

Transformation of the Mental Health System Through Client and Family Leadership

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

Introduction

The Mental Health Services Act (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 insufficient, inequitable, unjust and, in some cases, abusive mental health practices of the past.¹ The MHSA replaces this legacy with services and supports informed by a recovery/resiliency model based in dignity and hope in which clients and families access and receive culturally competent, relevant, effective 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 a vision of recovery, resiliency and other revolutionary principles, the MHSA stands out as the first large scale mechanism with the capacity to accomplish the comprehensive "mental health systems transformation" called for by leadership across the nation.

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*², 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.

Beginning in the 1960s many progressive efforts to create and advance better supports for mental health had been initiated. The scope of change these new efforts called for, however, must be thought of in terms of transformation because the model of recovery and

¹ "Client" as recognized by the CFLC is a very imperfect term. As referenced herein it should be construed to mean anyone who is or has been a recipient of services for mental health symptoms or conditions, including the focal population (for MHSA purposes) as recipients of public system services, many of whom are in recovery, some of whom are disabled for long or short terms. The other term of "mental health consumer" is preferred by some as more generic across the country but the CFLC has chosen to employ this one in order to cohere with the language of the MHSA. "Family member" should be interpreted broadly herein to include not only parents, children and relatives of clients or those in need of services who have not for one reason or another received them, but also parents of young children associated with serious emotional disorders (SED) which do not fall within the diagnostic spectrum of mental illness for adults and which are often receiving services from multiple entities such as schools, foster care and juvenile justice. Additionally it is important to the CFLC that family member embraces caregivers, non-related adoptive and foster parents and culturally grounded caregiving relationships among extended family, etc.

² 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.

DRAFT
5-6-11

resiliency, based on startling findings about what makes a difference for people challenged by mental illness symptoms³, represents a reversal from the institutional containment, symptom-management and deficit focus approaches of prior eras, to community-based services and supports that foster independence and promote individual strengths and goals.

Transforming massive and complex systems of care and services away from long-held beliefs and entrenched practices, however, requires risk where risk-aversion is the norm. Broad-scale efforts, top-level leadership and public support and focused resources are essential to such a program and, for the most part, these did not exist anywhere in the nation.

Meanwhile in California, recovery-based initiatives driven by clients and family were making significant progress. Assembly Bill 3632 (AB 3632) programs, founded in 1984 through the work of mental health advocates who were parents of children in need, established a commitment statewide to the provision of services to school children with serious emotional disorders. In 1989, California Assembly Bill 3777 (AB 3777), developed through the leadership and hard work of two California parents of adults with mental illness, Dan Weisburd and Rose King, created pilot programs for adults to demonstrate outcomes in the delivery of community based, client directed, recovery focused services

Subsequent innovative efforts were spearheaded by advocates and such leaders as then, Assembly Member, later-Senate President Pro Tempore, Darrell Steinberg, which included AB 34 and AB 2034. These bills funded client-centered programs in 32 counties and two cities across California. The remarkable achievements of these outcome-based projects showed how recovery-based services and supports led to significant reductions in hospitalization, incarceration and homelessness.

Proposition 63, the Mental Health Services Act (MHSA), based on these successful initiatives, was approved by the voters in 2004 to fund these new model mental health programs across the state. Across the nation then, the MHSA, with its focused resource vision, was viewed as the first state-level effort to include all of the elements that could realize transformation including services for prevention and early intervention, efforts to expand and transform the mental health workforce, investments in technology and infrastructure and a commitment to innovation. The MHSA offered the way for California, to show that the promise of transforming mental health care in America *could* be achieved.

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

In addition no discussion of progress in the arena of public mental health or social change in America today can be thorough without acknowledgment of the role of race, culture and

³ American Journal of Psychiatry, 1987, Harding, Brooks, Ashikaga, Strauss and Breier

DRAFT
5-6-11

ethnicity and the history of disparities associated with these. Not all races or cultures see mental health issues, symptoms or recovery in the same way. This, along with history of discrimination, racial injustice and trauma, has fostered systems in which disparities of access to and quality of care leave many communities un-served, underserved or inappropriately served. The numerous races, languages, and cultures of California in particular demand that mental health transformation address client and family needs in the context of diversity and cultural-effectiveness. 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 ways that eliminate disparities in access to and quality of care, and create successful outcomes for all individuals and families being served.

