA requires that 20% of MHSA funds be spent on PEI services intended to improve timely access for underserved and/or inappropriately served populations and reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Homelessness
- School failure or drop-out
- Removal of children from their homes
- Incarceration
- Unemployment
- Prolonged suffering

Frequently lack of understanding and education about mental health issues, combined with stigma and discrimination, prevent persons and families from seeking PEI services that could prevent negative life outcomes. Statewide PEI funds are available to develop programs and major campaigns focused on suicide prevention, stigma and discrimination reduction, student mental health and the reduction of disparities in access for underserved and/or inappropriately served cultural/ethnic groups. It is essential that these programs and campaigns feature persons with lived experience including persons from underserved and/ or inappropriately served cultural/ethnic groups. Additionally, if both outreach and service interventions are provided by persons with lived experience, including those from cultural and ethnic communities, then hesitance to accept services may be successfully overcome and negative outcomes avoided.

In a transformed mental health system:

1. Long term strategies and campaigns aimed at reducing stigma and discrimination toward persons with mental illness or serious emotional disturbance in California have been successfully developed and promoted for many years.
2. Stigma and discrimination that is cultural, systemic, and personal is significantly reduced.
3. Information regarding prevention and early intervention is widely disseminated and available including to persons from underserved and/or inappropriately served cultural/ethnic communities.
4. People are educated and made aware of the full range of prevention and early intervention services available.
5. The full range of assistance, including peer support, is available for early intervention when an individual experiences the early signs of potentially severe and disabling mental illness.
6. Support is provided for dignified approaches for early interventions that do not undermine hope for the future.
7. Information is given to at-risk children and transition-age youth so they are better able to understand their own mental health experience.

MHSA Provision Related to Prevention and Early Intervention:

1. WIC Section 5840 (b) (1) provides, "The [PEI] program shall include...(1) Outreach to families, employers, primary care health providers, and others to recognize the early signs of potentially severe and disabling mental illnesses."

Stigma, Abuse and Discrimination:

Dynamics involving the abuse of people with lived experience of mental health challenges, as well as stigma and discrimination towards such people, their family members and the mental health professional community, are pervasive across lines of community, ethnicity, economic class, profession, media and popular cultures.

The barriers resulting from these dynamics cause great harm to groups and individuals, impede knowledge of and access to much needed services, prevent a broader

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understanding of mental health and the communities affected by mental health challenges, and block individuals from achieving their life aspirations in areas including career, housing and education.

With MHSA funds a concerted effort can be made to educate people through exposure to relevant facts, statistics and other information, including the perspectives of people with a lived experience of mental health challenges and their family members. These efforts should create opportunities for direct and substantial interaction between persons with lived experience and the communities where they live.

Additionally enforceable policies and mechanisms need to be created, where needed, to address both specific and systemic instances of discrimination and abuse while preventing retaliation against those who seek to use them.

In a transformed mental health system:

1. Clients and family members, including those from underserved and/or inappropriately served cultural/ethnic groups are employed at all levels in the mental health system.
2. Linguistic barriers are reduced through multilingual supports.
3. Persons with mental illness are accurately portrayed in the media resulting in reduced stigma, abuse, and discrimination.
4. Mental health systems and the media work in partnership to portray the successes experienced by persons with mental illness and the corresponding benefit to the community.
5. There are increased opportunities to reduce stigma by letting the public hear directly from persons with mental illness and their family members including those from underserved and/or inappropriately served cultural/ethnic groups.
6. The public are more aware that persons with mental illness are no more violent than the general population and are frequently the victims of violence.
7. The mental health workplace culture values client/family service recipients as whole individuals and not just as clients.
8. Persons with mental illness in residential or institutional care settings are not stigmatized due to their residence.
9. Housing supports are in place to reduce evictions that occur as a result of the behaviors of a family member with mental illness.
10. Physical healthcare policy includes mental health in a systematic way.
11. An increased awareness and understanding of existing laws and regulations protect individuals living with mental health challenges and their family members against discrimination, (i.e., persons under conservatorship have the right to vote.)
12. The compliance and enforcement of current anti-discrimination laws and regulations is promoted.
13. Current laws are routinely examined to ensure they are not adding to stigma and discrimination.
14. Persons with mental health issues and others in their community have the opportunity to interact and discuss mental health issues.
15. Teachers and family members are provided with tools to prevent bullying.

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16. Abuse is decreased through an increase in the ratio of patient's rights advocates to the population they serve in institutional and residential settings.

MHSA Provision Related to Stigma and Discrimination:

1. WIC Section 5840(b) (3) and (4) provide, "The [PEI] program shall include the following components: . . . (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. (4) Reduction in discrimination against people with mental illness."

Conclusion

The objective for the CFLC was to draft a policy paper suggesting ways the mental health system might account for and recognize system transformation that is client-centered, family focused and guided by persons whose life experience includes mental health challenges. As presented, this paper identifies elements of a system already transformed in the way it values, utilizes and promotes the voices and wisdom of clients and family members, including those from underserved and/or inappropriately served cultural/ethnic groups.

Clients and family members at the center of the transformation described will have experienced both the negative outcomes of untreated mental illness such as suicide, homelessness, incarceration, unemployment, school drop-out, removal of children from their homes and/or prolonged suffering, as well as positive experiences of wellness, recovery and resiliency. Their wisdom is essential to serving others with similar circumstances and critical to achieving positive outcomes for mental health systems and communities.

Even in a climate of constant change with both budgetary crises and healthcare reform, the MHSA stands out for both its vision and capacity to effect positive changes in California's public mental health system and for its community partners. One change essential to success is a mental health system increasingly guided and informed by individuals with a life experience of mental health challenges who have significant roles in that system.

The MHSOAC offers this paper as a reference for those seeking to create a "transformed" mental health system that is effective, efficient and critically informed by the voices and wisdom of clients and family members.