The California Mental Health Services Oversight and Accountability Commission (MHSAOAC) 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. This guidance combined with a continuous focus on outcomes for programs, systems, individuals, families and communities will inform mental health policies and service delivery and provide information about how the MHSA has changed California's public mental health system over time, i.e. -whether transformation has in fact taken place.

What is certain is that the massive wave of change initiated through the MHSA continues. MHSA programs are fostering innovation, doing new and better things across California and doing them in different ways. The combination of this with today's budgetary crises, healthcare reform and other challenges ensures the pace of these changes will not slow.

Every informed policy discussion on the vision of a transformed mental health system highlights the crucial role of involving people whose lives have been directly affected by mental illness at all levels of policy, planning and service implementation. The MHSA was designed to ensure this engagement at the local level, and the MHSAOAC was committed a-priori to this as an operating principle, as evidenced in the Commission's membership, the work of the Client and Family Leadership Committee (CFLC) and the many active efforts to engage people with lived experience across the spectrum of MHSAOAC efforts.

Though it may not be clear for some time whether a comprehensive transformation has occurred in California, it is clear that transformative changes have happened through the MHSA. The goal of the present document is to help us notice signposts along this path of change. It is not within our scope here to identify the entire universe of elements that could transform mental health systems. What is offered here rather, as a contribution to other bodies of work with similar goals is something of a snapshot-- a vision of mental health system transformation as seen through the eyes of client and family leadership that identifies many critical elements that may be used to measure results.

The hope of the CFLC is that further investigation and discussion along these lines will inspire increased client and family leadership as envisioned by the MHSA. As a result, where the MHSA vision is embraced here in California or elsewhere, more client and family member expertise will be brought to the fore, and more stakeholders will be inspired. These partnerships are necessary to transformative change. They are the best resource to engage the difficult and crucial work of transforming our communities into

DRAFT

5-6-11

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.

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DRAFT

5-6-11

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 illness and thereby improve outcomes for individuals, families and communities.

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, family-focused, culturally competent, wellness focused, 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 from clients and family members in planning and service delivery, cultural and linguistic competence and effectiveness, services and supports that are comprehensive, integrated and focused on wellness/recovery/resiliency, housing, prevention and early intervention services, funding for innovation and resources for workforce education and training to enable new best practice programs to be realized. Although the word "transformation" is not used in MHSA statutes, the perception of many, particularly clients and family members, has been that transformation is both a goal and expectation for the MHSA. 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? What are the most significant elements of transformation? A primary goal of the MHSOAC is to utilize evaluation efforts to answer these questions and measure progress toward achieving specific MHSA goals that can be associated with transformation.

At the July 2010 MHSOAC meeting, Commissioner Vega made a presentation to the Commissioners, staff and public 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 racial, linguistic, cultural and ethnic backgrounds, advocates, service providers, policy leaders, youth and older adults and people with multiple disabilities.

DRAFT
5-6-11

In response to its July 2010 charge, the CFLC convened to create the present document 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 illness, including those from underserved ethnic and cultural communities. One general topic affecting all others was choosing preferred, inclusive language and terminology when referring to clients and family members. Of primary importance to the CFLC was that the language used show dignity and respect for the individuals being mentioned. There was discussion about whether to refer to “persons with mental illness”, “persons with mental health challenges”, or “persons with lived mental health experience”. As written this paper utilizes all of these terms in a spirit of maximum respect.

Related discussions and input dealt with the need to use inclusive terminology when referring to clients and family members. Input was received about the need to acknowledge age when referring to clients and family members and include clients and family members “across the life span”. With regard to family members, because children and youth frequently have non-family members acting as caregivers, the CFLC agreed that references to family members should include “persons acting as caregivers”. Rather than repeat this acknowledgement throughout the document a footnote addressing these concerns is found on Page 8.

Other discussions and input dealt with the need to expand references to “underserved” populations to include: (1) populations that have been “inappropriately served” over time such as Native Americans and frequently African Americans; and (2) those persons or populations that may never have been served and as a result never become “clients and family members”. This paper addresses both of these concerns.

Additionally, clients and family members with the lived experience of the co-occurring disorders of mental illness and substance use, are identified as a “cultural group” that is “underserved and/or inappropriately served. The co-occurring conditions of mental illness and substance use are highly prevalent and frequently not addressed in a coordinated way by mental health and alcohol and drug programs. Numerous studies demonstrate that integrated care is necessary for successful treatment of co-occurring disorders however the availability of comprehensive, integrated treatment for mental health and substance use problems is currently the exception rather than the rule. As a result individuals with co-occurring mental illness and substance use are among California’s most underserved and/or inappropriately served groups. The unmet need for integrated mental health and substance use treatment in underserved racial and ethnic communities is even greater.

Over several months, the CFLC met to examine the many questions raised in their discussions 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.

The CFLC’s goal was to present a picture of how things would look in a transformed mental health system informed through client and family leadership. As part of that process and discussion the committee identified areas of the mental health system they wanted this paper to address and barriers in each of those areas that would have to be overcome for transformation to occur. In the end this paper presents a vision of how

DRAFT

5-6-11

things would look in a transformed mental health system in the following 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 the major elements of a vision for 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.

As presented, this paper developed by the CFLC first identifies broad goals by subject area for transforming the mental health system through client and family leadership. (Pages 8 – 11) The paper then examines what it would take to achieve those goals. Specific aspects of change are identified including barriers to be overcome to meet the identified goals and create an ideal “transformed system”. (Pages 12 – 27) Additionally the paper identifies MHPA statutory provisions and language relevant to each subject area discussed.

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 and expertise of persons with lived experience including those from un-served, underserved and/or inappropriately served racial, ethnic and cultural groups and
 2. robust and ongoing regardless of fiscal issues.
- Clients and family members from served, un-served, underserved and/or inappropriately served⁴ community groups set local mental health goals and resource priorities.

Goals for Policymaking:

- Clients and families including those from un-served, underserved racial, ethnic, cultural communities, drive mental health system policymaking.
- Mental health policy is continuously informed by culturally-relevant wellness, recovery, and resiliency principles, the lived experience of clients and family members, including those from un-served, underserved and/or inappropriately served racial, ethnic, cultural communities, community needs and values, and evidence from ongoing outcome evaluation.
- Clients and family members have active roles in ongoing local and statewide efforts to evaluate mental health services, analyze client and system outcomes, and ensure that the findings are used to inform future funding and program decisions.

Goals for Cultural Competence and Effectiveness:

- As a result of individuals with mental health challenges, from un-served, underserved and inappropriately served racial, ethnic, cultural populations, being employed by or working in collaboration with the mental health system at all levels:
 1. the mental health community has an understanding of how racial, ethnic and cultural groups view mental health issues and services.
 2. racial, ethnic and cultural groups have a better understanding about mental health issues and mental health services.

⁴ References to “underserved and/or inappropriately served” cultural groups includes clients and family members with the lived experience of mental illness and substance use as co-occurring conditions.

3. outcomes document that:
 - historical discrimination and barriers to access for racial, ethnic, cultural groups are diminished
 - a vision of culturally-relevant wellness, recovery and resiliency is evident: (1) in the public systems serving racial, ethnic and cultural communities; and (2) in those communities.
4. The mental health workforce is a blend of persons with and without lived experience including those from underserved and/or inappropriately served racial, ethnic, cultural populations.
5. 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, regardless of the setting are strength-based, and 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, promote self-determination, and employ respectful and effective intervention modes.
- Clients and family members have access to and receive services that are relevant to their age, race, ethnicity, culture and/or specific cultural circumstance such as homelessness.
- Services are designed to support clients where they are. As such, services, supports and training are provided for persons at all stages of recovery including those that have not been served in the mental health system previously.
- Clients and family members are provided with what they need to recover in an integrated and supportive network of care that addresses their comprehensive needs, such as housing, physical health, or presence of co-occurring conditions such as mental illness and substance use and/or physical disability.
- Outcomes document improved life outcomes for clients and family members and improved system outcomes for mental health and its community partners.
- Clients and family members are fully empowered in all program settings.
- Programs designed and run by clients and family members are an integral part of the mental health system.
- Services for children and youth are strength-based, wellness/recovery/resiliency focused, family-centered, and needs driven.

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, supportive 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 and Community Workforce:

- Clients and family members, including those from underserved and/or inappropriately served racial, ethnic, cultural groups, are recognized for the value of their lived experience and are employed in significant roles throughout the mental health system and community workforce.
- 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.

Goals for Education:

- The mental health system views education and the necessary supports to advance job skills and return to the community 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 or other relevant service systems.
- There are no systemic barriers to persons with lived mental health experience completing higher education programs that prepare them for employment in the community workforce.
- Outcomes document that persons with lived mental health experience or at risk of mental illness are able to meet their educational goals.

Goals for Prevention and Early Intervention:

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

Goals for Reduction in Stigma, Abuse and Discrimination:

- People with mental health issues are included and supported in living full and meaningful lives within the communities of their choice and stigma does not lead to social exclusion or isolation for anyone.
- Mental illness, in its various forms, is demystified at the basic level of human understanding so that those with mental illness are seen as fully a part of the human community with hopes, dreams, and fears like everyone else.
- Stigma does not prevent persons from seeking help with mental health issues, family well-being, and personal recovery for the individual.
- Through empowerment and strength-based programs the internalized stigma (i.e., shame, guilt, low self-esteem and low self-efficacy) of persons with mental health issues and their families is reduced.
- 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, social or civic activities and communities in general.

Transformation – What Will It Take?

So far this paper has identified broad goals for transforming the mental health system through client and family leadership. The question remains, what exactly will it take in each of these areas to achieve those goals? What follows is a discussion of both the barriers to transformation in mental health systems and the identification of specific elements of change that could eliminate those barriers.

Community Planning Processes

Community planning processes are integral to mental health systems understanding the impact of their 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 racial, ethnic and cultural populations that are un-served, underserved and/or inappropriately served. Although “inclusion” of clients and family members from multiple backgrounds in community planning is one goal being sought, the truth is that what persons with lived mental health experience bring to the table cannot be found elsewhere. Community planning efforts and their eventual outcomes improve when informed by the perspective of persons with lived mental health experience. That experience includes firsthand understanding of: (1) mental illness; (2) the strength and capacity of persons with or at risk of mental illness; (3) how the system impacts the individuals it serves; (4) what services and supports are needed; and (5) what works. The MHSA clearly values the voices of clients and families⁵ 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 approximately 130,000 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 and county staff experienced burnout over time. While acknowledging that Counties did excellent work in organizing and implementing MHSA community planning processes across California, we know that frequently stakeholders, particularly those from un-served, underserved and/or inappropriately served racial, ethnic and cultural communities, were expected to participate in planning activities while experiencing a lack of comfort and familiarity with the process, an inability to take time off from work, a lack of transportation or child care, and a lack of translation or other cultural supports. Continuing to engage and maintain the interest of stakeholders who have previously been part of the process, while reaching out to new

⁵ All references to clients and family members include family members acting as caregivers and include clients and family members across the life span from un-served, underserved and/or inappropriately served racial, ethnic, cultural populations.

stakeholders, is challenging. However as discussed above, the benefit is worth the effort. Although stakeholder outreach and support may become even 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 understand the value of listening and learning from persons with lived mental health experience and how this contributes to establishing programs and services that produce the best life outcomes for the persons served which in turn translate to positive, cost efficient system outcomes
2. Clients and family members involved in community planning processes, including representatives of underserved and/or inappropriately served racial, ethnic or cultural groups, are able to revisit earlier discussions and input before any prospective use or non-use of their input is finalized and are engaged in all phases of planning, implementation and evaluation.
3. It is acknowledged that learning is mutual between mental health systems and clients and family members engaged in community planning processes.
4. 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.
5. Counties commit adequate resources to support community planning efforts including outreach, and the supports necessary to encourage and increase stakeholder involvement. Fiscal problems do not translate to less of an investment in community planning and stakeholder involvement.
6. Opportunities for stakeholder input are characterized by open two-way communication whereby information is solicited and provided.
7. Outreach continues to increase to existing stakeholders and community groups, persons with lived experience including those from un-served, underserved and/or inappropriately served racial, ethnic, cultural 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.
8. Improved outreach to un-served, underserved racial, ethnic and cultural populations is enhanced by collaboration with partners and community leaders from those communities.
9. Smaller focus groups or meetings within racial, ethnic and cultural communities are held in languages other than English to expand the ability to obtain stakeholder input from un-served, underserved and inappropriately served populations that do not speak English.

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 racial, ethnic and cultural communities. As a result, policies and procedures are sometimes developed without an understanding of and commitment to the wellness/recovery/resiliency model, without knowledge about the needs of specific racial, ethnic and cultural populations, without outcome information and generally without information from key informants that could improve overall individual, family and system outcomes. Frequently clients and family members lack the information, education, and/or resources 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 racial, ethnic, cultural 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. Persons with lived mental health experience are included in the hiring processes of mental health systems and as such participate on interview panels for positions at all levels of the system.
3. Clients and family members not employed in policymaking positions, including those from un-served, underserved and/or inappropriately served racial, ethnic, cultural population groups, are offered the information, education and resources or supports necessary to effectively participate in policymaking activities.
4. System resources are dedicated to policy positions for those with lived mental health experience, advocacy training for clients and family members and mentorship of those leaders seeking to become policymakers.
5. Mental health policies are informed by ongoing local and statewide efforts to evaluate mental health services and analyze client, family, and system outcomes. Clients and family members including knowledgeable representatives from racial, ethnic and cultural communities have active roles in all these efforts
6. Clients and family members are frequently employed in the mental health system to contribute to evaluation design as well as collect and analyze various types of outcome data from individuals being served as part of local and/or statewide evaluations..
7. 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 expertise throughout the system.
8. As a result of a continuous dialogue, collaboration, and the information exchanged between policymakers and clients and family members, learning takes place among all participants and appropriate shifts in policy are implemented.

9. Policymakers openly disclose themselves as clients and/or family members without fear of stigma and discrimination.
10. To support the ongoing participation of stakeholders, mental health professionals and others employ strategies to level the playing field with clients and family members by avoiding the use of jargon or other confusing language, providing user-friendly materials, tutorials, mentoring, pre-meetings or other opportunities for education and/or questions and answers.
11. Interpretation services, translated materials and other cultural supports 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. Not all cultures see mental health issues, symptoms or recovery in the same way nor does the mental health community necessarily understand how those diverse groups view mental health issues and services. This, combined with a history of discrimination and trauma of racial injustice, has fostered disparities in access to system services and disparities in quality and outcomes of care for racial, ethnic and cultural 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 and that bring about positive mental health outcomes for diverse individuals and families.

The many cultures and languages of Californians in particular require that broad-scale thinking and practice on mental health transformation address client and family needs in

DRAFT
5-6-11

the context of diversity and cultural-effectiveness. As used here “cultural effectiveness” means that services provided to members of a community are effective within the natural context of that community. Simply translating materials or providing cultural competence training to providers does not ensure that services and supports are effectively serving people. To effectively serve racial, ethnic and cultural populations requires the development of thoughtful, collaborative relationships with each un-served, underserved and/or inappropriately served community group.

In a transformed mental health system:

1. The mental health system has engaged and developed successful relationships with all of the racial, ethnic and cultural communities who were historically un-served, underserved and/or inappropriately served.
2. There are mental health service providers and/or programs in every county from traditionally un-served, underserved and/or inappropriately served racial, ethnic and cultural communities.
3. What have been traditional disparities in access to and outcomes of mental health services for un-served, underserved and/or inappropriately served persons from racial, ethnic, and cultural 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. It all begins with the level of engagement between providers and the persons they serve. The typical dimensions of power that place the provider in the position of expert and the client and/or family members in the position of having to go along with the expert’s plan, do not promote successful outcomes for systems or the persons they serve. Clients and family members must share power with service providers, have choice and participate fully in shared decision-making.

Additionally, a sincere understanding of and commitment to recovery and resiliency should be both obvious and practiced in all 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 wellness, recovery and resiliency, individuals and families being served by the system are less likely to achieve those outcomes. Individual and system actions must include providing services with dignity and respect for the individuals being served from the first moment of engagement on. Consistent with engaging individuals with dignity and respect, restraint and involuntary seclusion must be eliminated and replaced with more respectful and effective intervention modes.

Evidence of “the recovery model” is present in mental health systems when large numbers of persons with lived mental health experience are employed in the system, client-designed, 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, priorities, race, ethnicity and culture. This may require addressing the comprehensive needs of individuals and families such as housing, physical health, and/or co-occurring 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 and be able to make effective use of 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. This includes mental health systems working in collaboration with law enforcement and the courts to provide services that when appropriate result in persons diverted from jail to programs that support their recovery and meet their comprehensive needs.

In a transformed mental health system:

1. MHSA values, including the focus on wellness, 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 that includes clients and family members from racial, ethnic and cultural communities, reporting to the county mental health director on all program planning and to the local mental health board or commission.
3. Programs and services are “integrated” at the level of the service experience for clients and family members, with an identified single point of responsibility for individual service planning and commitment to outcomes.
4. All mental health systems work with law enforcement and the courts to provide jail diversion programs for persons with mental illness or the co-occurring conditions of mental illness and substance use.
5. Systems have successful strategies for meeting persons where they are including positively engaging persons with symptoms of untreated mental illness.
6. Persons at all stages of recovery have the services, supports and/or training necessary to live successfully in the community.
7. Services are voluntary in nature.
8. Services foster self-determination.
9. Programs and services consider various racial, ethnic and cultural issues including delivering services where people live, in their own language and with regard to their economic situation.
10. Mental health systems proactively recruit, train and employ persons with lived mental health experience including those from un-served, underserved and/or inappropriately served racial, ethnic, cultural populations.
11. Training in peer support and peer support standards are standardized across programs and the state to support the employment of persons with lived experience in mental health or other relevant systems.
12. System resources are dedicated to supporting programs and services designed and run by clients and family members, including family members of minor children, and underserved and/or inappropriately served racial, ethnic, cultural/ population groups.
13. Fiscal and organizational resources are available to client-run groups and organizations.
14. All mental health systems and schools have eliminated restraints and involuntary seclusion.
15. All mental health systems have alternatives to crisis services that utilize respectful and effective intervention modes.
16. All mental health systems have processes for “whistle-blowing” and resolving issues 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 that best met the needs of persons coming from the streets, hospitals and jails, frequently with the co-occurring conditions of mental illness and substance use. Consistent with identified “best-practice” programs⁶, several AB 34/2034 programs developed different types of housing for persons with the co-occurring conditions of mental illness and substance use based on where an individual was in their recovery. Types of supported housing available for clients to choose from could include abstinence-required, abstinence-encouraged or “wet” meaning abstinence is not the immediate goal of the person being served. The evidence of program success is in the outcomes documented for these programs which showed that the approximately 5,000 persons served in these programs through January 2004 experienced: a 71.5% reduction in homeless days; a 75% reduction in jail days; and a 61% reduction in hospital days

⁶ “Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-occurring Disorders”, Minkoff and Cline, 2004

Given the understanding that flexible programs, flexible program dollars and fiscal housing supports are critical elements of effective programs leading to positive and measurable mental health outcomes, 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 eliminated or reduced and, when encountered, overcome with effective engagement strategies.
2. Everyone with a serious mental illness has stable housing that reflects their priorities, such as living alone, living with family, or living in shared housing.
3. 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.
4. There are sufficient resources to finance affordable housing for persons with mental illness and/or their families.
5. Rules and regulations do not inappropriately prevent family members without mental health diagnoses from sharing housing with a family member receiving mental health services.
6. Support services are available for persons in all types of housing.
7. 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 racial, ethnic, cultural population groups.
8. In-home-support services are widely available.
9. 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 previously un-served, underserved and/or inappropriately served racial, ethnic, cultural population groups.
10. Persons with mental health challenges do not experience discrimination in housing as a result of their illness.
11. Community members with mental health challenges, mental health service providers, housing providers, property managers and landlords understand HUD regulations.
12. There are processes in place to protect persons from losing their housing when they are hospitalized or experience short-term incarceration.
13. Housing is available for persons with multiple disabilities: including but not limited to developmental, physical, and/or substance use co-occurring with mental illness.
14. Clients with criminal records or credit issues are able to secure housing because property management firms and others are familiar with waivers or accommodations frequently offered to persons with mental health issues.

15. Adequate numbers of collaborative groups working on housing projects (partnerships) are established.
16. The mental health system provides for recovery, respite and crisis housing as an alternative to hospitalization.
17. People with serious mental illness who participate in housing programs experience wellness, recovery, resilience, and other positive life outcomes.
18. 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 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:

Although MHSA provisions speak only to the goal of “promoting the employment mental health consumers and family members in the mental health system” and do not reference employment in the community workforce as a goal for persons served in the mental health system, this paper includes the general goal of “employment in the community workforce or other productive activity” as a focus for services and supports.

With this said it must be noted that the intent is not to externally impose the goal of employment as a mandate or condition of service, but to establish a service or program atmosphere that identifies and promotes the goals, possibilities and capacity of clients and supports their efforts to become meaningfully employed.

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. A significant element of stigma is the fact that 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

DRAFT

5-6-11

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.

In addition to the general value of employment as a key element of recovery, there are particular systemic benefits, including stigma reduction, when people with experience of mental illness are employed throughout the mental health system. 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 racial, ethnic or cultural 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 racial, ethnic cultural 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 and outcome for persons receiving mental health services.
2. Mental health services include a focus on and help bring about 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. An assessment tool to evaluate "lived experience" is available to mental health systems in California to utilize in their hiring practices.
5. Clients and family members, including those from underserved and/or inappropriately served racial, ethnic, cultural groups are employed at all levels in the mental health system and are appropriately supported once employed.
6. Mental health staff and other community partners are trained to respect and learn from those with lived experience.
7. Clients and family members, including those from underserved and or inappropriately served racial, ethnic, cultural 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. This form of stigma is a frequent barrier for someone with mental illness seeking an education that will prepare them for employment. For clients whose career goals include working in the mental health system, there is also a lack of information about careers for persons with lived experience, including those from underserved and/or inappropriately served racial, ethnic, cultural 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 and facilitate attainment of 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.
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. Mental health services include supports for education and employment that establish goals and result in clients earning a living wage.
6. All institutions of higher learning have mental health peer support groups and other supports for students with mental illness on their campuses.
7. Educational scholarships are available to people with lived experience including those from underserved and/or inappropriately served cultural/ethnic populations.
8. Higher education systems and persons working in higher education settings are:
(1) trained and educated about mental illness and related challenges; and (2)

systematically include persons with lived mental health experience in their planning, program-design and program-delivery.

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 services⁷ intended to: (1) improve timely access for underserved and/or inappropriately served populations; (2) provide outreach to families, employers, primary health care providers and others to recognize the early signs of potentially severe and disabling mental illness; (3) reduce stigma associated with mental illness; (4) reduce discrimination toward persons with mental illness or emotional disturbance and their families; and (5) 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 suffering⁸

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 resulting from mental illness. Statewide PEI funds are available to develop programs and major campaigns focused on suicide

⁷ Welfare and Institutions Code Section 5892(a)(3)

⁸ Welfare and Institutions Code 5840 (a), (b) (1) (3) (4), and (d) (1) (2) (3) (4) (5) (6) (7)

DRAFT
5-6-11

prevention, stigma and discrimination reduction, student mental health and the reduction of disparities in access for un-served, underserved and/or inappropriately served racial, ethnic, cultural groups. It is essential that these programs and campaigns feature persons with lived experience including persons from un-served, underserved and/ or inappropriately served racial, ethnic, cultural groups. Additionally, if both outreach and service interventions are provided by persons with lived experience, including those from racial, ethnic, cultural 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 with demonstrated reductions in stigma and discrimination against persons with mental health challenges and their families.
2. Community members including family members, teachers, healthcare workers, law enforcement, employees of community-based organizations and others, have the knowledge, skills and access to resources to respond effectively and supportively when it appears someone may have mental health challenges.
3. Stigma and discrimination that is cultural, systemic, and personal is significantly reduced.
4. Information regarding prevention and early intervention is widely disseminated and available including to persons from underserved and/or inappropriately served racial, ethnic, cultural communities.
5. People are educated and aware of the full range of prevention and early intervention services available.
6. 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.
7. Support is provided for dignified approaches for early interventions that do not undermine hope for the future.
8. 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, race, ethnicity, economic class, profession, media and popular cultures.

The barriers that result from these dynamics cause great harm to groups and individuals, impede knowledge of and access to much needed services, prevent a broader understanding of and support for 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 racial, ethnic, cultural groups are employed at all levels in the mental health system.
2. Linguistic barriers are eliminated 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 racial, ethnic, cultural 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 and general public values client/family service recipients as whole individuals and not just as persons with mental health issues.
8. Persons with mental illness in residential or institutional care settings have the same rights, respect and privileges as anyone else.
9. Housing supports are in place to prevent 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 and accomplished.
13. Current laws are routinely examined to ensure they are not adding to stigma and discrimination.

DRAFT
5-6-11

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.
16. Abuse is eliminated partially 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, promote and recognize system transformation that is client-centered, family focused and guided by diverse persons whose life experience includes mental health challenges. As presented, this paper identifies elements of a system already transformed in the ways it values, utilizes and promotes the voices and wisdom of clients and family members, including those from un-served, underserved and/or inappropriately served racial, ethnic and cultural groups.

Clients and family members at the center of the transformation described will have experienced both the negative outcomes of 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. Two changes essential to success are a mental health system increasingly guided and informed by: (1) individuals with a life experience of mental health challenges who have significant roles at all levels of the system; and (2) individual, family, system and community outcomes including the cost effectiveness of services for mental health and its community partners.

The MHSAOAC offers this paper and the elements of transformation it identifies, 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.